VERIFICATION OF ELIGIBILTY: FOSTER YOUTH TO INDEPENDENCE

INSTRUCTIONS: This form identifies the Applicant's eligibility for the Foster Youth to Independence voucher program. One portion of the form must be completed by a Missouri Department of Social Services, Children's Division staff and the other by a supportive service provider. This form should be provided to the Public Housing Authority when making a referral for the Foster Youth to Independence voucher.

Applicant name: _____ **Date of Birth**:_____

This portion of the form may be filled out only by a person who is employed by the State of Missouri, Department of Social Services, Children's Division and is qualified to make the determination regarding state custody. The person completing this form (or their employer) must maintain appropriate documentation verifying the state custody.

☐ **Left foster care, or will leave foster care within 90 days, in accordance with a transition plan described in section 475(5)(H) of the Social Security Act at age 16 or older;**

This youth was in foster care from (date) ___/___/_____ to (date) ___/___/_____, aging out on their (age)_____ birthday.

I have personally verified the eligibility criteria specified above. I certify that the Applicant meets the eligibility criteria and should be referred to the Foster Youth to Independence program.

_____ _____
(Print Name of Person Verifying State Custody) (Signature)

Agency (required): _____ Date: _____

This portion of the form may be filled out by a person who is providing supportive services to the applicant and has the knowledge to make the determination regarding the statements below. The person completing this form (or their employer) must maintain appropriate documentation verifying the statements below.

☐ **Youth has attained at least 18 years and not more than 24 years of age;**

☐ **Is homeless or is at risk of becoming homeless as these terms are defined at 24 CFR 578.3 and 24 CFR 576.2, and has completed a coordinated entry assessment.**

I have personally verified the eligibility criteria specified above. I certify that the Applicant meets the eligibility criteria and should be referred to the Foster Youth to Independence program.

_____ _____
(Print Name of Person Verifying Age and Homelessness) (Signature)

Agency (required): _____ Date: _____