COLUMBIA - GREENE COUNTY CONTINUUM OF CARE MAINSTREAM ASSESSMENT

ARE YOU SEEKING HOUSING SERVICES?	HAVE YOU PREVIOUSLY COMPLETED AN APPLICATION FOR ASSISTANCE THROUGH COORDINATED ENTRY?
❑ No ❑ Yes	❑ No ❑ Yes

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

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

PREVENTION STOP HERE – REFER CLIENT TO APPROPRIATE PREVENTION SERVICES AND SEND THIS FORM TO THE APPROPRIATE CE COORDINATOR

HMIS INFORMATION

*INTAKE DATE	*FIRST NAME	*LAST NAME (and Suffix)
/ /		

*NAME DATA QUALITY	ALIAS
❑ Full Name Reported ❑ Partial Name, Street Name or Code Name Reported ❑ *Data Not Collected* ❑ *Client Doesn't Know* ❑ *Client Refused*	

*SOCIAL SECURITY NUMBER	*SSN DATA QUALITY
(enter "9" for any missing numbers in an Approximate or Partial SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___	❑ Full SSN Reported ❑ Approximate or Partial SSN Reported ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

*GENDER (Please select all that apply)

❑Female ❑Male ❑Transgender
❑Questioning ❑A gender that is not singularly 'Female' or 'Male'

❑ *Client Doesn't Know*
❑ *Client Refused*
❑ *Data Not Collected*

*BIRTHDATE	*BIRTHDATE DATA QUALITY
_____/_____/_____	❑ Full DOB Reported ❑ Approximate or Partial DOB Reported ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

*ETHNICITY

❑Hispanic/Latin(a)(o)(x) ❑Non- Hispanic/Latin(a)(o)(x)

❑ *Client Doesn't Know*
❑ *Client Refused*
❑ *Data Not Collected*

*RACE (choose all that apply)

❑American Indian, Native Alaskan, or Indigenous ❑Asian or Asian American
❑Black, African American, African ❑Native Hawaiian or Pacific Islander
❑White

❑ *Client Doesn't Know*
❑ *Client Refused*
❑ *Data Not Collected*

*DO YOU HAVE A PHONE NUMBER AT WHICH YOU CAN BE REACHED?	
❑ No ❑ Yes (SEE RIGHT)	**IF YES**: PLEASE PROVIDE YOUR PHONE NUMBER **WITH AREA CODE** (____) - _____ - _____

---NEXT PAGE---

*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
❑ **Place not meant for human habitation** (vehicle, abandoned building, bus/train/subway station etc) ❑ **Emergency shelter**, including **hotel or motel** paid for **with emergency shelter voucher** ❑ Safe Haven	❑ 1 night or less ❑ 2 to 6 nights ❑ 1 week or more, but less than 1 month ❑ 1 month or more, but less than 90 days ❑ 90 days or more, but less than 1 year ❑ 1 year or longer ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

*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
❑ 1 ❑ 2 ❑ 3 ❑ 4+ ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12 ❑ More than 12 ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

OR

INSTITUTIONAL SITUATIONS:

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

DID THE CLIENT STAY LESS THAN 90 DAYS	**IF YES:** THE NIGHT BEFORE THAT, DID THEY STAY ON THE STREETS, ES, or SH?
❑ No ❑ Yes	❑ No ❑ 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
❑ 1 ❑ 2 ❑ 3 ❑ 4+ ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12 ❑ More than 12 ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

OR

TEMPORARY AND PERMANENT HOUSING SITUATIONS:

TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)		*LENGTH OF STAY IN PREVIOUS PLACE
❑ **Hotel or Motel** paid for **without** emergency shelter voucher ❑ Owned by client, **no** ongoing subsidy ❑ Owned by client **WITH** ongoing subsidy ❑ Permanent housing **(other than RRH)** for formerly homeless persons ❑ Rental by client, **no** ongoing subsidy ❑ Rental by client with GPD TIP subsidy ❑ Rental by client with VASH subsidy ❑ Rental by client with RRH or equivalent subsidy ❑ Rental by client with HCV voucher (tenant or project based) ❑ Rental by client in a public housing unit	❑ Rental by client with other ongoing housing subsidy ❑ Residential project or halfway house with no homeless criteria ❑ **Staying or in a family** member's room, apartment or house ❑ **Staying or in a friend's** room, apartment or house ❑ **Transitional housing** for homeless persons (incl. homeless youth) ❑ Host Home (non-crisis)	❑ 1 night or less ❑ 2 to 6 nights ❑ 1 week or more, but less than 1 month ❑ 1 month or more, but less than 90 days ❑ 90 days or more, but less than 1 year ❑ 1 year or longer ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

