MARYLAND BEHAVIORAL HEALTH ADMINISTRATION
CONTINUUM OF CARE HOUSING PROGRAM
Documentation Checklist

Name: ________________ County: ____________ # of Bedrooms: ____________

Initial Application Process: PART I

___________ Intake form

___________ Verification of Disability

___________ Documentation of Homelessness

___________ Service Plan

___________ Disclosure of Legal History/Consent to Release Information

___________ Documentation of Legal History

___________ Signed Due Process Acknowledgement

___________ Participant Agreement

___________ Federal Privacy Act

___________ Household Composition

___________ HMIS Consent

___________ HMIS Release
BEHAVIORAL HEALTH ADMINISTRATION
CONTINUUM OF CARE PROGRAM
Intake Form

Application Date: ____________

Applicant's Name: ____________________________

Current Living Situation (check one and specify current program if appropriate):

_____ emergency shelter

_____ transitional shelter/housing

_____ place not meant for habitation (streets)

_____ fleeing or attempting to flee from domestic violence

_____ Safe Haven

_____ jail, prison, juvenile facility

_____ other specify: ____________________________

If currently incarcerated/ institutionalized 90 days or less, indicate living situation prior to incarceration or institutionalization:

_____ Street, park, car, bus station, etc.

_____ Emergency Shelter

_____ Transitional Housing for homeless persons

_____ Living with relatives/friends

_____ Domestic violence situation

_____ Other, please specify

_____ Rental Housing

Address: ____________________________

City: ____________________________ State: ________ ZipCode: ________

Date of Birth: ____________

SS#: ____________________________

Place of Birth: ____________________________

Age: ____________

Gender: □ F  □ M

Other Family Dependents (under 18 years of age) who will be residing with applicant:

Name  SSN  Gender  DOB  RACE

__________________________  ____________________________

__________________________  ____________________________

__________________________  ____________________________

__________________________  ____________________________

Race:

_____ American Indian/Alaskan Native

_____ Asian

_____ Black or African American

_____ Native Hawaiian or Other Pacific Islander

_____ White

_____ Don't Know

_____ Multiple Races

_____ Refused

Marital Status: ____________

Domestic Violence: ______ Yes  ______ No

Ethnicity: □ Hispanic  □ Non-Hispanic

Disability Status: ______ SMI

_____ SMI/Substance Abuse

_____ SMI/HIV/AIDS

_____ SMI/Alcohol Abuse

_____ SMI/Develop. Disab.
Veteran: ____ Yes  ____ No
Veteran's Benefits: ____ Yes  ____ No

Is the applicant chronically homeless?  ____ Yes  ____ No
Either (1) an unaccompanied homeless individual or family with a disabling condition who has been continuously homeless for a year or more, OR (2) an unaccompanied individual or family with a disabling condition who has had at least four episodes of homelessness in the past three years.

Previous Participation in the Shelter Plus Care Housing:  ____ Yes  ____ No
If yes, Where ____________________________

Cash Income Received  Monthly Amount  Non Cash Benefits
List others not included below
SSI  ____________
SSDI  ____________
Social Security Retirement  ____________
TANF  ____________
TCA or General Public Assist.  ____________
Veterans Benefits  ____________
Unemployment Insurance  ____________
Employment Income  ____________
No Financial  ____________
Other  ____________

List all benefits including health care from plan or ACA
Food Stamps  ____________
Medicare Number:  ____________
Medicaid Number:  ____________
TANF Child Care  ____________
Veterans Health Care  ____________
Other Entitlements  ____________
TDAP  ____________

Current Diagnosis: __________________________________________

DSM-V Code: __________________________________________

Psychiatric History:
Number of psychiatric hospitalizations:  ____________
Date of most recent hospitalization:  ____________
List the dates, locations, length of stays and briefly describe psychiatric history:

________________________________________
________________________________________
________________________________________
________________________________________

All Current Medications:  __________________________________
Dosage/Frequency  __________________________________

