

HMIS INTAKE

HUD: CoC – Coordinated Entry Head of Household or Adult (18+)

*INTAKE DATE / /		PRIMARY WORKER	
*FIRST NAME		MIDDLE NAME	*LAST NAME (and Suffix)
*NAME DATA QUALITY			ALIAS
<input type="checkbox"/> Full Name Reported <input type="checkbox"/> Partial Name, Street Name or Code Name Reported		<input type="checkbox"/> Data Not Collected <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
*SOCIAL SECURITY NUMBER <i>(enter "9" for any missing numbers in an Approximate or Partial SSN)</i> - - - - - - - -		*SSN DATA QUALITY	
		<input type="checkbox"/> Full SSN Reported <input type="checkbox"/> Approximate or Partial SSN Reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	
*GENDER			
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans Male(FTM) <input type="checkbox"/> Trans Female(MTF) <input type="checkbox"/> Gender Non-Conforming		<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	
*BIRTHDATE / /		*BIRTHDATE DATA QUALITY	
		<input type="checkbox"/> Full DOB Reported <input type="checkbox"/> Approximate or Partial DOB Reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	
*ETHNICITY			
<input type="checkbox"/> Hispanic		<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Data Not Collected <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
*RACE (choose all that apply)			
<input type="checkbox"/> American Indian/Native Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White		<input type="checkbox"/> Data Not Collected <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
*DO YOU HAVE A PHONE NUMBER AT WHICH YOU CAN BE REACHED?			
<input type="checkbox"/> No	<input type="checkbox"/> Yes (SEE RIGHT)	IF YES: PLEASE PROVIDE YOUR PHONE NUMBER WITH AREA CODE () - - - - - - - -	
*VETERAN STATUS			
<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> Data Not Collected <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	

*PRIOR LIVING SITUATION

Based on the client's living situation **the night before project entry**, record responses in one (1) section:
 Homeless Situation, Institutional Situation, Transitional/Permanent Situation, OR Unknown (**only** if necessary)

HOMELESS SITUATIONS:	
TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)	
<input type="checkbox"/> Place not meant for human habitation (vehicle, abandoned building, bus/train/subway station etc) <input type="checkbox"/> Emergency shelter , including hotel or motel paid for with emergency shelter voucher <input type="checkbox"/> Safe Haven <input type="checkbox"/> Interim Housing	
*LENGTH OF STAY IN PREVIOUS PLACE	
<input type="checkbox"/> 1 night or less <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> 2 to 6 nights <input type="checkbox"/> Client Refused <input type="checkbox"/> 1 week or more, but less than 1 month <input type="checkbox"/> Data Not Collected <input type="checkbox"/> 1 month or more, but less than 90 days <input type="checkbox"/> 90 days or more, but less than 1 year <input type="checkbox"/> 1 year or longer	
*APPROXIMATE DATE HOMELESSNESS STARTED: / /	
*REGARDLESS OF WHERE THEY STAYED LAST NIGHT NUMBER OF TIMES ON THE STREETS, IN ES, OR SH IN THE PAST THREE YEARS	
<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4+ <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	
*TOTAL NUMBER OF MONTHS HOMELESS ON THE STREETS, IN ES, OR IN SH IN THE PAST THREE YEARS	
<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> More than 12 <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	

OR

INSTITUTIONAL SITUATIONS:	
TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)	
<input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail , prison or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center	
*LENGTH OF STAY IN PREVIOUS PLACE	
<input type="checkbox"/> 1 night or less <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> 2 to 6 nights <input type="checkbox"/> Client Refused <input type="checkbox"/> 1 week or more, but less than 1 month <input type="checkbox"/> Data Not Collected <input type="checkbox"/> 1 month or more, but less than 90 days <input type="checkbox"/> 90 days or more, but less than 1 year <input type="checkbox"/> 1 year or longer	

---GO ON---

DID THE CLIENT STAY LESS THAN 90 DAYS		IF YES: THE NIGHT BEFORE THAT, DID THEY STAY ON THE STREETS, ES, or SH?	
<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	
IF YES TO 'ON THE NIGHT BEFORE DID YOU STAY ON THE STREETS, ES OR SH?' PROVIDE DETAILS OF PREVIOUS HOMELESSNESS:			
*APPROXIMATE DATE HOMELESSNESS STARTED: ____/____/____			
*REGARDLESS OF WHERE THEY STAYED LAST NIGHT NUMBER OF TIMES ON THE STREETS, IN ES, OR SH IN THE PAST THREE YEARS		*TOTAL NUMBER OF MONTHS HOMELESS ON THE STREETS, IN ES, OR IN SH IN THE PAST THREE YEARS	
<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4+ <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> More than 12 <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	

