SHELTER PLUS CARE

APPLICATION
Part I
MARYLAND MENTAL HYGIENE ADMINISTRATION
SHELTER PLUS CARE HOUSING PROGRAM
Documentation Checklist

Name: __________________ County: __________ # of Bedroom/s: ___

Application Process: PART 1

__________ Intake form

__________ Verification of Disability

__________ Documentation of Homelessness

__________ Service Plan

__________ Legal History Form/Consent to Release Criminal History

__________ Documentation of Legal History

__________ Signed Termination Procedures

__________ Consumer Agreement

__________ Federal Privacy Act
MENTAL HYGIENE ADMINISTRATION
SHELTER PLUS CARE HOUSING PROGRAM
Eligibility Criteria

MHA's Shelter Plus Care Housing Program (S+C) is targeted to serve individuals and families who are homeless as defined by the Department of Housing and Urban Development, have a serious mental illness, and are currently incarcerated due to misdemeanor charges or nonviolent felony charges. First priority for the Shelter Plus Care Housing Program is given to those currently in the detention center for misdemeanor charges or nonviolent felony charges related to their mental disability and/or homelessness status. The S+C Program will also serve individuals who have been recently released (within 2 year period) who are on the intensive caseloads of parole and probation, or a participant of the Trauma Addictions Mental Health and Recovery (TAMAR) Program, the Chrysalis House Health Start Program or PATH Programs who meet the disability and homelessness criteria.

In order to qualify for MHA's Shelter Plus Care Program, the applicant must meet the following criteria.

☐ The applicant must be a U.S. citizen or a legal resident of the U.S. and at least 18 years of age and,

☐ The individual or family must receive less than the median income for that jurisdiction and,

☐ The applicant must have a completed service plan identifying all appropriate services, supports and planned meaningful activities. The applicant must comply with the aftercare plan to retain HUD Shelter Plus Care assistance and,

☐ Must meet legal criteria for the program (see policy of legal criteria). Adult family members residing with the participant must also meet the legal criteria. For those entering directly from the local detention center, a copy of the release papers must be submitted to the Mental Hygiene Administration prior to housing placement.

☐ The applicant must have a serious and persistent mental illness, as identified by the following diagnostic categories.
Eligible Disabilities:

b. Major Affective Disorders (DSM IV 296.33 and 296.34)
c. Bipolar Disorders (DSM IV 296.43, 296.44, 296.53, 296.54, 296.63, 296.64, 296.80 and 296.89)
d. Delusional Disorder (DSM IV 297.10)
e. Psychotic Disorder, NOS (DSM IV 298.90)
f. Schizotypal Personality Disorder (DSM IV 301.22)
g. Borderline Personality Disorder (DSM IV 301.83); and

- The disability is expected to be of long-term and indefinite duration (Verification of disability form must be completed).
- The applicant has impairment in role functioning, on a continuing or intermittent basis, for at least two years.
- The nature of the applicant's disability will be improved by more suitable housing.
- The applicant has social behavior that results in interventions by the mental health system.
- The applicant needs assistance with basic living skills or procuring financial assistance.

The applicant must also be homeless based on HUD's definition of homelessness as defined below:

HUD's Definition of Homelessness:

- Homelessness is defined as:

  A. Persons who are sleeping in the following places in places not meant for human habitation (e.g. cars, tunnels, parks, sidewalks, bridges, streets, abandoned buildings or condemned building); or

  B. Persons sleeping in an emergency shelters; or
Definition of Homelessness – Continued:

A family or individual living in transitional housing. Transitional housing is defined as a temporary housing program (usually up to 2 years) for people who are homeless;

♦ Documentation other than the client’s statement must also be provided on agency letterhead.

Definition of Chronic Homeless:

A. An unaccompanied individual with a disabling condition (serious mental illness), who has been continuously homeless for a year or more; or

B. An unaccompanied individual with a disabling condition (serious mental illness), who has experienced four or more episodes of homelessness over the last three years.

Exclusions:

A. The time an individual spends in an institution, i.e. jail or hospital is not considered as homeless and cannot be used to qualify someone as being chronically homeless.

B. A family (adult with child or a married couple) is not considered as chronically homeless by HUD.

♦ Please note that all of the one-year renewal grants are not targeted to those who are chronically homeless but may serve this population.

