

# SCHENECTADY COUNTY COORDINATED ENTRY APPLICATION

ARE YOU SEEKING HOUSING SERVICES?	HAVE YOU PREVIOUSLY COMPLETED AN APPLICATION FOR ASSISTANCE THROUGH COORDINATED ENTRY?
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

**IF CLIENT IS NOT SEEKING HOUSING SERVICES, A HOUSING ASSESSMENT DOES NOT NEED TO BE COMPLETED**

BEFORE STARTING THIS APPLICATION PLEASE MAKE SURE THE APPLICANT:

1. Meets the HUD definition of homeless.  
Lacks a fixed, regular, and adequate nighttime residence, meaning:
  - (i) Has a primary nighttime residence that is a public or private place not meant for human habitation;
  - (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs);
  - OR
  - (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution
2. Spent last night in Schenectady County.
3. Does not have a pending CE application. Check with your CE lead if the applicant is not sure.
4. Is not paying for a motel/hotel. DSS must be paying for the stay at the time of application to meet the above definition.

STAFF MEMBER COMPLETING ASSESSMENT	AGENCY NAME	
STAFF MEMBER'S EMAIL	PHONE NUMBER	FAX NUMBER

### PRESCREENING INFORMATION

ARE YOU CURRENTLY HOMELESS	ARE YOU AT RISK OF BECOMING HOMELESS
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
ADDRESS (Please indicate if this is a <input type="checkbox"/> current or <input type="checkbox"/> previous address)	MAILING ADDRESS (if different than address provided)

### HMIS INFORMATION

*INTAKE DATE	*FIRST 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	*SSN DATA QUALITY	
(enter "9" for any missing numbers in an Approximate or Partial SSN) ____-____-____	<input type="checkbox"/> Full SSN Reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Approximate or Partial SSN Reported <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	
*GENDER (Please select all that apply)		
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Questioning <input type="checkbox"/> A gender that is not singularly 'Female' or 'Male' <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected		
*BIRTHDATE	*BIRTHDATE DATA QUALITY	
____/____/____	<input type="checkbox"/> Full DOB Reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Approximate or Partial DOB Reported <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	
*ETHNICITY		
<input type="checkbox"/> Hispanic/Latin(a)(o)(x) <input type="checkbox"/> Non- Hispanic/Latin(a)(o)(x) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected		
*RACE (choose all that apply)		
<input type="checkbox"/> American Indian, Native Alaskan, or Indigenous <input type="checkbox"/> Asian <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Black, African American, African <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Client Refused <input type="checkbox"/> White <input type="checkbox"/> Data Not Collected		
*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 (____)-____-____	
IF NO PHONE: HOW CAN APPLICANT BE CONTACTED (Email, Case Manager, Day Program, Lunch Site)		

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**\*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)	*LENGTH OF STAY IN PREVIOUS PLACE	
<input type="checkbox"/> <b>Place not meant for human habitation</b> (vehicle, abandoned building, bus/train/subway station etc) <input type="checkbox"/> <b>Emergency shelter</b> , including <b>hotel or motel</b> paid for with <b>emergency shelter voucher</b> <input type="checkbox"/> Safe Haven <input type="checkbox"/> Interim Housing	<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"/> <i>Client Doesn't Know</i> <input type="checkbox"/> <i>Client Refused</i> <input type="checkbox"/> <i>Data Not Collected</i>
*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"/> <i>Client Doesn't Know</i> <input type="checkbox"/> <i>Client Refused</i> <input type="checkbox"/> <i>Data Not Collected</i>	<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"/> <i>Client Doesn't Know</i> <input type="checkbox"/> <i>Client Refused</i> <input type="checkbox"/> <i>Data Not Collected</i>