OR

TRANSITIONAL AND PERMANENT HOUSING SITUATIONS:	
TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)	*LENGTH OF STAY IN PREVIOUS PLACE
<input type="checkbox"/> Hotel or Motel paid for without emergency shelter voucher <input type="checkbox"/> Owned by client, no ongoing subsidy <input type="checkbox"/> Owned by client WITH ongoing subsidy <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons (PSH, HOPWA) <input type="checkbox"/> Rental by client, no ongoing subsidy <input type="checkbox"/> Rental by client with GPD TIP subsidy <input type="checkbox"/> Rental by client with VASH subsidy <input type="checkbox"/> Rental by client with other housing subsidy (including RRH)	<input type="checkbox"/> 1 night or less <input type="checkbox"/> 2 to 6 nights <input type="checkbox"/> 1 week or more, but less than 1 month <input type="checkbox"/> 1 month or more, but less than 90 days <input type="checkbox"/> 90 days or more, but less than 1 year <input type="checkbox"/> 1 year or longer <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected
<input type="checkbox"/> Rental by client with other housing subsidy (including RRH) <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Staying or in a family member's room, apartment or house <input type="checkbox"/> Staying or in a friend's room, apartment or house <input type="checkbox"/> Transitional housing for homeless persons (incl. homeless youth)	
DID YOU STAY LESS THAN 7 DAYS?	
IF YES: THE NIGHT BEFORE THAT, DID THEY STAY ON THE STREETS, ES, or SH?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	
IF YES TO 'ON THE NIGHT BEFORE DID YOU STAY ON THE STREETS, ES OR SH?' PROVIDE DETAILS OF PREVIOUS HOMELESSNESS:	
*APPROXIMATE DATE HOMELESSNESS STARTED: ____/____/____	
*REGARDLESS OF WHERE THEY STAYED LAST NIGHT NUMBER OF TIMES ON THE STREETS, IN ES, OR SH IN THE PAST THREE YEARS	*TOTAL NUMBER OF MONTHS HOMELESS ON THE STREETS, IN ES, OR IN SH IN THE PAST THREE YEARS
<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4+ <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> More than 12 <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected

OR

UNKNOWN (ONLY IF NECESSARY)
TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)
<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

***CURRENT LIVING SITUATION**

HOMELESS SITUATIONS:
<input type="checkbox"/> Place not meant for human habitation (vehicle, abandoned building, bus/train/subway station etc) <input type="checkbox"/> Emergency shelter , including hotel or motel paid for with emergency shelter voucher <input type="checkbox"/> Safe Haven <input type="checkbox"/> Interim Housing

OR

INSTITUTIONAL SITUATIONS:
<input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail , prison or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center

OR

TRANSITIONAL AND PERMANENT HOUSING SITUATIONS:	
<input type="checkbox"/> Hotel or Motel paid for without emergency shelter voucher <input type="checkbox"/> Owned by client, no ongoing subsidy <input type="checkbox"/> Owned by client WITH ongoing subsidy <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons (PSH, HOPWA) <input type="checkbox"/> Rental by client, no ongoing subsidy <input type="checkbox"/> Rental by client with VASH subsidy <input type="checkbox"/> Rental by client with GPD TIP subsidy <input type="checkbox"/> Rental by client with other housing subsidy (including RRH)	<input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Staying or in a family member's room, apartment or house <input type="checkbox"/> Staying or in a friend's room, apartment or house <input type="checkbox"/> Transitional housing for homeless persons (incl. homeless youth)

---GO ON---

UNKNOWN (ONLY IF NECESSARY)	LIVING SITUATION VARIFIED BY: (Agency Name)
<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected	