♦ Some of the five-year grants are targeted to those who are chronically homeless. Therefore, those who do not meet the definition of chronic homelessness may not be considered for participation under the grant.

Participation in Supportive Services:

A. Applicant must be in need of mental health and supportive services and participate in services. The value of the supportive services must equal the amount of rental assistance received from the Shelter Plus Care Housing Program.
<table>
<thead>
<tr>
<th>JURISDICTION</th>
<th>NUMBER OF PRSONS IN HOUSEHOLD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Allegheny</td>
<td>$37,050</td>
</tr>
<tr>
<td>Anne Arundel</td>
<td>$43,050</td>
</tr>
<tr>
<td>Baltimore</td>
<td>$43,050</td>
</tr>
<tr>
<td>Baltimore City</td>
<td>$43,050</td>
</tr>
<tr>
<td>Calvert</td>
<td>$43,050</td>
</tr>
<tr>
<td>Caroline</td>
<td>$37,050</td>
</tr>
<tr>
<td>Carroll</td>
<td>$43,050</td>
</tr>
<tr>
<td>Cecil</td>
<td>$41,600</td>
</tr>
<tr>
<td>Charles</td>
<td>$43,050</td>
</tr>
<tr>
<td>Dorchester</td>
<td>$37,050</td>
</tr>
<tr>
<td>Frederick</td>
<td>$43,050</td>
</tr>
<tr>
<td>Garrett</td>
<td>$37,050</td>
</tr>
<tr>
<td>Harford</td>
<td>$43,050</td>
</tr>
<tr>
<td>Howard</td>
<td>$43,050</td>
</tr>
<tr>
<td>Howard-Columbia Area</td>
<td>$43,050</td>
</tr>
<tr>
<td>Kent</td>
<td>$37,050</td>
</tr>
<tr>
<td>Montgomery</td>
<td>$43,050</td>
</tr>
<tr>
<td>Prince George's</td>
<td>$43,050</td>
</tr>
<tr>
<td>Queen Anne's</td>
<td>$43,050</td>
</tr>
<tr>
<td>Somerset</td>
<td>$37,050</td>
</tr>
<tr>
<td>St. Mary's</td>
<td>$43,050</td>
</tr>
<tr>
<td>Talbot</td>
<td>$38,800</td>
</tr>
<tr>
<td>Washington</td>
<td>$37,050</td>
</tr>
<tr>
<td>Wicomico</td>
<td>$37,050</td>
</tr>
<tr>
<td>Worcester</td>
<td>$37,050</td>
</tr>
</tbody>
</table>
MARYLAND COMMUNITY CRIMINAL JUSTICE TREATMENT PROGRAM  
SHELTER PLUS CARE HOUSING PROGRAM  
*Intake Form*  

Applicant’s Name:  
Current Living Situation:  

Address:  
City  
State:  
ZipCode:  

Date of Birth:  
SS#:  
Place of Birth:  
Age:  
Gender:  □F  □M  

Other Family Dependents of the Applicant (under 18 years of age)  

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

Race:  
___ American Indian/Alaskan Native  
___ Native Hawaiian/Other Pacific Islander  
___ American Indian/Alaskan Native & White  
___ Black/African American & White  
___ American Indian/Alaskan Native & Black/African American  
___ Other Multi-Racial  

Marital Status:  
Domestic Violence:  ____ Yes  ____ No  

Ethnicity:  
___ Hispanic  
___ Non-Hispanic  

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

Veteran  ____ Yes  ____ No  
Veteran’s Benefits  ____ Yes  ____ No  

If incarcerated please indicate living situation prior to incarceration:  (If in the community, list present living  
___ 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  

Is the applicant chronically homeless?  ____ Yes  ____ No  

Revised 3/18/09 kej
Previous Participation in the Shelter Plus Care Housing:  ______ Yes  ______ No
If yes, Where

Current Entitlements and Income (Fill in amounts and check insurances that apply.)
$______ SSI  $______ SSDI  $______ Social Security  $______ TANF  $______ SCHIP
$______ General Public Assistance/TCA  ______ Veterans Benefits  $______ Employment
$______ Unemployment  ______ No Financial  ______ Medicaid No.
______ Other, Please Specify