**OR**

INSTITUTIONAL SITUATIONS:		
TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)	*LENGTH OF STAY IN PREVIOUS PLACE	
<input type="checkbox"/> <b>Foster care</b> home or foster care group home <input type="checkbox"/> <b>Hospital</b> or other residential non-psychiatric medical facility <input type="checkbox"/> <b>Jail</b> , prison or juvenile detention facility <input type="checkbox"/> <b>Long-term care facility</b> or <b>nursing home</b> <input type="checkbox"/> <b>Psychiatric hospital</b> or other psychiatric facility <input type="checkbox"/> <b>Substance use treatment</b> facility or detox center	<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"/> <i>Client Doesn't Know</i> <input type="checkbox"/> <i>Client Refused</i> <input type="checkbox"/> <i>Data Not Collected</i>
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"/> <i>Client Doesn't Know</i> <input type="checkbox"/> <i>Client Refused</i> <input type="checkbox"/> <i>Data Not Collected</i>	<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"/> <i>Client Doesn't Know</i> <input type="checkbox"/> <i>Client Refused</i> <input type="checkbox"/> <i>Data Not Collected</i>

**OR**

TRANSITIONAL AND PERMANENT HOUSING SITUATIONS:		
TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)	*LENGTH OF STAY IN PREVIOUS PLACE	
<input type="checkbox"/> <b>Hotel or Motel</b> paid for <b>without</b> emergency shelter voucher <input type="checkbox"/> Owned by client, <b>no</b> ongoing subsidy <input type="checkbox"/> Owned by client <b>WITH</b> ongoing subsidy <input type="checkbox"/> Permanent housing ( <b>other than RRH</b> ) for formerly homeless persons (PSH, HOPWA) <input type="checkbox"/> Rental by client, <b>no</b> 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 ( <b>including RRH</b> ) <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> <b>Staying or in a family member's</b> room, apartment or house <input type="checkbox"/> <b>Staying or in a friend's</b> room, apartment or house <input type="checkbox"/> <b>Transitional housing</b> for homeless persons (incl. homeless youth)	<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"/> <i>Client Doesn't Know</i> <input type="checkbox"/> <i>Client Refused</i> <input type="checkbox"/> <i>Data Not Collected</i>
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		<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"/> <i>Client Doesn't Know</i> <input type="checkbox"/> <i>Client Refused</i> <input type="checkbox"/> <i>Data Not Collected</i>	<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"/> <i>Client Doesn't Know</i> <input type="checkbox"/> <i>Client Refused</i> <input type="checkbox"/> <i>Data Not Collected</i>

**OR**

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

**---NEXT PAGE---**

**\*CURRENT LIVING SITUATION**

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

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

**OR**

<b>INSTITUTIONAL SITUATIONS:</b>	
TYPE OF RESIDENCE (TONIGHT)	
<input type="checkbox"/> <b>Foster care</b> home or foster care group home	<input type="checkbox"/> <b>Long-term care facility</b> or <b>nursing home</b>
<input type="checkbox"/> <b>Hospital</b> or other residential non-psychiatric medical facility	<input type="checkbox"/> <b>Psychiatric hospital</b> or other psychiatric facility
<input type="checkbox"/> <b>Jail</b> , prison or juvenile detention facility	<input type="checkbox"/> <b>Substance use treatment</b> facility or detox center
IS CLIENT GOING TO LEAVE WITHIN 14 DAYS?	HAS A SUBSEQUENT RESIDENCE BEEN IDENTIFIED?
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Client Doesn't Know</i> <input type="checkbox"/> Client Refused <input type="checkbox"/> <i>Data Not Collected</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Client Doesn't Know</i> <input type="checkbox"/> Client Refused <input type="checkbox"/> <i>Data Not Collected</i>
DOES INDIVIDUAL OR FAMILY HAVE RESOURCES OR SUPPORT NETWORKS TO OBTAIN OTHER PERMANENT HOUSING?	
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Client Doesn't Know</i> <input type="checkbox"/> Client Refused <input type="checkbox"/> <i>Data Not Collected</i>	
HAS THE CLIENT HAD A LEASE OR OWNERSHIP INTEREST IN A PERMANENT HOUSING UNIT IN THE LAST 60 DAYS?	
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Client Doesn't Know</i> <input type="checkbox"/> Client Refused <input type="checkbox"/> <i>Data Not Collected</i>	
HAS THE CLIENT MOVED 2 TIMES OR MORE IN THE LAST 60 DAYS?	
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Client Doesn't Know</i> <input type="checkbox"/> Client Refused <input type="checkbox"/> <i>Data Not Collected</i>	

