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 specifiy current program if appropriate):

_____emergency shelter
_____place not meant for habitation (streets)
_____Safe Haven
_____transitional shelter/housing
_____fleeing or attempting to flee from domestic violence
_____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.
___Transitional Housing for homeless persons
___Domestic violence situation
___Rental Housing
___Emergency Shelter
___Living with relatives/friends
___Other, please specify

Address: _____ **Phone:** _____

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
___Black or African American
___White
___Multiple Races
___Asian
___Native Hawiian or Other Pacific Islander
___Don't Know
___Refused

Marital Status: _____ **Domestic Violence:** _____**Yes** _____**No**

Ethnicity: _____ Hispanic _____ Non-Hispanic

Disability Status:
_____ SMI
_____ SMI/HIV/AIDS
_____ SMI/Develop. Disab.
_____ SMI/Substance Abuse
_____ SMI/Alcohol Abuse

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**
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	_____

Non Cash Benefits
List all benefits including health care from plan or ACA

Food Stamps _____
Medicare Number: _____
Medicaide 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 currrently 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: _____

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

Healthy Start

_____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

Name	SSN	Gender	DOB	RACE

Race:

___American Indian/Alaskan Native
___Asian
___Black or African American
___Native Hawiian 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		List all benefits including health care from plan or ACA	
SSI	_____	Food Stamps	_____
SSDI	_____	Medicare Number:	_____
Social Security Retirement	_____	Medicaide Number:	_____
TANF	_____	TANF Child Care	_____
TCA or General Public Ass	_____	Veterans Health Care	_____
Veterans Benefits	_____		
Unemployment Insurance	_____		
Employment Income	_____		
Other	_____		

Has applicant signed consent for HMIS participation? ____Yes _____No

Has applicant data been entered into the local HMIS? ____Yes _____No

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

BEHAVIORAL HEALTH ADMINISTRATION
CONTINUUM OF CARE PROGRAM

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.

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:_____

Needs/Goals	Measurable Short Term Goals (1st 6months)	Intervention	By Whom	Target Date	Outcomes (2nd 6months)
Housing: • Placement in housing • Maintenance of housing		Client: CM:			
Increase skills and/or income: • Budgeting • Entitlements • Employment • Educational/ Vocational Training		Client: CM:			

MARYLAND BEHAVIORAL HEALTH ADMINISTRATION

CONTINUUM OF CARE HOUSING PROGRAM

Service Plan

Client Name: _____

Needs/Goals:	Measurable Short Term Goals (1st 6months)	Intervention	By Whom	Target Date	Outcomes (2nd 6months)
Achieve greater self-determination: • Mental Health, Substance Abuse & Medical Services • Case Management & Support Services • Meaningful day-time activity • Legal		Client: CM:			

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:

Criminal Charge:	Date of Criminal Charge:	Disposition:

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: _____

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 re-certification 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: _____

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. <u>The decision by the BHA appeal panel is final and cannot be appealed further.</u>

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):

Name	Relation	DOB	SS#	Employment	FT Student	Income
	(Participant)					

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: _____

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

Section 1. Who is the Individual

Last Name:	First Name:	Middle Initial:
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), Anne 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), Anne 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 Priotization 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

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 a 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.