***INCOME & SOURCES / NON-CASH BENEFITS**

*INCOME FROM ANY SOURCE	
<input type="checkbox"/> No <input type="checkbox"/> Yes (SEE BELOW) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	
IF YES: CHECK & FILL IN MONTHLY AMOUNT FOR ALL THAT APPLY	
<input type="checkbox"/> Earned Income \$ _____ <input type="checkbox"/> SSI \$ _____ <input type="checkbox"/> VA Service-Connected Disability Compensation \$ _____ <input type="checkbox"/> Private Disability Insurance..... \$ _____ <input type="checkbox"/> TANF \$ _____ <input type="checkbox"/> Retirement from SSA \$ _____ <input type="checkbox"/> Child Support..... \$ _____ <input type="checkbox"/> Other \$ _____	<input type="checkbox"/> Unemployment Insurance \$ _____ <input type="checkbox"/> SSDI \$ _____ <input type="checkbox"/> VA Non-Service Connected Disability Pension..... \$ _____ <input type="checkbox"/> Worker's Compensation..... \$ _____ <input type="checkbox"/> General Public Assistance \$ _____ <input type="checkbox"/> Pension or Retirement from former job \$ _____ <input type="checkbox"/> Alimony or Other Spousal Support..... \$ _____
*NON-CASH BENEFITS FROM ANY SOURCE	
<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	
IF YES: CHECK ALL THAT APPLY	
<input type="checkbox"/> SNAP (Food Stamps) <input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants and Children <input type="checkbox"/> Other TANF Funded Srvcs <input type="checkbox"/> TANF Child Care Services <input type="checkbox"/> TANF Transportation Service	

***HEALTH INSURANCE / DISABLING CONDITIONS**

*COVERED BY HEALTH INSURANCE	
<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	
IF YES: CHECK ALL THAT APPLY	
MEDICAID <input type="checkbox"/> No <input type="checkbox"/> Yes State Children's Health Insurance Program <input type="checkbox"/> No <input type="checkbox"/> Yes Employer provided Health insurance..... <input type="checkbox"/> No <input type="checkbox"/> Yes Private Pay Health Insurance..... <input type="checkbox"/> No <input type="checkbox"/> Yes Indian Health Services <input type="checkbox"/> No <input type="checkbox"/> Yes	MEDICARE..... <input type="checkbox"/> No <input type="checkbox"/> Yes VA Medical Services <input type="checkbox"/> No <input type="checkbox"/> Yes Health ins. via COBRA..... <input type="checkbox"/> No <input type="checkbox"/> Yes State Health Ins. Adults..... <input type="checkbox"/> No <input type="checkbox"/> Yes
*PHYSICAL DISABILITY	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
*DEVELOPMENTAL DISABILITY	IF YES: EXPECTED TO 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
*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 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
*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

---GO ON---

*** DV STATUS**

*DOMESTIC ABUSE VICTIM/SURVIVOR					
<input type="checkbox"/> No		<input type="checkbox"/> Yes (SEE BELOW)		<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	
IF YES: WHEN EXPERIENCE OCCURRED			IF YES: ARE YOU CURRENTLY FLEEING?		
<input type="checkbox"/> Within the past 3 months	<input type="checkbox"/> From 6 to 12 months ago	<input type="checkbox"/> Client Doesn't Know		<input type="checkbox"/> Client Doesn't Know	
<input type="checkbox"/> 3 to 6 months ago	<input type="checkbox"/> More than a year ago	<input type="checkbox"/> Client Refused		<input type="checkbox"/> Client Refused	
		<input type="checkbox"/> Data Not Collected		<input type="checkbox"/> No <input type="checkbox"/> Yes	
				<input type="checkbox"/> Data Not Collected	

***NON-HMIS DATA ELEMENTS**

*ZIP CODE OF LAST PERMANENT ADDRESS	

SERVICES SOUGHT	
<input type="checkbox"/> Has CDPHP Medicaid	<input type="checkbox"/> Does not have CDPHP Medicaid

---END---

PROCEED TO CLIENT RELEASE OF INFORMATION

CRHMIS CLIENT INCLUSION DISCLOSURE & RELEASE OF INFORMATION

PURPOSE: To inform clients of HMIS data entry and for clients to authorize or modify data sharing preferences within the HMIS for the project listed below:

AGENCY/PROVIDER: <input type="text"/>
PROJECT: <input type="text"/>
CONTACT NUMBER: <input type="text"/>

INSTRUCTIONS: This form must be completed for every independent adult (18 years of age and over) and every unaccompanied minor PRIOR to data collection and entry into the HMIS at all CRHMIS-participating providers. This form also covers any household members under the client's guardianship, which includes all minors (persons under 18 years of age) and any incapacitated/disabled adults. The client is to be given pages 1 and 2 after completion.