**OR**

<b>TRANSITIONAL AND PERMANENT HOUSING SITUATIONS:</b>	
TYPE OF RESIDENCE (TONIGHT)	
<input type="checkbox"/> <b>Hotel or Motel</b> paid for <b>without</b> emergency shelter voucher	<input type="checkbox"/> Rental by client with GPD TIP subsidy
<input type="checkbox"/> Owned by client, <b>no</b> ongoing subsidy	<input type="checkbox"/> Rental by client with other housing subsidy ( <b>including RRH</b> )
<input type="checkbox"/> Owned by client <b>WITH</b> ongoing subsidy	<input type="checkbox"/> Residential project or halfway house with no homeless criteria
<input type="checkbox"/> Permanent housing ( <b>other than RRH</b> ) for formerly homeless persons (PSH, HOPWA)	<input type="checkbox"/> <b>Staying or in a family</b> member's room, apartment or house
<input type="checkbox"/> Rental by client, <b>no</b> ongoing subsidy	<input type="checkbox"/> <b>Staying or in a friend's</b> room, apartment or house
<input type="checkbox"/> Rental by client with VASH subsidy	<input type="checkbox"/> <b>Transitional housing</b> for homeless persons (incl. homeless youth)
IS CLIENT GOING TO LEAVE WITHIN 14 DAYS?	HAS A SUBSEQUENT RESIDENCE BEEN IDENTIFIED?
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Client Doesn't Know</i> <input type="checkbox"/> Client Refused <input type="checkbox"/> <i>Data Not Collected</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Client Doesn't Know</i> <input type="checkbox"/> Client Refused <input type="checkbox"/> <i>Data Not Collected</i>
DOES INDIVIDUAL OR FAMILY HAVE RESOURCES OR SUPPORT NETWORKS TO OBTAIN OTHER PERMANENT HOUSING?	
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Client Doesn't Know</i> <input type="checkbox"/> Client Refused <input type="checkbox"/> <i>Data Not Collected</i>	
HAS THE CLIENT HAD A LEASE OR OWNERSHIP INTEREST IN A PERMANENT HOUSING UNIT IN THE LAST 60 DAYS?	
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Client Doesn't Know</i> <input type="checkbox"/> Client Refused <input type="checkbox"/> <i>Data Not Collected</i>	
HAS THE CLIENT MOVED 2 TIMES OR MORE IN THE LAST 60 DAYS?	
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Client Doesn't Know</i> <input type="checkbox"/> Client Refused <input type="checkbox"/> <i>Data Not Collected</i>	

**OR**

<b>UNKNOWN (ONLY IF NECESSARY)</b>	
<input type="checkbox"/> <i>Client doesn't know</i> <input type="checkbox"/> <i>Client refused</i> <input type="checkbox"/> <i>Data not collected</i>	

<b>LIVING SITUATION VERIFIED BY (NAME OF AGENCY)</b>	
ACCEPTABLE FORMS OF HOMELESSNESS VERIFICATION	
<ul style="list-style-type: none"> <li>Written observation by outreach worker; or</li> <li>Written referral by another housing or service provider; or</li> <li>Certification by individual or head of household stating that (s) he was living on the street or in shelter; (Additional 3<sup>rd</sup> party verification may be required at a later date)</li> </ul> Individuals exiting an institution – one of the forms of evidence above and: <ul style="list-style-type: none"> <li>Discharge paperwork or written/oral referral, or</li> <li>Written record of intake worker's due diligence to obtain above evidence and certification by individual that they exited institution.</li> </ul>	
WAS HOMELESSNESS VERIFIED	IF YES, HOW WAS HOMELESSNESS VERIFIED – INCLUDE DOCUMENTATION WITH COMPLETED APPLICATION
<input type="checkbox"/> No <input type="checkbox"/> Yes	