DID YOU STAY LESS THAN 7 DAYS?	**IF YES: THE NIGHT BEFORE THAT, DID THEY STAY ON THE STREETS, ES, or SH?**
❑ No ❑ Yes	❑ No ❑ 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
❑ 1 ❑ 2 ❑ 3 ❑ 4+ ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12 ❑ More than 12 ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

OR

UNKNOWN (ONLY IF NECESSARY)

TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)

❑ *Client doesn't know* ❑ *Client refused* ❑ *Data not collected*

---NEXT PAGE---

*CURRENT LIVING SITUATION

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

HOMELESS SITUATIONS:

TYPE OF RESIDENCE (TONIGHT)

- ❑ **Place not meant for human habitation** (vehicle, abandoned building, bus/train/subway station etc)
- ❑ **Emergency shelter**, including **hotel or motel** paid for **with emergency shelter voucher**
- ❑ Safe Haven

OR

INSTITUTIONAL SITUATIONS:

TYPE OF RESIDENCE (TONIGHT)

- ❑ **Foster care** home or foster care group home
- ❑ **Hospital** or other residential non-psychiatric medical facility
- ❑ **Jail**, prison or juvenile detention facility
- ❑ **Long-term care facility** or n**ursing** home
- ❑ **Psychiatric hospital** or other psychiatric facility
- ❑ **Substance use treatment** facility or detox center

IS CLIENT GOING TO LEAVE WITHIN 14 DAYS?	HAS A SUBSEQUENT RESIDENCE BEEN IDENTIFIED?
❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*

DOES INDIVIDUAL OR FAMILY HAVE RESOURCES OR SUPPORT NETWORKS TO OBTAIN OTHER PERMANENT HOUSING?

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*

HAS THE CLIENT HAD A LEASE OR OWNERSHIP INTEREST IN A PERMANENT HOUSING UNIT IN THE LAST 60 DAYS?

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*

HAS THE CLIENT MOVED 2 TIMES OR MORE IN THE LAST 60 DAYS?

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*

OR

TEMPORARY AND PERMANENT HOUSING SITUATIONS:

TYPE OF RESIDENCE (TONIGHT)

- ❑ **Hotel or Motel** paid for **without** emergency shelter voucher
- ❑ Owned by client, **no** ongoing subsidy
- ❑ Owned by client **WITH** ongoing subsidy
- ❑ Permanent housing **(other than RRH)** for formerly homeless persons
- ❑ Rental by client, **no** ongoing subsidy
- ❑ Rental by client with VASH subsidy
- ❑ Rental by client with RRH or equivalent subsidy
- ❑ Rental by client with HCV voucher (tenant or project based)
- ❑ Rental by client in a public housing unit
- ❑ Rental by client with GPD TIP subsidy
- ❑ Rental by client with other ongoing housing subsidy
- ❑ Residential project or halfway house with no homeless criteria
- ❑ **Staying or in a family** member's room, apartment or house
- ❑ **Staying or in a friend's** room, apartment or house
- ❑ **Transitional housing** for homeless persons (incl. homeless youth)
- ❑ Host Home (non-crisis)

IS CLIENT GOING TO LEAVE WITHIN 14 DAYS?	HAS A SUBSEQUENT RESIDENCE BEEN IDENTIFIED?
❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*

DOES INDIVIDUAL OR FAMILY HAVE RESOURCES OR SUPPORT NETWORKS TO OBTAIN OTHER PERMANENT HOUSING?

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*

HAS THE CLIENT HAD A LEASE OR OWNERSHIP INTEREST IN A PERMANENT HOUSING UNIT IN THE LAST 60 DAYS?

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*

HAS THE CLIENT MOVED 2 TIMES OR MORE IN THE LAST 60 DAYS?