Current Psychiatric Diagnosis:
AXIS I: ____________________________________________
__________________________________________________
__________________________________________________
AXIS II: __________________________________________
__________________________________________________
AXIS III: __________________________________________

DSM-IV 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 # ____________________________  Significant Somatic Issues ____________________________
**Risk Assessment:** (Never past week, past month, past year, past 2 years)
Suicide Attempts: ____________________________________________________________
Suicide ideation: __________________________________________________________
Aggressive Behavior/Violence: ______________________________________________
Fire Setting: ______________________________________________________________

**Activities of Daily Living:**
What type of meaningful daytime activity will the applicant be involved in while participating in the Shelter Plus Care Housing 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:**

<table>
<thead>
<tr>
<th>Referring Party:</th>
<th>Referral Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency/Program:</td>
<td>Type of Program:</td>
</tr>
<tr>
<td>Agency Phone:</td>
<td>Fax #:</td>
</tr>
</tbody>
</table>

Please check if the referring party is from the following types of programs:

- [ ] MCCJTP
- [ ] TAMAR
- [ ] TAMAR's Children
- [ ] PATI
- [ ] Other

**Additional Comments to support application:**
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

**IF THERE ARE NO OTHER ADULT MEMBERS STOP HERE!**
**PROCEED TO PAGE 9**
Other Adults (over age of 18 years including Dependents)

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

PLEASE COMPLETE A SEPARATE FORM FOR EACH OTHER ADULT

Race:
___ American Indian/Alaskan Native  ___ Black/African American
___ Native Hawaiian/Other Pacific Islander  ___ White
___ American Indian/Alaskan Native & White  ___ Asian
___ Black/African American & White  ___ Asian/White
___ American Indian/Alaskan Native & Black/African American
___ Other Multi-Racial

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

Current Living Situation:
___ 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

Are other adults in the household chronically homeless? _____ Yes  _____ No

(Chronically homeless is defined as an unaccompanied individual who has been continuously homeless for a year or more or has had at least four episodes of homelessness in the past three years.)
Current Entitlements and Income (Fill in amounts and check insurances that apply.)

$_____ SSI $_____ SSDI $_____ Social Security $_____ TANF $_____ SCHIP

$_____ General Public Assistance/TCA $_____ Veterans Benefits $_____ Employment

$_____ Unemployment $_____ No Financial $_____ Medicare No.

$_____ Medicaid No. $_____ Other, Please Specify

Please complete if there is a psychiatric history:

Current Psychiatric Diagnosis: ________________________________

AXIS I: ________________________________

___________________________

AXIS II: ________________________________

___________________________

AXIS III: ________________________________

___________________________

DSM-IV 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:


Medical History:
Name of Primary Medical Provider__________________________________________
Address______________________________________________________________
Telephone #____________________________________________________________
Significant Somatic Issues_______________________________________________

Risk Assessment: (Never past week, past month, past year, past 2 years)
Suicide Attempts:_______________________________________________________
Suicide ideation:_______________________________________________________
Aggressive Behavior/Violence:___________________________________________
Fire Setting:___________________________________________________________

Has applicant signed consent for HMIS participation? Yes No

Has applicant data been entered into the local HMIS? Yes No
Consent Agreement for Shelter Plus Care Housing:

I, __________________, agree to release information contained in this application to the Mental Hygiene Administration and the Local Mental Health Authority to determine for the shelter Plus Care housing 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 Shelter Plus Care Housing Program requires me to be involved in supportive services such as case management and treatment services. 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 Shelter Plus Care Housing Program.

__________________________    __________________________
Client signature              Witness

__________________________    __________________________
Date                          Date

Updated 2/3/2005
By deciding to reside in a unit subsidized by the Shelter Plus Care Housing Program, I agree to the following:

- Assist your family member (A Shelter Plus Care Consumer) with complying with the treatment, rehabilitation and education indicated on their Service Plan;
- Report income and changes to the Shelter Plus Care case manager;
- Pay 30% of my income toward the rent as agreed each month;
- Assisting with keeping the housing unit reasonably clean and in good repair;
- Abide by the rules and requirements of the landlord, as indicated in the lease agreement;
- Assist with paying for damages made to the unit during tenancy;
- Not have any illegal activity in the unit or engage in any illegal activity;
- Not allow unauthorized person to live in the unit;
- Notify and obtain approval before allowing any unauthorized person to stay in the unit including family members.

I understand that failure to comply with these conditions may revoke my authorization to reside in the Shelter Plus Care Subsidized Housing Program through the Maryland Mental Hygiene Administration.

I understand that this agreement is valid for 12 months from the date of my signature.

Date __________________________ Signature __________________________

Date __________________________ Signature __________________________

Shelter Plus Care
6/18/09 kej
Verification of Disability Status:

I, ____________________________, have verified that the applicant has been diagnosed with the DSM IV disability as indicated on this application for Shelter Plus Care Housing. I understand that this disability has been given by a physician or a qualified mental health professional. (Please attach verification of disability form.)

______________________________  __________________________  ____________
Signature                       Title                          Date

Updated 11/29/2004
Mental Hygiene Administration
Shelter Plus Care Housing Program
Verification of Disability

MHA will serve those who have a serious mental illness and those who have co-occurring substance or alcohol abuse disorders as funded by HUD. A person is considered disabled if they meet the diagnostic criteria listed under the eligibility criteria. Please refer to the eligibility policy for the definition of disability approved by MHA.

A verification of disability form must also be completed and submitted at the time of application. The verification of disability form must come from a credentialed psychiatric or medical professional trained to make such a determination. A case manager, mental health counselor, or substance abuse counselor does not qualify as a person to make that determination. "Self certifications" will not be accepted. Since MHA is requiring a verification of disability, participants will be allowed the $400 disability allowance on the rent calculation worksheet.

If a family is applying for S + C, the adult member must have a serious mental illness or co-occurring substance and alcohol abuse disorder. If there are two married adult members who meet the disability criteria, they will be counted as a family.

Shelter Plus Care Policy and Procedures – Verification of Disability
12/3/04 mbv
Shelter Plus Care Housing Program
Verification of Disability

Shelter Plus Care Applicant: ________________________________

County: ________________________________

I hereby authorize the release of the information requested to the Mental Hygiene Administration for the purposes of determining my eligibility for the Shelter Plus Care Housing Program.

_________________________________________ Date

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________
MARYLAND MENTAL HYGIENE ADMINISTRATION
SHELTER PLUS CARE HOUSING PROGRAM
Documentation of Homelessness

All applicants applying for Shelter Plus Care rental assistance must complete the documentation of homelessness form, and sign and date the form. The applicant must describe his/her present living situation. The following items should be included on the documentation of homelessness form.

➢ Where is the person presently residing?

➢ How long the person has been residing in the jail, shelter, transitional housing program, the streets, etc.

➢ If incarcerated the reason for incarceration and information regarding where they were residing prior to incarceration.

➢ Who will be residing with the applicant, i.e. children whom they have legal custody for or a spouse? Documentation of legal custody must be forwarded along with the name, date of birth, social security number of each child. If married documentation the applicant must provide the spouse’s name, documentation of marriage, income of spouse, date of birth, social security number and report if spouse have a legal history.

➢ What resources those the individual or family have?

➢ If incarcerated when will the individual be released from jail?