HMIS PRIVACY NOTICE

This Notice applies to all CRHMIS-Participating Providers and addresses how information about clients may be used and disclosed at Providers as well as client rights over their information. This Notice may be amended at any time, and amendments may affect information obtained before the date of the amendment.

A. HMIS DATA COLLECTION & PURPOSE

A Homeless Management Information System (HMIS) is a local information technology system used to collect data on the housing and services provided to homeless individuals and families and persons at risk of homelessness. Providers participating in an HMIS are required to collect universal data elements from all clients, including Personally Identifying Information, demographic characteristics, and residential history. This information is critical for providers and communities to better understand the extent and nature of homelessness at a local level, evaluate program effectiveness, and improve future housing and service provision. Some providers are also required by their funders to obtain certain additional information to assess services, to determine eligibility, and to monitor outcomes. Most federally-funded homeless service providers are required to participate and record the clients they serve in an HMIS.

This agency is an HMIS-participating homeless service provider ("CRHMIS Provider"), meaning we collect and enter information about the persons we serve in the private and secure CARES Regional HMIS (CRHMIS) database, the local HMIS for this community. There are firm policies and procedures in place to protect against unauthorized disclosure of any personal information collected, and this information is critical to obtain an accurate picture of the homeless population we serve and for this agency to continue to offer you the service(s) you are accessing today. We only collect information deemed appropriate and necessary for program operation or information that is required by law or by the organizations that fund this program. We do not need your consent to enter a record of your visit into the CRHMIS, but you may refuse to have your personal identifying information within this record and still be eligible to receive services.

If you have any concerns or questions about the information provided above, please speak to an intake worker.

B. PERMITTED DATA USES AND DISCLOSURES

The CRHMIS is designed to protect the confidentiality of personal information while allowing for reasonable, responsible, and limited uses and disclosures of data, including Personally Identifying Information (PII is any information that can be used to identify a particular individual, including a client's name, Social Security Number, and Date of Birth). Once collected, we (as a CRHMIS Provider) have obligations about how these data may be used and disclosed (**uses** are internal activities for which providers interact with client PII; **disclosures** occur when providers share PII with an external entity). **CRHMIS Providers are limited to the following circumstances for the use and disclosure of HMIS PII:**

HUD required:

- (1) Client access to their information; and
- (2) Disclosures for oversight of compliance with HMIS privacy and security standards.

HUD permitted:

- (3) To provide or coordinate services to an individual;
- (4) For functions related to payment or reimbursement for services;
- (5) To carry out administrative functions, including but not limited to legal, audit, personnel, oversight and management functions;
- (6) For creating de-identified reporting from PII;
- (7) Uses and disclosures required by law;
- (8) Uses and disclosures to avert a serious threat to health or safety;
- (9) Uses and disclosures about victims of abuse, neglect or domestic violence;
- (10) Uses and disclosures for research purposes; and
- (11) Uses and disclosures for law enforcement purposes.

A client must provide prior written consent for any other use or disclosure of HMIS PII.

CRHMIS Providers must also ensure that **any use or disclosure does not violate other applicable local, state, or federal laws**. Therefore, some CRHMIS Providers **may have more restrictive privacy policies**, often dependent upon funding source or the nature of a projects. Specific, per-project information regarding data use and disclosure can be obtained upon request.

C. CLIENT CONTROL OVER DATA

The CRHMIS recognizes every independent legal adult (person over 17 years of age) as the owner of all information about themselves, and any parent, legal guardian, or legal power of attorney as the designated owner of all information about any household members under their guardianship (all minors and any incapacitated/disabled adults).

By seeking assistance from this CRHMIS Provider and consenting to your personal information being entered into a record within the CRHMIS, you transfer governance responsibility over your CRHMIS record to us, and we are responsible for handling your record in accordance with CRHMIS privacy policies and any applicable federal, state, or local requirements. You retain ownership of your information within your CRHMIS record, and as owner **you have the following rights, in general:**

- » **Refusal:** to refuse to answer a question you do not feel comfortable with and not have it recorded within the CRHMIS;
- » **Access/Correction:** to request and view a copy of your project information record within the CRHMIS from your provider, including those who have accessed and/or edited your record, and to request corrections to that record;
- » **Grievance:** to ask questions of or submit grievances to your provider regarding privacy and security policies and practices;
- » **Anonymized Record:** to request that your provider anonymize your personal data record within the CRHMIS; and
- » **Optional Data Sharing:** to choose if your information is shared outside of the CRHMIS with researchers and other providers, and to make this decision at each project you receive services from. (Please note that if you decide NOT to data share, it does not prohibit the project from entering your data into the CRHMIS – it prohibits the sharing of your data as outlined on the consent form).