**---NEXT PAGE---**

IF THE APPLICANT DOES NOT HAVE VERIFICATION AT THIS TIME, EXPLAIN STEPS WILL BE TAKEN TO OBTAIN THE VERIFICATION

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

**\*INCOME FROM ANY SOURCE**  
 No  Yes (SEE BELOW)  Client Doesn't Know  Client Refused  Data Not Collected

**IF YES: CHECK & FILL IN MONTHLY AMOUNT FOR ALL THAT APPLY**

<input type="checkbox"/> Earned Income .....	\$ _____	<input type="checkbox"/> Unemployment Insurance .....	\$ _____
<input type="checkbox"/> SSI .....	\$ _____	<input type="checkbox"/> SSDI .....	\$ _____
<input type="checkbox"/> VA Service-Connected Disability Compensation .....	\$ _____	<input type="checkbox"/> VA Non-Service Connected Disability Pension.....	\$ _____
<input type="checkbox"/> Private Disability Insurance.....	\$ _____	<input type="checkbox"/> Worker's Compensation.....	\$ _____
<input type="checkbox"/> TANF .....	\$ _____	<input type="checkbox"/> General Public Assistance .....	\$ _____
<input type="checkbox"/> Retirement from SSA.....	\$ _____	<input type="checkbox"/> Pension or Retirement from former job .....	\$ _____
<input type="checkbox"/> Child Support.....	\$ _____	<input type="checkbox"/> Alimony or Other Spousal Support.....	\$ _____
<input type="checkbox"/> Other .....	\$ _____		

**\*NON-CASH BENEFITS FROM ANY SOURCE**  
 No  Yes  Client Doesn't Know  Client Refused  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**  
 No  Yes  Client Doesn't Know  Client Refused  Data Not Collected

**IF YES: CHECK ALL THAT APPLY**

MEDICAID .....	<input type="checkbox"/> No <input type="checkbox"/> Yes	MEDICARE.....	<input type="checkbox"/> No <input type="checkbox"/> Yes
State Children's Health Insurance Program .....	<input type="checkbox"/> No <input type="checkbox"/> Yes	VA Medical Services.....	<input type="checkbox"/> No <input type="checkbox"/> Yes
Employer provided Health insurance.....	<input type="checkbox"/> No <input type="checkbox"/> Yes	Health ins. Via COBRA.....	<input type="checkbox"/> No <input type="checkbox"/> Yes
Private Pay Health Insurance.....	<input type="checkbox"/> No <input type="checkbox"/> Yes	State Health Ins. Adults.....	<input type="checkbox"/> No <input type="checkbox"/> Yes
Indian Health Services.....	<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?**  
 No  Yes (SEE RIGHT)  Client Doesn't Know  Client Refused  Data Not Collected

**\*DEVELOPMENTAL DISABILITY**  
 No  Yes  Client Doesn't Know  Client Refused  Data Not Collected

**\*CHRONIC HEALTH CONDITION** **IF YES: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?**  
 No  Yes (SEE RIGHT)  Client Doesn't Know  Client Refused  Data Not Collected

**\*HIV/AIDS**  
 No  Yes  Client Doesn't Know  Client Refused  Data Not Collected

**\*MENTAL HEALTH DISORDER** **IF YES: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?**  
 No  Yes (SEE RIGHT)  Client Doesn't Know  Client Refused  Data Not Collected

**\*SUBSTANCE USE DISORDER** **IF YES: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?**  
 No  Yes, Alcohol (SEE RIGHT)  Client Doesn't Know  No  Yes  
 Yes, Drug (SEE RIGHT)  Client Refused  Data Not Collected  Client Doesn't Know  Client Refused  Data Not Collected  
 Yes, Both (SEE RIGHT)  Data Not Collected

**ACCEPTABLE FORMS OF DISABILITY VERIFICATION**

- Written verification of the disability from a professional licensed by the state to diagnose and treat the disability and his or her certification that the disability is expected to be long-continuing or of indefinite duration and substantially impedes the individual's ability to live independently; or
- Written verification from the Social Security Administration; or
- The receipt of a disability check (e.g., Social Security Disability Insurance check or Veteran Disability Compensation); or
- Intake staff-recorded observation of disability that, no later than 45 days from the application for assistance, is confirmed and accompanied by evidence above