Current ability to take medication:
____ Independently  ____ With Reminders  ____ With Daily Supervision
____ Refuses Medication  ____ Medication Not Prescribed
Legal History:
Is the applicant currently in the detention center? ______ Yes ______ No
Does the applicant have any previous convictions? ______ Yes ______ No
Does the applicant have any pending charges? ______ Yes ______ No
Is the applicant on parole or probation? ______ Yes ______ No
Has the applicant been found NCR? ______ Yes ______ No
Is the applicant on (or will be on) Conditional release? ______ Yes ______ No

Parole or Probation Officer’s Name and Phone #: ____________________________

List all charges and convictions. Please include dates, the status of charges and describe the nature of the charges:
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

*** Please attach or send release papers.

Substance Abuse History
Drug Used (including alcohol)  Period of Use  Frequency  How Used
_________________________________________________________________
_________________________________________________________________

Drug Last Used  Date  Amount  How Used
_________________________________________________________________

Substance Abuse Treatment History (date and location)
A.A. __________________________________________ N.A. ____________________
Detox
Inpatient Services
Outpatient Services

Has the applicant ever been arrested for drug possession or distribution? ______ Yes ______ No
If so, when ____________________________

Medical History:
Name of Primary Medical Provider: _______________________________________
Address: __________________________________________________________________
Telephone Number: _______________________________________________________
Significant Somatic Issues: _________________________________________________

Risk Assessment: (Never past week, past month, past year, past 2 years)
Suicide Attempts: _________________________________________________________
Suicide ideation: _________________________________________________________
Aggressive Behavior/Violence: ______________________________________________
Fire Setting: _____________________________________________________________
Type of weapons owned by applicant: _______________________________________

revised February 2014
Activities of Daily Living:
What type of meaningful daytime activity will the applicant be involved in while participating in the Continuum of Care Program?

How does the applicant attend to activities of daily living?
____ Independent  _____ Needs significant support  _____ Needs moderate support

Has applicant signed consent for HMIS participation?  ____ Yes  ____ No

Has applicant data been entered into the local HMIS?  ____ Yes  ____ No

Referral Source:
Referring Party: ___________________________  Referral Date: _______________________
Agency/Program: ___________________________  Type of Program: _______________________
Agency Phone: _____________________________  Fax #: _____________________________

Please check if the referring party is from the following types of programs:
____ MCCJTP  __________ TAMAR  _______ Chrysalis House  ______ PATH

_____ Other (specify) ________________________

Additional Comments to support application:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

IF THERE ARE NO OTHER ADULT MEMBERS STOP HERE!

PROCEED TO CONSENT AGREEMENT ON THE LAST PAGE
Other Adults (over age of 18 years old including dependents)
PLEASE COMPLETE A SEPARATE FORM FOR EACH OTHER ADULT

<table>
<thead>
<tr>
<th>Name</th>
<th>SSN</th>
<th>Gender</th>
<th>DOB</th>
<th>RACE</th>
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</thead>
<tbody>
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</tbody>
</table>

Race:
___ American Indian/Alaskan Native  ___ Asian
___ Black or African American  ___ Native Hawaiian or Other Pacific Islander
___ White  ___ Don't Know
___ Multiple Races  ___ Refused

Marital Status: ________ Domestic Violence: _____ Yes  _____ No

Ethnicity:
_______ Hispanic  _____ Non-Hispanic

Disability Status:
_______ SMI  _____ SMI/Substance Abuse
_______ SMI/HIV/AIDS  _____ SMI/Alcohol Abuse
_______ SMI/Develop. Disab.  _____ None

Veteran: _____ Yes  _____ No  Veteran's Benefits: _____ Yes  _____ No

Cash Income Received  Monthly Amount  Non Cash Benefits
List others not included below
SSI  ________
SSDI  ________
Social Security Retirement  ________
TANF  ________
TCA or General Public Ass  ________
Veterans Benefits  ________
Unemployment Insurance  ________
Employment Income  ________
Other  ________

List all benefits including health care from plan or ACA
Food Stamps  ________
Medicare Number:  ________
Medicaide Number:  ________
TANF Child Care  ________
Veterans Health Care  ________

Has applicant signed consent for HMIS participation?  _____ Yes  _____ No

Has applicant data been entered into the local HMIS?  _____ Yes  _____ No

revised February 2014  Page 5 of 6
Consent Agreement for the Continuum of Care Program:

I, ________________________, agree to release information contained in this application to the Maryland Department of Health and Mental Hygiene, Behavioral Health Administration and the Local Mental Health Authority to determine for the Continuum of Care Program. I understand that this information will not be released to any other party without my written consent.