In addition to the documentation of homelessness completed by the applicant, HUD requires that a person homelessness status is verified and documentation from agency, i.e. shelter, program, case management agency be provided and maintained in the applicant’s file. See chart on the next page for acceptable forms of documentation.
<table>
<thead>
<tr>
<th>If your S+C program serves:</th>
<th>Then you need to...</th>
<th>This means</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons living on the street or places not meant for human habitation</td>
<td>Document their homeless status</td>
<td>You must verify that an individual is coming from the street through a certification from an outreach worker or organization that the person was living on the street. If you are unable to verify in this manner, the participant or a staff member may prepare a short written statement about the participant’s previous living place and have the participant sign the statement and date it.</td>
</tr>
<tr>
<td>Persons coming from an emergency shelter</td>
<td>Verify from the emergency shelter staff that the participant has been residing at the emergency shelter.</td>
<td>You need to obtain from the referring agency a written, signed, and dated verification that the individual has been a resident of the emergency shelter.</td>
</tr>
<tr>
<td>Persons coming from transitional housing for homeless persons</td>
<td>Verify with the transitional housing staff that the participant has been residing at the transitional housing.</td>
<td>You should obtain: 1) a signed statement from the transitional housing staff indicating that the individual is a resident there; and 2) the referring agency’s signed and dated verification as to the individual’s homeless status when he/she entered their program.</td>
</tr>
<tr>
<td>Persons from a short-term stay (up to 30 consecutive days) in an institution who previously resided on the street or in an emergency shelter</td>
<td>Verify from the institution staff that the participant has been residing at the institution and was homeless before entering the institution.</td>
<td>You must obtain: 1) written verification from the institution’s staff that the participant has been residing in the institution for less than 31 days; and 2) information on the previous living situation. Preferably, this will be the institution’s written, signed, and dated verification on the individual’s homeless status when he/she entered the institution.</td>
</tr>
<tr>
<td>Persons being discharged from a longer stay in an institution</td>
<td>Verify from the institution staff that the participant has been residing at the institution and will be homeless if not provided with assistance.</td>
<td>You need to obtain signed and dated documentation: 1) from the institution’s staff that the participant was being discharged within the week before receiving homeless assistance; and 2) of the following: - the income of the participant; - what efforts were made to obtain housing; and - why, without the homeless assistance, the participant would be living on the street or in an emergency shelter.</td>
</tr>
</tbody>
</table>
MARYLAND MENTAL HYGIENE ADMINISTRATION
SHELTER PLUS CARE HOUSING PROGRAM
Documentation of Homelessness

Please use the following space to have your client describe his or her living situation at the present time and prior to current living situation. If currently in an institution (jail, hospital, etc.), please have them also describe their living situation prior to institutionalization.

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

**Verification of homelessness documentation must also be provided.**

Date: ___________________ Signed: _______________________________________

Date: ___________________ Witness: _______________________________________

Updated 5/20/08 mvb
## Service Plan

### Needs/Goals

<table>
<thead>
<tr>
<th>Housing:</th>
<th>Measurable Short Term Goals (1st 6months)</th>
<th>Intervention</th>
<th>By Whom</th>
<th>Target Date</th>
<th>Progress Toward Goal (2nd 6months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Placement in housing</td>
<td></td>
<td>Client:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Maintenance of housing</td>
<td></td>
<td>CM:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Increase skills and/or income:

<p>| • Budgeting                        |                                         | Client:      |         |             |                                   |
| • Entitlements                     |                                         | CM:          |         |             |                                   |
| • Employment                       |                                         |              |         |             |                                   |
| • Educational/Vocational Training  |                                         |              |         |             |                                   |</p>
<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>Progress Toward Goal (2nd 6 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieve greater self-</td>
<td></td>
<td>Client:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>determination:</td>
<td></td>
<td>CM:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mental Health,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse &amp; Medical</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Case Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&amp; Support Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Meaningful day-time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Legal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</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 Shelter Plus Care Program.

Client's Signature ___________________ Date __________________

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

Case Manager's Signature ___________________ Date __________________

revised 9/15/10 syb
DIVISION OF SPECIAL POPULATIONS
MENTAL HYGIENE ADMINISTRATION
MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
8450 DORSEY RUN ROAD, P.O. BOX 1000
JESSUP, MD 20794-1000

Brian Hepburn, M.D., Director
Mental Hygiene Administration

Marian V. Bland, LCSW-C
Director of Shelter Plus Care Housing and Homeless Programs
Division of Special Needs Populations

SHELTER PLUS CARE HOUSING PROGRAM
Shelter Plus Care Renewal
Disclosure of Legal History/Consent to Release Information

I certify that:

_____ No Changes in Legal History - I have not incurred any legal convictions or have any pending charges at the present time or have incurred any legal charges during this Shelter Plus Care application/renewal period.

_____ Changes in Legal History (please attach supporting documentation)
I have incurred legal convictions or have pending legal charges in the past year.

I, ____________________________, hereby authorize the ____________________________
(Name of applicant) (Name of Referring Agency)

To obtain my legal record(s) from the Circuit and or District Courts or the Criminal Justice Information System for the purposes of determining eligibility and for referral to the Shelter Plus Care housing Program. I understand that this information will be released to the Mental Hygiene Administration for the purposes of determining eligibility for the program and for annual recertification. I understand that this information may be used to assist me with obtaining rental assistance through the Mental Hygiene Administration Shelter Plus Care Housing Program. I understand that the Shelter Plus Care Housing Program will not exclude me from participating based on misdemeanor charges. However, I may be denied rental assistance based on felony or drug related charges. I understand that this consent will remain valid and in force for a period of one year.

I understand that if I fail to disclose, or give false information, pertaining to the Shelter Plus Care Program application, I may forfeit my participation in this HUD regulated housing subsidy program.

By signing below, I acknowledge that this consent has been explained to me and that I understand and agree to its terms.

Signature: ____________________________ Date of Birth: ____________________________

Today’s Date: ____________________________ Witness: ____________________________
Please attach copy of release papers and document legal history below based on verification from the local detention center (jail) record/s:

<table>
<thead>
<tr>
<th>Legal Charge</th>
<th>Date of Legal Charge</th>
<th>Disposition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I, __________________________ agency, have verified __________________________ legal history, based on criminal justice search the charges listed above are accurate to my knowledge.

Signature: __________________________ Title: __________________________

Date: __________________________

Consent Agreement:

I, __________________________, hereby authorize the __________________________ to obtain my legal record/s from the Circuit and/or District Court or the Criminal Justice Information System for the purposes of determining eligibility and to refer me to the Shelter Plus Care Housing Program. I understand that this information will be forwarded to the Mental Hygiene Administration for the purposes of determining my eligibility for the program and for annual recertification. I understand that I may be denied rental assistance based on felony or drug related charges.

By signing below, I am acknowledging that the information I reported is true and that I am in agreement to this consent. I understand that this consent will remain valid and in force for a period of one year (12 months).

Signature: __________________________ Date of Birth: __________________________

Today's Date: __________________________ Witness: __________________________

5/14/08 mwb
Termination of Rental Assistance:
The Mental Hygiene Administration (MHA) and/or the Core Service Agency may terminate assistance to a participant for ongoing violations of program requirements or conditions of occupancy. The decision to terminate a participant will only be made after all extenuating circumstances have been examined to ensure that a participant’s violations are serious enough to warrant termination, and the participant’s assistance is terminated in the most severe cases. It is expected that termination from the program will only occur as an absolute last resort due to continued uncooperativeness with the program and/or occupancy requirements.

Case Manager’s Responsibilities:
It is expected that the case manager will be working with the participant to help insure that the conditions of remaining in the program are written for the participant and are clearly understood by the participant. The case manager will explain the consequences of continued non-compliance with program and/or occupancy agreements, with the ultimate consequence being termination of rental assistance for violations of program requirements and/or eviction from the premises by the landlords for occupancy agreement violations. If a case manager thinks a participant is in jeopardy of eviction or termination of rental assistance, he/she must notify the Local Mental Health Authority (Core Service Agency) and the Mental Hygiene Administration (MHA) (Marian Bland) in writing as soon as this information is learned.

If the violations persist, the case manager shall document the reasons outlining the recommendation for termination in writing. Violations include repeated non-compliance with supportive services, non-payment of rent for two months or greater, criminal drug activity, repeated misdemeanor charges or conviction, a felony charge or conviction, refusal to abide the requirements for re-inspection, providing fraudulent information.

The case manager must also describe in writing what specific behavior is expected from the participant in order to remain in the program. This documentation shall be forwarded to Mental Hygiene Administration (Marian Bland) before sending it to the Shelter Plus Care participant. If the Mental Hygiene Administration agrees that the behavior warrants beginning the termination process, a written letter should be sent to the applicant by the case manager or the Local Mental Health Authority. The written termination letter should state the reasons why the applicant is being terminated, the date he/she will be terminated, indicate what the appeal process is, a deadline date for the appeal and the person to be contacted to schedule an appeal hearing.
Landlord’s Responsibilities:
If his/her landlord evicts an applicant, the landlord shall abide by Maryland State laws in effecting an eviction of a participant, with the due process afforded under said laws. According to State laws, landlords may evict a client upon thirty-(30) calendar days' notice. The landlord must notify the participant in writing his/her intent to evict the participant. The landlord must file for an eviction of tenancy through the court in order to legally evict a tenant from the property.