All verification must be current (within one year of the date of application)

**WAS DISABILITY VERIFIED** **IF YES, HOW WAS DISABILITY VERIFIED – INCLUDE DOCUMENTATION WITH COMPLETED APPLICATION**  
 No  Yes

IF THE APPLICANT DOES NOT HAVE VERIFICATION AT THIS TIME, EXPLAIN STEPS WILL BE TAKEN TO OBTAIN THE VERIFICATION

**---NEXT PAGE---**

**\* DV STATUS**

<b>*DOMESTIC ABUSE VICTIM/SURVIVOR</b>		
<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"/> 3 to 6 months ago <input type="checkbox"/> More than a year ago <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	

**IF YES:** It is advised to connect the client with the domestic violence hotline at 518-374-3386 if they are not already engaged in services. If the location of the client is not safe or they are fleeing, note his/her name with INITIALS ONLY and location as UNDISCLOSED/SHELTERED. Refer to the P&P for additional instructions if needed.

**\*NON-HMIS DATA ELEMENTS**

EMPLOYMENT STATUS	IF YES: TYPE OF EMPLOYMENT	IF NO: WHY NOT EMPLOYED
<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	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal	<input type="checkbox"/> Looking for Work <input type="checkbox"/> Unable to Work <input type="checkbox"/> Not Looking for Work
CURRENTLY PREGNANT?	IF YES: DUE DATE	
<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	_____/_____/_____	
*VETERAN STATUS	IF YES: SELECT BRANCH	
<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	<input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Navy <input type="checkbox"/> Marines <input type="checkbox"/> Coast Guard <input type="checkbox"/> Other <input type="checkbox"/> Data Not Collected <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
DISCHARGE STATUS		
<input type="checkbox"/> Honorable <input type="checkbox"/> General Under Honorable Discharge <input type="checkbox"/> Under Other than Honorable Conditions <input type="checkbox"/> Bad Conduct <input type="checkbox"/> Dishonorable <input type="checkbox"/> Uncharacterized <input type="checkbox"/> Data Not Collected <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		
HOMELESS CAUSE (check only one)		
<input type="checkbox"/> Benefits loss/reduction <input type="checkbox"/> Job income loss/reduction <input type="checkbox"/> Eviction <input type="checkbox"/> Relocation <input type="checkbox"/> Released from prison/jail <input type="checkbox"/> Released from hospital	<input type="checkbox"/> Released behavioral health facility <input type="checkbox"/> Illness <input type="checkbox"/> Injury/ Disability <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Asked to leave shared residence (e.g. living in a home of another due to hardship)	<input type="checkbox"/> Drug/alcohol abuse <input type="checkbox"/> Other: _____ <input type="checkbox"/> Don't know <input type="checkbox"/> Refused
*ZIP CODE OF LAST PERMANENT ADDRESS	ZIP CODE DATA QUALITY	
_____	<input type="checkbox"/> Full or Partial Zip Code Reported <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	
DATE LEFT LAST PERMANENT ADDRESS	HAVE YOU BEEN CONVICTED OF A FELONY	
____/____/____	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	
CURRENTLY ON PROBATION OR PAROLE?	REQUIRED TO REGISTER ADDRESS UNDER SOAR	
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	
HAVE YOU OR ANY MEMBER OF YOUR HOUSEHOLD BEEN INVOLVED WITH ANY PROTECTION AGENCY		
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected		
IF YES: SELECT AGENCY	IF YES: IS THIS A CURRENT CASE	
<input type="checkbox"/> CPS <input type="checkbox"/> APS <input type="checkbox"/> Juvenile Justice <input type="checkbox"/> Family Court <input type="checkbox"/> Foster Care <input type="checkbox"/> Other: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	
IF CPS: Provide Protective Agency Worker's Name and Contact Number	IF CPS, IS A REUNIFICATION PLAN IN PLACE	
Name: _____ Contact Number: ( ) - _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>NOTES:</b> If there is any other information the client wishes to disclose to help with this process/placement, please note it here. (e.g. CL does not want treatment, CL is only available after 4p on Tuesdays, CL med docs are with Agency DCBA, CL does not want to work with Agency ABCD, etc.)		