I understand that this consent is valid for 12 months from the date of my signature. I also understand that the Continuum of Care Program requires me to be involved in supportive services such as case management. I understand that I must participate in some type of meaningful daytime activity such as school, work, other vocational or skill training in order to receive rental assistance through the Continuum of Care Program.

_________________________________________  _______________________
Applicant signature  Date

_________________________________________
Witness signature  Date
Verification of Disability
Authorization to Release Information

Continuum of Care Applicant: ____________________________________________

County: _______________________________________________________________

I hereby authorize the release of the information requested below to the Maryland Department of Health and Mental Hygiene, Behavioral Health Administration for the purpose of determining my eligibility for the Continuum of Care Housing Program.

_________________________________________  ________________
CoC Applicant’s Signature                          Date

________________________________________________________________________
, has applied for housing through the DHMH Mental Hygiene Administration’s Continuum of Care Program. The Department of Housing and Urban Development’s regulations governing the Continuum of Care Program requires verification of disability as a condition of participation in the program.

This release authorizes you to provide information regarding the physical/mental condition on the above applicant as follows:

1. Does the applicant have a diagnosis of schizophrenia (DSM V 295.90, 295.40, 295.70, 295.80), major affective disorders (DSM V 296.33 and 296.34), Bipolar disorders (DSM V 296.43, 296.44, 296.53, 296.54, 296.40, 296.7, and 296.89), delusional disorder (DSM V 297.1), psychotic disorder (DSM V 298.8 and 298.9), schizotypal personality disorder (DSM V 301.22), and borderline personality disorder (DSM V 301.83).
   Yes: _____  No: _____  Diagnosis and DSM V Code: __________________________

2. Has the applicant had the disability for two years or longer?
   Yes: _____  No: ______  Date of Disability: __________________________

3. Is the disability expected to be of long- continued and indefinite duration?
   Yes: _____  No: ______

4. Would the nature of the applicant’s disability be improved by more suitable housing conditions?
   Yes: _____  No: ______

   Physician’s Name: __________________________________

   Street Address: _______________________________________

   City: ______________  State: ______________  Zip Code: ______________

________________________________________________________________________
Signature of Physician, Psychiatrist or Licensed Professional  Phone Number  Date Completed
Documentation of Homelessness

Please use the following space to have your client describe his or her current living situation. If currently in the detention center, please have them describe their living situation prior to incarceration. Their living situation prior to incarceration is required. Please use an additional sheet of paper as necessary.

Also, the referring agency must attach verification of current, or a history within the past 3 years or more of, applicant’s homelessness from either the referring agency and/or a third party source if practical such as from an emergency shelter, emergency feeding program, DSS, HMIS, etc.

________________________________________________________________________

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________________________________________________________________________

Participant’s Signature: ___________________________ Date: ________________

Witness Signature: ___________________________ Date: ________________
# MARYLAND BEHAVIORAL HEALTH ADMINISTRATION

## CONTINUUM OF CARE HOUSING PROGRAM

### Service Plan

Client Name: ________________________________  Date Service Plan Takes Effect: ____________

Most Recent DSM V Diagnosis: ____________________________  Date of Most Recent Diagnosis: ____________

<table>
<thead>
<tr>
<th>Needs/Goals</th>
<th>Measurable Short Term Goals (1st 6 months)</th>
<th>Intervention</th>
<th>By Whom</th>
<th>Target Date</th>
<th>Outcomes (2nd 6 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing:</td>
<td></td>
<td>Client:</td>
<td>CM:</td>
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<tr>
<td>• Placement in housing</td>
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<td>• Maintenance of housing</td>
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<td>Increase skills and/or income:</td>
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<td>Client:</td>
<td>CM:</td>
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<td>• Budgeting</td>
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<td>• Entitlements</td>
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<td>• Employment</td>
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<td>• Educational/Vocational Training</td>
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<td>Needs/Goals: Achieve greater self-determination:</td>
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<td>• Mental Health, Substance Abuse &amp; Medical Services</td>
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<td>• Case Management &amp; Support Services</td>
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<td>• Meaningful day-time activity</td>
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<td>• Legal</td>
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<tr>
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<td>CM:</td>
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</table>

I agree to release this information to the Mental Hygiene Administration and the Local Mental Health Authority as a part of my application packet. I also agree to comply with the services listed in the service plan as a condition of participation in the Continuum of Care Program.