Participant’s Responsibilities:
If the participant is evicted by the landlord, the participant shall provide a copy of the eviction letter to the case manager, who shall forward a copy to the Local Mental Health Authority and the Mental Hygiene Administration, Division of Special Populations. Legal eviction by a landlord constitutes extreme violation of occupancy requirements and subjects the participant to possible termination from the program through termination of rental assistance. The participant should not be evicted or terminated rental assistance without going through the due process outlined below for program requirement violations. However, in situations whereby the participant or family is involved in violent or criminal activity that endangers the safety of the participant, family members in the household, or the safety of other tenants the participant may be required to leave the housing unit immediately. In this instance, the case manager will assist the participant with locating other housing arrangement or services.

The participant is expected to abide by the conditions of the program. This includes participating in services as agreed upon in their service plan, to pay his/her portion of the rent or utilities, report any changes in income or family status, abide by the conditions of lease agreements and other program guidelines as agreed upon at program entrance and/or during the annual renewal process. The participant must review and sign termination agreement prior to entrance into the Shelter Plus Care Housing Program.

Due Process:
Please note that the Mental Hygiene Administration has two time frames for termination based on the type of program. For tenant-based participants a 30 days written notice must be provided. For sponsor-based participants, a 45 days written notice must be provided to the participant by the sponsor agency or landlord.
If the applicant begins to show improvement by complying with services or making payments towards rent, or complying with conditions of his/her lease, the termination must be rescinded. If a landlord or sponsor agency is evicting the participant, only the landlord or the court can rescind this decision.

If the termination is pursued, the participant has thirty (30) calendar days from the date of notification of intent to terminate to appeal this decision in writing to the Local Mental Health Authority. The Local Mental Health Authority’s name, address and phone number should be stated in the letter. The Local Mental Health Authority will forward a copy of the letter to MHA (Marian Bland). The Local Mental Health Authority shall hold or have scheduled a hearing within ten (10) business days to review the decision to terminate assistance. At the hearing the participant will have the right to present written and/or oral objections to a person other than the person making the decision to terminate assistance (or his/her subordinate). The contract monitor or designee shall submit a written decision to the participant and MHA (Marian Bland) within ten (10) business days.

If the participant disagrees with the appeal decision, he/she may appeal to MHA (Marian Bland), Division of Special Populations, 8450 Dorsey Run Road, Jessup, Maryland 20794-1000 in writing within ten (10) business days of the date of the written decision. MHA shall conduct or schedule a hearing within ten (10) business days to review the decision of the Local Mental Health Authority. Again, the participant will have the right to present written and/or oral objections to the appeal decision to MHA personnel. A written decision shall be sent by MHA to the participant and Local Mental Health Authority within 10 business days.

During the appeal process the rent and utility subsidy should continue to be paid by the local mental health authority.
Shelter Plus Care Participant Agreement:

I, __________________________, Shelter Plus Care applicant/participant, have read the termination procedures or had the termination procedures explained to me. I have also received a copy of the termination procedures. I understand that I can be terminated from the program due ongoing severe violations of program requirements and/or occupancy agreements. I understand that I must participate in supportive services in order to receive rental assistance through the Shelter Plus Care Housing Program. I also understand the appeal process as discussed in the Shelter Plus Care termination procedures discussed on the attached pages.

Client's Signature __________________________ Date ____________

Witness’ Signature and Title __________________________ Date ____________
Maryland Mental Hygiene Administration
Shelter Care Housing Program

Consumer Agreement

By deciding to participate in the Shelter Plus Care Housing Program, I agree to the following:

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

I understand that failure to comply with these conditions may result in my not continuing to receive rental assistance through the Maryland Mental Hygiene Administration Shelter Plus Care Housing Program.

____________________________  ______________________________
Date                                      Signature

____________________________  ______________________________
Date                                      Witness
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 age 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 ________________________ Social Security Number ________________________

Updated 11/29/04 mvb
CLIENT CONSENT FOR DATA COLLECTION

I, ____________________________________________, (insert client’s name), understand and acknowledge that ____________________________________________, (the “Agency”) is affiliated with the HMIS, and I consent to and authorize the collection of information and preparation of records pertaining to the services provided to me by the Agency. 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 Community Partnership to End Homelessness to:

a) Provide individual case management
b) Produce aggregate-level reports regarding use of services
c) Track individual program-level outcomes
d) Identify unfilled service needs and plan for the provision of new services
e) Allocate resources among agencies engaged in the provision of services

I understand that the following data will be collected and agree to share it with other agencies in the HMIS group.