---END---

PROCEED TO VULNERABILITY INDEX

<b>VULNERABILITY INDEX SCORING FOR Prevention</b>		
<b>Total Months Owed:</b>	<b>Total arrears owed:</b>	
<b><u>Prioritization Criteria</u></b>		
<b>Urgency of Housing Situation</b>		<b>SCORE</b>
		<b>SUBTOTAL</b>
Lock out -Sheriff	3	
Warrant (stayed or not)	2	
Court/Trial date	1	
14 day rent demand	1	
<b>Potential Barriers and Vulnerabilities</b>		<b>SCORE</b>
		<b>SUBTOTAL</b>
No income or Income to housing ratio 80 +	3	
Income to Housing 50 – 80	2	
Income to Housing 30 – 50	1	
COVID (Sick, Quarantined, income affected due to COVID)	3	
Household of 5 or More	3	
Single Parent w/ Minor Child(ren)	2	
At Risk of Losing Public Housing	2	
At Risk of Losing Supportive Housing	1	
Homeless in past 5 years (street, shelter or motel)	3	
Eviction in past 5 years (Court order or left after notice to quit)	2	
Domestic Violence Victim/Survivor in the past 5 years	3	
Sex Trafficking Victim/Survivor in the past 5 years	3	
Household member with Disabling Condition (SMI, Chronic Illness, Substance Abuse, developmental, physical and/or other disabling condition)	3	
Experienced Chronic Homelessness in past 5 years	3	
<b>TOTAL POINTS</b>		

**CONTINUE ON TO NEXT PAGE IF WORKING WITH A HOUSEHOLD OF TWO OR MORE  
IF NOT, SKIP TO CCHMIS INCLUSION DISCLOSURE**

Questions below are required for: Any Additional Household Members

FIRST NAME / LAST NAME		GENDER		RELATIONSHIP TO HEAD OF HOUSEHOLD	
SOCIAL SECURITY NUMBER <i>(enter "9" for any missing numbers in an Approximate or Partial SSN)</i> ____ - ____ - _____		BIRTHDATE ____ / ____ / ____			
<b>PHYSICAL DISABILITY</b>		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			
<b>DEVELOPMENTAL DISABILITY</b>					
<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					
<b>CHRONIC HEALTH CONDITION</b>		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			
<b>HIV/AIDS</b>					
<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					
<b>MENTAL HEALTH DISORDER</b>		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			
<b>SUBSTANCE USE DISORDER</b>		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"/> Client Doesn't Know <input type="checkbox"/> Yes, Drug (SEE RIGHT) <input type="checkbox"/> Client Refused <input type="checkbox"/> Yes, Both (SEE RIGHT) <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			

Questions below are required for: Any Additional Household Members

FIRST NAME / LAST NAME		GENDER		RELATIONSHIP TO HEAD OF HOUSEHOLD	
SOCIAL SECURITY NUMBER <i>(enter "9" for any missing numbers in an Approximate or Partial SSN)</i> ____ - ____ - _____		BIRTHDATE ____ / ____ / ____			
<b>PHYSICAL DISABILITY</b>		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			
<b>DEVELOPMENTAL DISABILITY</b>					
<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					
<b>CHRONIC HEALTH CONDITION</b>		IF YES: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?			
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<b>HIV/AIDS</b>					
<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					
<b>MENTAL HEALTH DISORDER</b>		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			
<b>SUBSTANCE USE DISORDER</b>		IF YES: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?			
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IF THERE ARE MORE THAN TWO ADDITIONAL HOUSEHOLD MEMBERS, CONTINUE ONTO NEXT PAGE.