Client's Signature ___________________________ Date ________________

I, ___________________________, have verified that the applicant has been diagnosed with the DSM V disability as indicated on page 1 of this service plan and/or this application for Continuum of Care Housing. I understand that this disability has been given by a physician or a qualified mental health professional.

Case Manager's Signature ___________________________ Date ________________
BEHAVIORAL HEALTH ADMINISTRATION
CONTINUUM OF CARE PROGRAM

Documentation of Legal History

Applicant/Participant Name: ____________________________

Agency Documenting Legal History of the Applicant/Participant: ____________________________

To the agency documenting the Applicant/Participant’s legal history:

Please document the applicant/participant’s legal history based on records from the local detention center, Circuit Court, District Court, and/or the Criminal Justice Information System and attach a copy of the most recent detention center release papers:

<table>
<thead>
<tr>
<th>Criminal Charge:</th>
<th>Date of Criminal Charge:</th>
<th>Disposition:</th>
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This is to state that the above information is complete and is based on the criminal justice records available to this agency.

Signature of Agency Representative: ____________________________

Title: _________________________________________________________

Date: ____________________________

Legal History revised February 2015
BEHAVIORAL HEALTH ADMINISTRATION
CONTINUUM OF CARE PROGRAM

Documentation of Legal History
Consent Agreement

Applicant/participant’s authorization to obtain criminal records:

I, ____________________________, hereby authorize the (agency name) ______________________ to obtain my criminal record/s from the Circuit and/or District Court and/or the Criminal Justice Information System for the purposes of determining eligibility for the Continuum of Care Program. I understand that this information will be forwarded to the State of Maryland Department of Health and Mental Hygiene, Behavioral Health Administration for the purpose of determining my eligibility for the CoC Program and for the annual recertification to remain in the program. I understand that I may be denied CoC Program rental assistance based on felony or drug related charges.

I understand and agree to the requirement of maintaining my participation in the CoC Program is an annual search of the criminal justice system regarding any criminal involvement and this is part of my annual recertification process. This consent shall remain in force for the duration of my application process and if I am a CoC Program participant, I will be required to sign this authorization annually.

By signing below, I authorize the ______________________ (agency) to search for and obtain my criminal records as stated above.

Signature of Applicant/Participant: ____________________________________________

Date of Birth: ___________________________ Today’s Date: ___________________________

Witness: ____________________________

Legal History revised February 2015
Due Process Acknowledgement

This is to inform all applicants and participants in the Continuum of Care Program of their due process rights in the event of an adverse action by the program such as termination. All participants have the right to appeal a termination decision that results in the loss of their rent subsidy and other services.

The following are the steps to terminate a participant from the CoC Program and the participant’s due process steps to appeal the termination decision:

1. In the event of a decision to terminate a participant from the CoC Program, the case manager will verbally inform the participant and attempt to develop a written contract delineating the responsibilities of all concerned parties to avoid a termination action.
2. If the case manager and the local mental health authority (LMHA) determine that the contract is not being followed by the participant, the LMHA will inform the Maryland Behavioral Health Administration (BHA) of their recommendation to terminate the participant from the program.
3. A written letter will be sent to the participant by the LMHA and BHA with the date the termination and rental subsidy will end. The letter will have instructions for the participant to appeal this decision.
4. The participant will have thirty (30) calendar days after receipt of the termination letter to appeal the decision by sending a letter requesting an appeal to the LMHA.
5. After the LMHA receives the letter to appeal from the participant, the LMHA will conduct an appeal hearing within ten (10) business days (normally Monday through Friday) that the participant must attend in order to present their case.
6. The LMHA appeal panel must render a decision and inform the participant of their decision in writing within ten (10) business days following the appeal hearing.
7. If the participant disagrees with the LMHA appeal panel’s decision, the participant may request a second level of appeal to the Behavioral Health Administration within ten (10) business days after receipt of the LMHA appeal panel’s letter of the decision.
8. BHA will conduct the appeal hearing within ten (10) business days of receipt of the appeal request. The participant must attend the hearing to present their case.
9. The BHA appeal panel will inform the participant and LMHA in writing within ten (10) business days following the appeal hearing of their decision.
10. BHA may decide to uphold the termination, cancel the termination, or provide conditions the participant must meet to remain in the program and designate a follow-up progress report. If progress is not demonstrated by the participant to meet the BHA appeal panel conditions, the decision to terminate will be made. Likewise, if the participant demonstrates satisfactory progress towards meeting the conditions stated by BHA to remain in the program, the termination will be rescinded. The decision by the BHA appeal panel is final and cannot be appealed further.
Composition of the Appeal Panel

