



CHRONIC HEALTH CONDITION			IF YES: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?		
<input type="checkbox"/> No	<input type="checkbox"/> Yes (SEE RIGHT)	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected
HIV/AIDS			IF YES: EXPECTED TO SUBSTANTIALLY IMPAIR ABILITY TO LIVE INDEPENDENTLY?		
<input type="checkbox"/> No	<input type="checkbox"/> Yes (SEE RIGHT)	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected
MENTAL HEALTH PROBLEM			IF YES: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?		
<input type="checkbox"/> No	<input type="checkbox"/> Yes (SEE RIGHT)	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected
SUBSTANCE ABUSE PROBLEM			IF YES: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?		
<input type="checkbox"/> No	<input type="checkbox"/> Yes, Alcohol (SEE RIGHT) <input type="checkbox"/> Yes, Drug (SEE RIGHT) <input type="checkbox"/> Yes, Both (SEE RIGHT)	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected

*DISABLING CONDITION		
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected

***NON-HMIS DATA ELEMENTS**

SERVICES SOUGHT	
<input type="checkbox"/> Shelter/Housing <input type="checkbox"/> Mental Health Care <input type="checkbox"/> Legal Aid - CRJS/Civil	<input type="checkbox"/> Drug Treatment <input type="checkbox"/> Medical Care <input type="checkbox"/> Legal Aid - Immigration

--- END ---

PROCEED TO CLIENT RELEASE OF INFORMATION



CRHMIS CLIENT RELEASE OF INFORMATION

FOR HOUSEHOLD MEMBERS UNDER THE AGE OF 18 AND ADULTS WHO ARE UNABLE TO SIGN ON THEIR OWN

To better support the coordination and provision of your services, we are requesting your permission to share a limited amount of information about you with other homeless services providers. As owner of your own data within the CRHMIS, you have the right to choose how much personal information, if any, is shared within the database. This permission will be in effect for a minimum of 36 months, but you may revoke consent at any time. HIV/AIDS information, Domestic Violence information, Behavioral Health information (including mental illness and substance abuse), and client notes are NOT shared through the HMIS.

Please check one (1) box below to indicate the level at which you are willing to share your information with the homeless services coordinators and providers in the community:

I agree to share my name, gender, and program enrollment history through the HMIS with other partner homeless services agencies.

I agree to share my name, gender, program enrollment history, demographic, income, and contact information through the HMIS with other partner homeless services agencies.

I do NOT agree to share any of my information through the HMIS with other partner homeless services agencies.

Print the names of all minor and/or developmentally disabled household members covered by this agreement:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

By signing this form, I agree to share the level of information indicated above with other partner agencies via the HMIS Computer System:

PRINT name of Guardian or Power of Attorney

PRINT name of Witness

SIGNATURE of Guardian or Power of Attorney

SIGNATURE of Witness

DATE

DATE