IF NOT, SKIP TO CCHMIS INCLUSION DISCLOSURE

Questions below are required for: Any Additional Household Members

FIRST NAME / LAST NAME		GENDER	RELATIONSHIP TO HEAD OF HOUSEHOLD
SOCIAL SECURITY NUMBER <i>(enter "9" for any missing numbers in an Approximate or Partial SSN)</i> ____ - ____ - _____		BIRTHDATE ____ / ____ / ____	
<b>PHYSICAL DISABILITY</b>		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	
<b>DEVELOPMENTAL DISABILITY</b>			
<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			
<b>CHRONIC HEALTH CONDITION</b>		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	
<b>HIV/AIDS</b>			
<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			
<b>MENTAL HEALTH DISORDER</b>		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	
<b>SUBSTANCE USE DISORDER</b>		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"/> Client Doesn't Know <input type="checkbox"/> Yes, Drug (SEE RIGHT) <input type="checkbox"/> Client Refused <input type="checkbox"/> Yes, Both (SEE RIGHT) <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	

Questions below are required for: Any Additional Household Members

FIRST NAME / LAST NAME		GENDER	RELATIONSHIP TO HEAD OF HOUSEHOLD
SOCIAL SECURITY NUMBER <i>(enter "9" for any missing numbers in an Approximate or Partial SSN)</i> ____ - ____ - _____		BIRTHDATE ____ / ____ / ____	
<b>PHYSICAL DISABILITY</b>		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	
<b>DEVELOPMENTAL DISABILITY</b>			
<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			
<b>CHRONIC HEALTH CONDITION</b>		IF YES: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?	
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<b>HIV/AIDS</b>			
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<b>SUBSTANCE USE DISORDER</b>		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"/> Client Doesn't Know <input type="checkbox"/> Yes, Drug (SEE RIGHT) <input type="checkbox"/> Client Refused <input type="checkbox"/> Yes, Both (SEE RIGHT) <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	

IF THERE ARE MORE THAN FOUR ADDITIONAL HOUSEHOLD MEMBERS, PLEASE PHOTOCOPY THIS PAGE TO COMPLETE OR REACH OUT TO CARES TEAM

---END---

PROCEED TO CCHMIS COORDINATED ENTRY CLIENT INCLUSION DISCLOSURE

# CCHMIS COORDINATED ENTRY CLIENT INCLUSION DISCLOSURE

**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: **SCHENECTADY COUNTY COORDINATED ENTRY**

**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 CCHMIS-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 CCHMIS-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 ("CCHMIS Provider"), meaning we collect and enter information about the persons we serve in the private and secure CARES Regional HMIS (CCHMIS) 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 CCHMIS, 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 CCHMIS 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 CCHMIS 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). CCHMIS **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.

CCHMIS Providers must also ensure that **any use or disclosure does not violate other applicable local, state, or federal laws**. Therefore, some CCHMIS 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 CCHMIS 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 CCHMIS Provider and consenting to your personal information being entered into a record within the CCHMIS, you transfer governance responsibility over your CCHMIS record to us, and we are responsible for handling your record in accordance with CCHMIS privacy policies and any applicable federal, state, or local requirements. You retain ownership of your information within your CCHMIS 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 CCHMIS;
- » **Access/Correction:** to request and view a copy of your project information record within the CCHMIS 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 CCHMIS; and
- » **Optional Data Sharing:** to choose if your information is shared outside of the CCHMIS 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 CCHMIS – it prohibits the sharing of your data as outlined on the consent form).

*CCHMIS 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 CCHMIS. The CCHMIS 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 CCHMIS 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 CCHMIS staff and staff at providers may receive authorization to access the CCHMIS, and authorization requires comprehensive initial training and annual privacy and security training thereafter;
- » **Confidentiality Agreements:** Every CCHMIS Provider and every person authorized to read or enter information into the CCHMIS signs an agreement every year that includes: (1) commitments to maintain the confidentiality of all CCHMIS 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 CCHMIS providers to ensure compliance with privacy and security policies; and
- » **Reporting:** Published CCHMIS 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 CCHMIS policies from your intake worker. Further information regarding CCHMIS privacy and security is also available in the CCHMIS Policies and Procedures (accessible online at [www.caresny.org/](http://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 CCHMIS directly at [hmis@caresny.org](mailto:hmis@caresny.org) or (518) 489-4130.