The LMHA appeals panel shall consist of members of other LMHAs that are not party to the termination decision.

The BHA appeals panel shall consist of members of LMHAs that are not party to the termination decision and the Director of the BHA CoC Program or his/her designee.

What are the factors leading to the decision to terminate a participant from the CoC Program?

The LMHA will only recommend termination as a last resort. Usually, participants are terminated for failure to pay rent, being a nuisance and disrupting their neighbors, violating key lease or occupancy agreement conditions, violence, using and selling illegal drugs, and committing felony offenses. Compliance to the agreed upon service agreement to obtain or seek treatment, income, and other services may also be a factor, but not the sole reason for termination.

If the participant makes substantial progress in resolving the reasons for program termination, the LMHA may rescind the termination at any point in the process.

I acknowledge the above due process and termination procedures, have received a copy of this form, and understand or have had them read and/or explained to me.

__________________________________________  ______________________________
Applicant/participant signature                  Date

__________________________________________  ______________________________
CoC Program representative signature            Date
Participant Agreement

I agree to the following in order to participate in the Continuum of Care Program:

- Participate in developing my Service Plan and comply with the case management, rehabilitation and education indicated on my Plan;
- Report any changes in income, marital status, or my living status to my case manager;
- Notify my case manager within 30 days if I intend to leave my current housing;
- Pay my rent as stated on my Rent Calculation Worksheet and BHA approval letter;
- Keep my housing unit reasonably clean and in good repair;
- Agree that only individuals listed on the lease and approved by the Continuum of Care Program are living in the Continuum of Care unit (this includes spouse and children who are not listed on the lease);
- Agree to meet with my Continuum of Care Case Manager in the rented Continuum of Care unit, and;
- Abide by the rules and requirements of the landlord, as indicated in my occupancy or lease agreement.

I understand that failure to comply with these conditions may result in my not continuing to receive rental assistance through the Behavioral Health Administration Continuum of Care Housing Program.

_________________________  __________________________
Date  Participant Signature

_________________________
Date  Witness
Federal Privacy Act Notice

PURPOSE: Family income and other information is being collected by the Department of Housing and Urban Development (HUD) to determine an applicant's eligibility, the recommended unit size, and the amount the family must pay toward rent and utilities.

USE: HUD uses family income and other information to assist in managing and monitoring HUD-assisted housing programs, to protect the Government’s financial interest; and to verify the accuracy of the information furnished. HUD or a public housing agency/Indian housing agency may conduct a computer match to verify the information you provided. This information may be released to appropriate Federal, State, and local agencies, when relevant, and to civil, criminal or regulatory investigators and prosecutors. However, the information will not be otherwise disclosed or released outside of HUD, except as permitted or required by law.

PENALTY: You must provide all of the information requested by the public housing agency/Indian housing agency, including all Social Security numbers you, and all other household members six (6) years and older, have and use. Giving the Social Security numbers of all household members six (6) years of age and older is mandatory, and not providing the Social Security numbers will affect your eligibility. Failure to provide any of the requested information may result in a delay or rejection of your eligibility approval.