(Initial appropriate information)

_____ Identifying information (name, birth date, gender, race, social security number, residential information, phone number, family information.)

_____ Medical records, psychological records and evaluations, vocational assessment, care coordinators recommendations and direct observations, employment status, etc.

_____ Financial information (income verification, public assistance payments and allowances, food stamp allotments.)

_____ HIV/AIDS diagnosis

_____ Substance abuse diagnoses, treatment plan, progress in treatment, discharge.

_____ (please initial) I understand that I have the right to inspect, copy, and request all records maintained by the Agency relating to the provision of services to me and to receive a paper copy of this form.

_____ (please initial) This consent terminates automatically 730 days after my last treatment or discharge from an Agency. My records are protected by federal, state, and local regulations governing confidentiality of client records and cannot be disclosed without my written consent unless provided for in the regulations.

Additionally, I understand that participation in data collection is optional, and I am able to access shelter and housing services if I choose not to participate in data collection.

Date __________________________ Signature ________________________

Board of Directors
Phillip Livingstone, Chairman; Katharine Boucher; Betty Coleman; Betty McGarvie Crowley; Rodney Davis; Richard Doles; Jessica Herrman; Michael Irwin; Lynn Krause; Phyllis Marshall; Rosalie Maltzner; Kathy Miller; Frances Phillips; Gail Smith; Thomas Shanahan; Roberta VanMeter
CLIENT CONSENT FOR RELEASE OF INFORMATION

CLIENT NAME: (first, middle, last) ________________ D.O.B ________________ SS# ________________

In accordance with Federal Regulation Code 42, Part 2, I hereby authorize:

To release to/share with:

________________________
Agency

The following information: (including patient records related to any attempted suicide, emotional illness, psychological services records, if any, social services records, if any; including communications made by me to a social worker, counselor, psychologist, physician, or other health care provider; and information regulated by Federal Public Law 92-282, confidentiality of alcohol and drug abuse patients and records documenting the diagnosis and/or treatment of communicable diseases and/or serious disease and infections as defined by the US Department of Health and Human Services rules which include venereal disease, tuberculosis, AIDS, ARC, HIV status and other related diseases, if any)

___ Diagnosis/Test Results
___ Medical Records/Hospital Records
___ Psychological/Psychosocial Assessments
___ Substance Abuse Assessments/ Evaluations/History
___ Psychiatric Evaluation/
Consultation/Medications
___ Diagnostic Impressions/ Prognosis
___ Treatment Plan/Treatment Recommendations
___ Discharge/Treatment Summary
___ Police/Prison Records
___ Financial Information
___ Housing Requirements
___ Transportation Requirements
___ Nutritional Requirements
___ Chart/Progress Notes
___ Other (describe)

This agreement applies for services covering the dates from: ____________ to ____________ for the specific purpose of Meeting Homeless Management Information System data entry requirements. I release the above cited individuals or facilities of any legal ability that may arise from the release of the information requested. I understand that the agency cannot release information obtained from other sources. I understand that the individual/institution/agency receiving this information may not re-release it to any other individual, institution or agency. I also understand that this authorization for release of information will expire in 730 days.

This release can be revoked by me at any time and the revocation must be signed and dated by me and that the revoking of the release will not affect information released prior to the revoking of the release.

________________________
Signature

________________________
Date

________________________
Relationship (if minor)

________________________
Witness Name (print)

________________________
Witness Signature

________________________
Date

**I hereby revoke my consent for the release of the previously stated information**

________________________
Signature

________________________
Date

Board of Directors
Phillip Livingstone, Chairman; Katharine Boucher; Betty Coleman; Betty McGarvie; Rodney Davis; Richard Doles; Jessica Herrmann; Michael N. Lynn Krause; Phyllis Marshall; Rosalie Mallonee; Kathy Miller; Frances Phillips; Gail Smith; Thomas Stanahan; Roberta VanMeter