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*

OR

UNKNOWN (ONLY IF NECESSARY)	LIVNG SITUATION VERIFIED BY (NAME OF AGENCY)
❑ *Client doesn't know* ❑ *Client refused* ❑ *Data not collected*	

---NEXT PAGE---

*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

❑ Earned Income ..... $_____	❑ Unemployment Insurance ..... $_____
❑ SSI ..... $_____	❑ SSDI ..... $_____
❑ VA Service-Connected Disability Compensation ..... $_____	❑ VA Non-Service Connected Disability Pension ..... $_____
❑ Private Disability Insurance ..... $_____	❑ Worker's Compensation ..... $_____
❑ TANF ..... $_____	❑ General Public Assistance ..... $_____
❑ Retirement from SSA ..... $_____	❑ Pension or Retirement from former job ..... $_____
❑ Child Support ..... $_____	❑ Alimony or Other Spousal Support ..... $_____
❑ Other ..... $_____	

***NON-CASH BENEFITS FROM ANY SOURCE**

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

IF YES: CHECK ALL THAT APPLY

❑ SNAP (Food Stamps) ❑ Special Supplemental Nutrition Program for Women, Infants and Children ❑ Other TANF Funded Srvcs
❑ TANF Child Care Services ❑ 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 ..... ❑ No ❑ Yes	MEDICARE ..... ❑ No ❑ Yes
State Children's Health Insurance Program ..... ❑ No ❑ Yes	VA Medical Services ..... ❑ No ❑ Yes
Employer provided Health insurance ..... ❑ No ❑ Yes	Health ins. Via COBRA ..... ❑ No ❑ Yes
Private Pay Health Insurance ..... ❑ No ❑ Yes	State Health Ins. Adults ..... ❑ No ❑ Yes
Indian Health Services ..... ❑ No ❑ 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*	❑ No ❑ Yes ❑ *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*	❑ No ❑ Yes ❑ *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*	❑ No ❑ Yes ❑ *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) ❑ Yes, Drug (SEE RIGHT) ❑ Yes, Both (SEE RIGHT ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

* DV STATUS

*DOMESTIC ABUSE VICTIM/SURVIVOR

❑ No ❑ Yes (SEE BELOW) ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

IF YES: WHEN EXPERIENCE OCCURRED			**IF YES:** ARE YOU CURRENTLY FLEEING?	
❑ Within the past 3 months ❑ 3 to 6 months ago	❑ From 6 to 12 months ago ❑ More than a year ago	❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes	❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

DO YOU NEED A CONFIDENTIAL LOCATION TO STAY?

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

IF YES: It is advised to offer a connection to your local domestic violence services if they are not already engaged in services.

---NEXT PAGE---

*ADDITIONAL INFORMATION

*VETERAN STATUS	IF YES: SELECT BRANCH
❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ Army ❑ Air Force ❑ Navy ❑ Marines ❑Coast Guard ❑ Other ❑ *Data Not Collected* ❑ *Client Doesn't Know* ❑ *Client Refused*

DISCHARGE STATUS
❑ Honorable ❑ General Under Honorable Discharge ❑ Under Other than Honorable Conditions ❑ Bad Conduct ❑ Dishonorable ❑Uncharacterized ❑ *Data Not Collected* ❑ *Client Doesn't Know* ❑ *Client Refused*

DOES THE CLIENT HAVE MANAGED MEDICAID THROUGH CDPHP? *Clients that answer yes to this question will be contacted by CDPHP for case management services.*
❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

*ZIP CODE OF LAST PERMANENT ADDRESS	ZIP CODE DATA QUALITY
_____ _____ _____ _____ _____	❑ Full or Partial Zip Code Reported ❑ Don't Know ❑ Refused
DATE LEFT LAST PERMANENT ADDRESS	
_____/_____/_____	

I understand that the information collected on this form will be used to help me gain housing services and this information will be shared with the partnering agencies of the Columbia - Greene County Continuum of Care to make referrals on my behalf and to discuss the details of my case.

If a referral is made to the Columbia - Greene County Department of Social Services, I give permission to Social Services to speak to the referring agency as to the status of my housing.