AUTHORITY FOR INFORMATION COLLECTION: The following laws authorize the collection of this information by HUD or the public housing agency/Indian housing agency: the U.S. Housing Act of 1937 (42 U.S.C., 1437 et. Seq.), Title VI of the Civil Rights Act of 1964, and Title VIII of the Civil Rights Act of 1968. The Housing and Community Development Act of 1987 (42 U.S.C. 3543) requires applicants and residents to submit the Social Security numbers of all household members at least six (6) years old.

I read, or had explained to me, the Privacy Act Notice on ____________________________.

Date

Signature of Applicant/Participant _______________ Social Security Number ___________________
BEHAVIORAL HEALTH ADMINISTRATION
CONTINUUM OF CARE PROGRAM

Documentation of Individuals Living in the Home

Please list all individuals residing in the Continuum of Care subsidized property (including the participant):

<table>
<thead>
<tr>
<th>Name</th>
<th>Relation</th>
<th>DOB</th>
<th>SS#</th>
<th>Employment</th>
<th>FT</th>
<th>Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Participant)</td>
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</table>

For all those who are 18 years old and older, including dependents, please complete the additional forms for Other Family Adults and sign the Other Authorized Participant Agreement and the Federal Privacy Act Form. In addition, for all adults, a criminal background check must be completed; and the Disclosure of Legal History form and the Documentation of Legal History form must be completed. All additional adults must provide proof of income or student status. These items must be completed PRIOR to an additional person moving into the home. The Continuum of Care Program must authorize the individual to be living in the home before they move in and the individual must be on the authorized lease. Any violations of this could result in the participant’s termination from the Continuum of Care Program.
Anne Arundel And Annapolis Coalition To End Homelessness
HMIS Fact Sheet / Consent to Collect

WHAT IS HMIS:

HMIS is the Homeless Management Information System. Anne Arundel County uses ServicePoint as their HMIS. A web based information system that homeless services agencies across AACO use to capture information about the persons they serve.

WHY DO WE USE HMIS:

To understand client needs and help programs plan for appropriate resources.

WHO HAS ACCESS:

Only staff that work directly with clients, or have administrative responsibilities, and have gone through training can look at, enter, or edit client records. No information is released to other agencies without signed consent form.

RIGHT OF REFUSAL:

A Client has the right to not answer any question, unless entry into a program requires it; client has the right to know who has added to, deleted, or edited their ServicePoint record. Information that is transferred over the internet is through a secure encrypted connection.

HOW INFORMATION IS USED:

Case manager and client can use information to assist clients in obtaining resources that will help them meet their needs. Information is also used to perform aggregate reports to better understand the homeless population and areas of need.

CONFIDENTIALITY:

A signed consent form is required prior to client information being entered into the HMIS. The participating agency will uphold Federal and State Confidentiality regulations to protect client records and privacy. The participating agency will abide specifically by COMAR 07.01.07.00 through 07.01.07.9999 and 42 CFR Part 2. The participating agency will not solicit or input information from clients unless it is essential to meet minimum data requirements, provide services, or conduct evaluations or research.

GRIEVANCE:

Clients have the right to file a grievance form regarding potential violations of their privacy rights regarding HMIS participation. To complete the Grievance Process, a client must request and complete a grievance form from the participating agency and may choose to turn the form into person of authority not related to the grievance or may mail the form directly to the DSS HMIS Administrator. The DSS HMIS Administrator will review the grievance, research the nature of the complaint, and respond to the grievant within 30 days.

I consent to the collection of information and preparation of records pertaining to the services provided to me. The information gathered and prepared by the Agency will be included in a Homeless Management Information System (HMIS) database and shall be used by Anne Arundel and Annapolis Coalition to End Homelessness.

Client Signature: ___________________________________ Date: _______________________

Revised 7/2015
Anne Arundel And Annapolis Coalition To End Homelessness
Authorization to Use or Disclose Protected Health Information (PHI)

Section 1. Who is the Individual

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>Middle Initial:</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Provider Completing Assessment: Date Of Birth: Social Security Number:

I hereby authorize the use or disclosure of protected health information about the individual named above

I am:  
□ the individual named above (complete Section 8 below to sign this form)
□ A personal representative because the patient is a minor, incapacitated, or deceased (complete section 9 below)

Section 2. Who Will Be Disclosing Information About the Individual?

