HOMELESS DECLARATION

Patient Name: ____ Date of Birth: ______________________ Account#: _________________

As a Federally Qualified Heath Center and a HRSA homeless services grantee, Health Partnership Clinic (HPC) allows a provision for waiving charges for patients experiencing homelessness. Homelessness is defined by the U.S. Department of Health and Human Services in section 330(h)(5)(A) as:

1. An individual whose primary residence during the night is a supervised temporary public or private facility (i.e. shelters) and/or an individual who is a resident in transitional housing.
2. A homeless person is an individual without permanent housing who may live on the streets, stay in a shelter, mission, single room occupancy facility, abandoned building or vehicle or any other unstable or non-permanent situation.
3. An individual may be recognized a homeless if that person has instability in their living arrangements and is forced to stay with a series of friends and/or extended family members.
4. Individuals who are to be released from a prison or hospital may be considered homeless if they do not have a stable housing situation to which they can return.

Provide a brief explanation of your current living arrangements:

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Can you provide documentation supporting your homeless status? For example, letter from shelter or transitional housing authority, prison release document, etc.? ☐ Yes ☐ No [***If yes, please submit copy of documentation***]

If no, can you provide contact information for someone who can attest to status? ☐ Yes ☐ No

If yes, Name: ____ Phone Number: ________________________

<u>Declaration</u>

I understand that my signature confirms I am currently experiencing homelessness per the definition within this document and that Health Partnership Clinic may verify the information I have provided. I further understand the homeless status waiver is assigned temporarily and I will be required to update my status within 90 days of the date of this declaration.

Patient Signature ____ Date _______________________________

--- DO NOT WRITE BELOW THIS LINE-FOR HPC USE ONLY ---

Does the patient meet the HHS definition of homelessness? ☐ Yes ☐ No

If no, why not? ____

Staff Signature ____ Date _______________________________

<u>Patient Account Update</u>

☐ Patient status documented in eCW, structured data assigned, Homeless insurance carrier added in patient registration effective for 90 days, add as a Secondary Insurance if patient has health coverage.

☐ 90-day alert set on account: ______________________