Client Signature:_____ Date: _____/_____/_____

---END---

PROCEED TO VULNERABILITY INDEX

VULNERABILITY INDEX SCORING

Chronic Homelessness (CH) Status (CoC Priority)
Client has been continuously homeless for at least one year **OR** experienced 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

	SCORE	SUBTOTAL
Have you slept and are going to sleep in a place not meant for human habitation, a safe haven, or in an emergency shelter?	**3**	
Have you experienced homelessness at least one year or on at least four separate occasions in the last 3 years?	**2**	
Has aging out of foster care impacted your ability to remain stably housed and/or obtain housing?	**1**	
Have conflicts around gender identity or sexual orientation contributed to your homelessness?	**1**	
Has lack of access to current educational opportunities been a barrier to being stably housed?	**1**	
Has violence at home between family members contributed to your homelessness?	**1**	
Has a Domestic Violence situation contributed to your homelessness?	**2**	
Has being a victim of sexual assault, and/or stalking contributed to your homelessness?	**1**	
Are you a survivor of human trafficking?	**1**	
Is there substance use within your family which has impacted your living situation?	**1**	
Has the distribution or use of substances led to being unstably housed or homeless?	**1**	
Are you a veteran?	**1**	
Do you have no income or receive public assistance only?	**1**	
Has pending/existing legal issues impacted your ability to access housing?	**1**	
If there was space available in a program that specifically assists people that live with HIV or AIDS, would that be of interest to you?	1	
Does identifying an affordable multi-bedroom unit serve as barrier to housing?	**1**	
Does identifying an affordable single unit serve as a barrier to accessing housing?	**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**	
Does any household member have a serious underlying medical condition and may be at higher risk for severe illness from COVID-19 due to:		
Currently pregnant	**1**	
Adults older than 65	**1**	
Diagnosed with chronic lung disease	**1**	
Diagnosed with moderate to severe asthma	**1**	
Diagnosed with severe obesity	**1**	
Diagnosed with diabetes	**1**	
Diagnosed as immunocompromised	**1**	
Diagnosed with chronic kidney disease	**1**	
Diagnosed with liver disease	**1**	
TOTAL POINTS – If documented CH status, add "C" 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	BIRTHDATE
(enter "9" for any missing numbers in an Approximate or Partial SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___	_____/_____/_____

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*	❑ No ❑ Yes ❑ *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*	❑ No ❑ Yes ❑ *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*	❑ No ❑ Yes ❑ *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) ❑ Yes, Drug (SEE RIGHT) ❑ Yes, Both (SEE RIGHT ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *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	BIRTHDATE
(enter "9" for any missing numbers in an Approximate or Partial SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___	_____/_____/_____

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*	❑ No ❑ Yes ❑ *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*	❑ No ❑ Yes ❑ *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*	❑ No ❑ Yes ❑ *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) ❑ Yes, Drug (SEE RIGHT) ❑ Yes, Both (SEE RIGHT ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *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

Questions below are required for: Any Additional Household Members

FIRST NAME / LAST NAME	GENDER	RELATIONSHIP TO HEAD OF HOUSEHOLD

SOCIAL SECURITY NUMBER	BIRTHDATE
(enter "9" for any missing numbers in an Approximate or Partial SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___	_____/_____/_____

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*	❑ No ❑ Yes ❑ *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*	❑ No ❑ Yes ❑ *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*	❑ No ❑ Yes ❑ *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) ❑ Yes, Drug (SEE RIGHT) ❑ Yes, Both (SEE RIGHT ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *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	BIRTHDATE
(enter "9" for any missing numbers in an Approximate or Partial SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___	_____/_____/_____

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*	❑ No ❑ Yes ❑ *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*	❑ No ❑ Yes ❑ *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*	❑ No ❑ Yes ❑ *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) ❑ Yes, Drug (SEE RIGHT) ❑ Yes, Both (SEE RIGHT ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *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 AND RELEASE OF INFORMATION

CCHMIS CLIENT INCLUSION DISCLOSURE FOR COORDINATED ENTRY PROJECTS

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 -519 Columbia - Greene 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 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/).

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

CONSENT TO RELEASE PERSONAL INFORMATION

Signing this consent allows Coordinated Entry-participating programs in the Columbia and Greene Continuum of Care to review some personal information related to your application, and to determine eligibility for housing and/or prevention services. Regardless of which housing/prevention 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 and services in the county:

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

I further understand that the information on this form may be shared with Partner Members of the Columbia and Greene 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:

St. Catherines
Community Action of Greene County
Mental Health Association
Greene County DSS
DSS Greene County Mental Health

VA
Columbia Opportunities
Columbia County Mental Health
Columbia County
CDPHP

_____ _____

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 for services and, if eligible, coordinate placement in housing through the Columbia and Greene 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: _____