The following person(s) or entity may use or disclose the information:

All providers within the Anne Arundel and Annapolis continuum of care (Anne Arundel And Annapolis Coalition To End Homelessness) who utilize the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) pre-screen assessment and the homeless management information system (HMIS) including: Anne Arundel County Department Of Social Services, Anne Arundel County Partnership For Children, Youth, & Families, Arundel House Of Hope, Anne Arundel County Mental Health Agency, Arundel Lodge Inc, Arundel Community Development Services (ACDS), Arundel Crisis Response System, Blessed In Tech Ministries, Housing Commission Of Anne Arundel County (HCAAC), The Light House, People Encouraging People, Sarah’s House Catholic Charities, We Care & Friends, Community Residences, and PDG Rehab.

Section 3. Who Will Be Receiving Information About The Individual?

The information may be disclosed to:

All providers within the Anne Arundel and Annapolis continuum of care (Anne Arundel And Annapolis Coalition To End Homelessness) who utilize the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) pre-screen assessment and the homeless management information system (HMIS) including: Anne Arundel County Department Of Social Services, Anne Arundel County Partnership For Children, Youth, & Families, Arundel House Of Hope, Anne Arundel County Mental Health Agency, Arundel Lodge Inc, Arundel Community Development Services (ACDS), Arundel Crisis Response System, Blessed In Tech Ministries, Housing Commission Of Anne Arundel County (HCAAC), The Light House, People Encouraging People, Sarah’s House Catholic Charities, We Care & Friends, Community Residences, and PDG Rehab.

Section 4. What Information About the Individual Will Be Disclosed?

The information to be disclosed may include records on drug abuse, alcoholism, behavioral health, mental health, sickle cell anemia, human immunodeficiency virus (HIV) infection, acquired immunodeficiency syndrome (AIDS), or tests for HIV information.

The information to be disclosed, including behavioral health and/or substance abuse services includes the following:

All information contained within the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) pre-screen assessment and the 2014 HMIS Data Standards, including

- A. History of Housing and Homelessness
- B. Risks and Income
- C. Socialization and Daily Functioning
- D. Wellness

Revised 7/2015
Section 5. What is the Purpose of the Disclosure?

To improve access and service alignment by assessing various health and social needs, and then to match those assessed with the most appropriate housing interventions available. The VI-SPDAT is a tool to help guide those assessed to appropriate services and housing opportunities and HMIS is the information system used by homeless services agencies across Anne Arundel County to collect information about the persons they serve.

Section 6. What is the Expiration Date or Event?

This authorization will expire 2 years from the date this document was signed in Section 8 or Section 9 below.

Section 7. Important Rights and Other Required Statements You Should Know

- You can revoke this authorization at any time by writing to the Anne Arundel and Annapolis Coalition To End Homelessness, at 2666 Riva Road 2nd Floor, Annapolis, MD 21401. Any revocation will not apply to information that has already been used or disclosed.
- The information disclosed based on this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.
- No disclosure will be made where authorization has expired, fails to meet a requirement of 42 CFR Part 2, is revoked, or is known to be false or through reasonable effort could be known to be false.
- If you refuse the authorization or revoke the authorization, you will continue to receive all the medical care and benefits for which you are eligible. You do not need to sign this form in order to obtain enrollment, eligibility, payment, or treatment for services and these cannot be conditioned on signing this authorization.
- This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.
- You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask us for a copy at any time by writing to Anne Arundel and Annapolis Coalition To End Homelessness, at 2666 Riva Rd 2nd Floor, Annapolis, MD 21401.
- If you have any questions about anything on this form, or how to fill it out, we can help. Please call the Homeless Coordinator at 410-269-4749.

Section 8. Signature of the Individual

Signature ___________________________________________ Date (required) ______________________

Section 9. Signature of Personal Representative (if applicable)

Signature ___________________________________________ Date (required) ______________________

Please describe your relationship to the individual and/or your legal authority to act on behalf of the individual in making decisions related to healthcare. You may be asked to provide us with the relevant legal document giving you this authority.

Relationship to the individual (required) _________________________________________________

Notice To Recipient of information

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization of the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.