## E. ACKNOWLEDGEMENT OF INCLUSION

No client consent is required to enter client data from provider forms into the CCHMIS, 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.

Please indicate method by which acknowledgement was received.

- Phone
- In Person

**IMPORTANT - CLIENT IS TO BE GIVEN A COPY OF THE CCHMIS COORDINATED ENTRY CLIENT INCLUSION DISCLOSURE**

**---NEXT PAGE---**

REFERRAL FOR SERVICES				
Please indicate the agencies/programs this referral will be sent to:				
Agency	Program	Primary Diagnosis	Description	Contact
<b>INDIVIDUALS ONLY</b>				
Bethesda House	<input type="checkbox"/> Liberty Consolidated	Chronic Homelessness	PSH, Rent 40% of income, 12 beds (834 State St)	Danny Payne (dpayne) and Crystal Thatcher (cthatcher)
	<input type="checkbox"/> Pathways to the Future	Chronic Homelessness	PSH, Rent 40% of income, 4 beds (834 State St)	
	<input type="checkbox"/> The Beacon	Chronic Homelessness	Scattered sties, Rent, 30% of income, 8 units	
YMCA	<input type="checkbox"/> Shelter Plus Care	Disabling Condition, Male only	SRO, Rent 30% of income or grants available for no income (845 Commons)	Ed Kowalczyk (ekowalczyk)
Mohawk Opportunities	<input type="checkbox"/> Permanent and Supported Housing	Mental Illness	PSH, Rent 30% of income, scattered sites	Bryan Gentile (BGentile)
	<input type="checkbox"/> Permanent Housing for Chronically Homeless	Chronic Homelessness w Mental Illness	PSH, Rent 30% of income, scattered sites	
YWCA	<input type="checkbox"/> Rosa's House	Disabling Condition, Female only	Supportive Housing, Rent is 30% of income, scattered sites	Tamara Flanders (tflanders)
Alliance for Positive Health		HIV+	One-time, short-term or potentially ongoing rental subsidy until Section 8 opening, rent is 30% of income, client locates apartment, and engage with housing retention services throughout enrollment	Randy Viele (rviele)
<b>INDIVIDUALS AND FAMILIES</b>				
New Choices	<input type="checkbox"/> Shelter Plus Care	Drug or Alcohol Addiction	Ongoing rental subsidy, Rent is 30% of income, client locates apartment	Tricia Le (tle)
SCAP	<input type="checkbox"/> Rapid Rehousing	None but must be able to increase income	Temporary rental subsidy, staff assist with housing search, case management required	Elizabeth Mosier (emosier)
	<input type="checkbox"/> SMHA Shelter Plus Care	Disabling Condition	Ongoing rental subsidy, rent is 30% of income, client locates apartment, MUST engage with treatment/case management	
	<input type="checkbox"/> Hillside	None	Fixed site, rent is based on income	
VCHC	<input type="checkbox"/> Rapid Rehousing	Veteran	Short-term financial assistance for permanent housing w/short term case management.	Johanna Guilfoyle (jguilfoyle)
Soldier On	<input type="checkbox"/> Rapid Rehousing	Veteran	Temporary rental subsidy or financial assistance to assist with placement in permanent housing	Katrina Middleton (kmiddleton)
<b>FAMILIES ONLY</b>				
SCAP	<input type="checkbox"/> Permanent Housing	Disabling Condition	PH, 27 units, 81 beds	Elizabeth Mosier (emosier)

## APPLICATION SUBMISSION INSTRUCTIONS

### To successfully submit this application:

Please scan and email the required documents (listed below) and any relevant supporting documents through the AWARDS messaging module to the Housing Agencies you indicated in the "REFERRAL FOR SERVICES" section above and **CC: kmcphail in AWARDS**

Faxed, hand-delivered, or applications sent via regular email will not be eligible for review.

### Required Coordinated Entry Documents:

- Completed Coordinated Entry Application
- Proof of Homelessness
- Proof of HUD-defined Disabling Condition