

ALBANY COUNTY COORDINATED ENTRY MAINSTREAM ASSESSMENT

APPLICATION SUBMISSION INSTRUCTIONS

Please scan and message 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 below and **CC: mgrillo in AWARDS****

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

If you do not have an AWARDS account email brobson@caresny.org to request an account to send messages

Required Coordinated Entry Documents: -

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

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

HMIS HOUSEHOLD 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 <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"/> 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"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Questioning <input type="checkbox"/> A gender that is not singularly 'Female' or 'Male'		<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"/> 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"/> Black, African American, African <input type="checkbox"/> White		<input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <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 (____) - _____ - _____	

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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, Temporary/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"/> 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"/> 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"/> 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 use treatment 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>		<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		
<input type="checkbox"/> No <input type="checkbox"/> Yes		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"/> <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

TEMPORARY 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 <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 RRH or equivalent subsidy <input type="checkbox"/> Rental by client with HCV voucher (tenant or project based) <input type="checkbox"/> Rental by client in a public housing unit		<input type="checkbox"/> Rental by client with other ongoing housing subsidy <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) <input type="checkbox"/> Host Home (non-crisis)
<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?		
<input type="checkbox"/> No <input type="checkbox"/> Yes		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"/> <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>		

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VULNERABILITY INDEX SCORING

Chronic Homelessness (CH) Status (CoC Priority)

Client has been continuously homeless for at least one year **OR** experience 4 or more episodes of homelessness within the last 3 years (where combined length of time homeless equals at least 12 months) **AND** has a documented disabling condition.

- Yes (If yes, add **“C”** to final score below) No Unable to determine

Assisted Outpatient Treatment (AOT) Status (County Priority; below CH)

Client has active court-ordered AOT, **verified** via court paperwork or AOT Care Coordinator.

- Yes (If yes, add **“A”** to final score below) No Unable to determine

	SCORE	SUBTOTAL
Have you slept and are you going to sleep (tonight) in a place not meant for human habitation?	2	
Have you slept and are you going to sleep in a safe haven or in an emergency shelter?	1	
Has your age impacted your ability to remain stably housed and/or to obtain housing?	2	
Are you a Veteran?	1	
Have conflicts around your gender identity or sexual orientation contributed to your homelessness?	2	
Has a lack of access to educational opportunities been a barrier to you being stably housed?	1	
Does your income source put you at greater risk for involvement with law enforcement and serve as a barrier to obtaining housing?	1	
Has a domestic violence situation contributed to your homelessness?	2	
Has violence at home between family members contributed to your homelessness?	1	
Has being a victim of sexual assault, stalking, or human trafficking contributed to your homelessness?	1	
Do you or someone in your household have a disabling condition or illness that substantially impairs your ability to independently access and sustain housing?	1	
Do you or someone in your household have two or more disabling conditions or illness that substantially impairs your ability to independently access and sustain housing?	1	
Do you or a member of your household have a disabling condition that requires accommodations for mobility or access?	1	
Have pending/existing legal issues impacted your ability to obtain housing?	2	
Is your current lack of stable housing because you ran away from your family home, group home, youth home, or foster home?	1	
Has having multiple points of contact (3+) with emergency responders and services such as ER visits, crisis, detox, emergency services and police/lead, contributed to your ability to obtain and maintain stable housing?	1	
Does any household member have a serious underlying medical condition and may be at higher risk of illness from COVID-19 due to:		
Currently pregnant	1	
Adults older than 65?	1	
Lung disease?	1	
Severe asthma?	1	
Obesity?	1	
Diabetes?	1	
Immunocompromised?	1	
Chronic kidney disease?	1	
Liver disease?	1	
TOTAL POINTS – If documented CH or AOT status, add “C” or “A” to score, respectively (i.e., “4C”)		

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

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	
_____ - _____ - _____		____/____/____	
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			
<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			
<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 DISORDER		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 USE DISORDER		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	
_____ - _____ - _____		____/____/____	
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			
<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			
<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 DISORDER		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 USE DISORDER		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 TWO ADDITIONAL HOUSEHOLD MEMBERS, CONTINUE ONTO NEXT PAGE.
IF NOT, SKIP TO CCHMIS INCLUSION DISCLOSURE AND RELEASE OF INFORMATION**

CONSENT TO RELEASE PERSONAL INFORMATION

Signing this consent allows Coordinated Entry-participating programs in The Albany County Continuum of Care to review some personal information related to your application, and to determine eligibility for housing. Regardless of which housing program you may prefer, all applications may be reviewed by the Coordinated Entry Committee which is comprised of representatives from participating provider agencies in the County. The purpose for this *Coordinated Entry Review* process is to ensure each applicant has information and fair access to the range of housing options in the county:

I acknowledge signing this consent allows my release of personal information related to my housing eligibility to representatives of the ACCH Coordinated Entry Committee

I further understand that the information on this form may be shared with Partner Members of Albany County Continuum of Care (CoC), and agency recipients of the Emergency Solutions Grant (ESG).