CRHMIS Providers reserve the following exceptions to the above: (1) Provider Right to Deny Review: if information is compiled in reasonable anticipation of litigation or comparable proceedings; if information about another individual other than the participating provider staff would be disclosed; if information was obtained under a promise of confidentiality other than a promise from this provider and disclosure would reveal the sources of the information; or if the disclosure of information would be reasonably likely to endanger the physical safety of any individual; and (2) Provider Right to Deny Access/Correction: in response to repeated or harassing requests.

D. RESPONSIBILITY TO PROTECT DATA

CARES of NY, Inc. (CARES) is the System Administrator of the CRHMIS. The CRHMIS uses Foothold Technology's AWARDS software application and database, which is maintained in compliance with all federal standards set forth in the Health Insurance Portability and Accountability Act (HIPAA) and its subsequent legislation – the standards required to protect medical records – as well as U.S. Department of Housing and Urban Development HMIS standards.

The CARES CRHMIS staff take the protection of client confidentiality and privacy seriously. **The following security measures, among others, are in place to ensure that your information is protected:**

- » **System Security:** HMIS data is encrypted and securely transmitted from Providers to the HMIS database, extensive procedures are in place to prevent unauthorized access, and the entire HMIS system and database is protected at the highest level of security for health data;
- » **Access:** Only CARES CRHMIS staff and staff at providers may receive authorization to access the CRHMIS, and authorization requires comprehensive initial training and annual privacy and security training thereafter;
- » **Confidentiality Agreements:** Every CRHMIS Provider and every person authorized to read or enter information into the CRHMIS signs an agreement every year that includes: (1) commitments to maintain the confidentiality of all CRHMIS information; (2) commitments to comply with all security measures in compliance with federal HMIS requirements and any applicable federal, state, or local laws; and (3) penalties for violation of the agreement;
- » **Monitoring:** Annual monitoring is conducted for CRHMIS providers to ensure compliance with privacy and security policies; and
- » **Reporting:** Published CRHMIS reports are comprised of aggregate data only, and never contain any client-level or identifying (PII) data.

IMPORTANT INFORMATION FOR ALL CLIENTS – PLEASE READ

If you do not understand any of the information within this form, you may ask your intake worker for further explanation or an alternate format.

You may **keep the first 2 pages** of this form (containing the HMIS Privacy Notice) for your records.

You may request a copy of any participating provider or CRHMIS policies from your intake worker. Further information regarding CRHMIS privacy and security is also available in the CRHMIS Policies and Procedures (accessible online at www.caresny.org/).

You may contact your participating provider regarding any of your rights as listed above, including if you feel that any of these rights have been violated. If your provider's response does not satisfy you, you may then contact the CRHMIS directly at hmis@caresny.org or (518) 489-4130.

INSTRUCTIONS: List all dependent household members (if any) in Section H on page 4, then complete Sections E through G.

E. ACKNOWLEDGEMENT OF INCLUSION

No client consent is required to enter client data from provider forms into the CRHMIS, including personally identifying information. All Protected Identifying Information (PII) entered into the HMIS for the purpose of Coordinated Entry may be shared with other participating providers through the HMIS to better serve your needs and streamline the intake process. Additional sharing of your PII will not happen without agreeing through the consent below.

To show you are aware of this, we ask you to initial below.

** _____ Please initial to indicate that you have read (or been read) and understand the above information.

F. CONSENT TO DATA SHARING

To facilitate the coordination and provision of your services, we are requesting to share your information confidentially **inside** the CRHMIS with organizations

To facilitate the coordination and provision of your services and reduce intake time at other participating agencies:

- I agree to allow my information to be shared inside the CRHMIS for coordination of care purposes.
- I do NOT agree to allow my information to be shared inside the CRHMIS for coordination of care purposes.

G. RELEASE OF INFORMATION

To facilitate the coordination and provision of your services, we are requesting to share your information confidentially **outside** the CRHMIS with organizations and government agencies for research and service delivery.

Note: clients of Solutions to End Homelessness Program (STEHP) projects will have their information shared with OTDA regardless of preference, because OTDA funds the STEHP program.

- I agree to allow my information to be shared with external sources for research purposes.
- I do NOT agree to allow my information to be shared with external sources for research purposes.

H. FINAL ACKNOWLEDGEMENTS & SIGNATURE

As a client of a CRHMIS-participating agency:

- » I understand that my information will be entered into the CRHMIS database, I understand my rights as a CRHMIS client, and I have been provided the first 2 pages of this form to retain for my records;
- » I understand that my information will be shared through the CRHMIS at the level I have authorized in Section F and that I have the right to withdraw or change this consent via written request at any time. I also understand that the level of consent I provide will be in effect for a minimum of 36 months, unless I submit a written request to change it.
- » I understand that agreeing to data sharing does not guarantee that I will receive services, and that not agreeing to data sharing does not prohibit the project from entering my information into the CRHMIS – it only prohibits the sharing of my information with other participating providers.

**** By signing below,** I confirm that I have read (or been read) this form in its entirety and I have had the opportunity to ask questions on this form and had them answered. My signature also confirms that I understand all information contained herein, and that I authorize the level of data-sharing indicated in Section F for myself and any dependent household members as listed on the back of this page:

PRINT name of Client	PRINT name of Witness/Intake Worker
SIGNATURE of Client, Guardian, or Power of Attorney	SIGNATURE of Witness/Intake Worker
DATE	DATE
AGENCY/PROVIDER	
PROJECT	

I. DEPENDENT HOUSEHOLD MEMBERS

Dependent household members include all minors (persons under 18 years of age) and/or any incapacitated/disabled adults under your guardianship.

All minors must be listed on one, and only one, adult's form.

Are any dependent household members living with you? No Yes

Are you the designated head of the household? No Yes

**** If you answered yes to both questions above, please list** all dependent household members (to which this form also applies) in the table below:

	HOUSEHOLD MEMBER NAME (FIRST AND LAST)	DATE OF BIRTH (MM/DD/YYYY)	RELATIONSHIP TO YOU
1			
2			
3			
4			
5			
6			

IMPORTANT - CLIENT IS TO BE GIVEN FIRST 2 PAGES OF THIS CONSENT

INSTRUCTIONS:

- 1) These are two separate forms sharing one page for convenience and resource conservation.
- 2) A form must be filled out for EACH household member. Minors may NOT sign for themselves or their children, even if they are the head of household. The additional MINOR consent should be filled out and signed by a parent or guardian for all minors or adult household members with developmental disabilities which would preclude them from signing the consent themselves.

CRHMIS Inclusion Disclosure

The CRHMIS has moved from *inferred consent* (a posted sign) to an *inclusion disclosure* for the HMIS. **No consumer consent is required by the CRHMIS to enter consumer data.** This disclosure replaces the posted sign but fulfills the same purpose. Consumers are asked to initial that they received the information. This is in addition to any agency specific or CoC specific forms that may be presented upon intake.

While individual agencies and projects may have their own, overriding policies, refusing to initial the inclusion disclosure does **NOT** indicate a refusal to be included in the HMIS and does not automatically disqualify consumers from receiving services from the agency or project; agency and CoC policy regarding how to handle that situation should still be followed as it has been in past years.

CRHMIS Client Release of Information

The CRHMIS is not an open system and does not automatically share data between agencies. In order to better coordinate case care; however, the CRHMIS Advisory Committee has agreed to a stepped implementation of consumer-driven data sharing. If your project allows data sharing (please contact kclark@caresny.org if you are not sure) the consumer may choose to share some or most of their data within the HMIS. This data is shared only to other HMIS users who have been through training in the system and agreed to all privacy and security polices. Special needs (i.e. mental health, HIV status, substance abuse status) are NEVER Shared between agencies.

If your agency or project DOES NOT participate in data sharing, you must check option 3 on this sheet and have the consumer sign, indicating that they understand that their data will NOT be shared regardless of preference. When entering the intake into HMIS, "No Sharing" is the default and, in this circumstance will be left at the default and the intake processed. Monitoring will include checking to ensure that physical forms and HMIS records match.

If your agency and project DOES participate in data sharing, you must give the consumer the choice to share at level 1 (most restrictive but still shared), 2 (less restrictive) or 3 (no sharing at all). The consumer must then sign and date the form. Monitoring will include checking to ensure that physical forms and HMIS records match