The content of information to be released includes: My identifying information, household composition, housing & homelessness history, income & benefit status, veteran status, health information, disabilities (if any), certain criminal justice information (if any), and accommodations required (if any).

Coordinated Entry-participating programs that will have access to this information include:

- | | |
|---|--|
| Capital Area Council of Churches (CCSES) | Capital City Rescue Mission (CCRM) |
| Community Maternity Services (CMS) | Catholic Charities |
| Equinox Inc | IPH (formerly Interfaith Partnership for the Homeless) |
| St. Catherine's Center for Children | St. Peter's Addiction Recovery Center (SPARC) |
| Schuyler Inn | Albany County Department of Social Services (DSS) |
| Albany Damien Center | Capital Area Peer Services (CAPS) |
| Albany Housing Coalition | Homeless and Travelers Aid Society (HATAS) |
| CARES, Inc | Rehabilitation Support Services (RSS) |
| Joseph's House | Legal Aid Society (LAS) |
| Support Ministries, Inc | Family Promise of the Capital Region |
| Albany County Department of Mental Health | United Tenants of Albany (UTA) |
| Alliance for Positive Health | Hope House |
| Capital Region Health Connections | St. Catherine's |
| CDPHP | Albany Community Action Partnership (ACAP) |
| Albany Stratton VA | |

Additional Agencies: _____

The following items **must be initialed** to be included in the use and/or disclosure of other protected health information:

- _____ HIV/AIDS related information and/or records.
- _____ Genetic testing information and/or records.
- _____ Drug/alcohol diagnosis, treatment, or referral information

I hereby authorize the periodic release of the above information to the organizations identified above as often as necessary to determine eligibility and, if eligible, coordinate placement in housing through Albany County Coordinated Entry. I understand that the information to be released is confidential and protected from further disclosure. The duration of this consent is one year from the date of my signature, unless I specify a date, event or condition upon which it will expire sooner. I understand that I may revoke this consent at any time by notifying my case manager, in writing, except to the extent that action has been taken in reliance on my consent.

Client signature: _____ **Date:** _____

Witness signature: _____ **Date:** _____

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:

PROJECT: NY -503 Albany County Coordinated Entry

CONTACT NUMBER:

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 Collaborative 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/).

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 or (518) 489-4130.

CCHMIS Inclusion Disclosure

The CCHMIS has moved from *inferred consent* (a posted sign) to an *inclusion disclosure* for the HMIS. **No consumer consent is required by the CCHMIS 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.

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 and explained the above information to the client and the client understands that their data is being entered into the CRHMIS.

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

Please indicate on the chart below which Housing Agencies that you are referring this application to.

The **Albany County CE Contact Index** can assist in completing this section; to request a copy, please email ce@hatas.org

REFERRAL FOR SERVICES

Please indicate the agencies/programs this referral will be sent to:

PERMANENT SUPPORTIVE HOUSING (PSH)

<input type="checkbox"/> Albany Damien Center PSH Program <input type="checkbox"/> Albany Housing Coalition Shelter Plus Care for CH Vets <input type="checkbox"/> Albany Housing Coalition Shelter Plus Care for Homeless Vets with Disabilities <input type="checkbox"/> Albany Housing Coalition Walter St Residence <input type="checkbox"/> Capital Area Peer Services (CAPS) 100 Clinton Ave Apts <input type="checkbox"/> CARES TBRA for Homeless Persons YR 3	<input type="checkbox"/> CARES TBRA for Homeless Persons YR 2 <input type="checkbox"/> CARES Housing <input type="checkbox"/> HATAS Shelter Plus Care <input type="checkbox"/> HATAS Pathways I <input type="checkbox"/> HATAS Pathways II <input type="checkbox"/> HATAS TBRA <input type="checkbox"/> HATAS Bonus Project <input type="checkbox"/> HAC SRO (Kendal House) <input type="checkbox"/> Hope House <input type="checkbox"/> IPH Hope Through Housing <input type="checkbox"/> IPH Sheridan Ave Housing Project	<input type="checkbox"/> IPH Sheridan Ave Housing Project II <input type="checkbox"/> IPH Bonus Project <input type="checkbox"/> SPARC <input type="checkbox"/> RSS SAIL <input type="checkbox"/> St. Catherine's Supportive Family Housing Program <input type="checkbox"/> St. Catherine's Bonus Project <input type="checkbox"/> Support Ministries Arvilla House <input type="checkbox"/> Support Ministries Project Help
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Notes:

RAPID RE-HOUSING (RRH)

<input type="checkbox"/> HATAS STEHP Rapid Re-Housing	<input type="checkbox"/> Legal Aid Society Rapid Re-Housing Families
<input type="checkbox"/> HATAS The Next Step RRH Program	

Notes: