

NY-511 STHC COORDINATED ENTRY PREVENTION ASSESSMENT

The following information should be collected in a private setting, allowing for confidentiality when responding to each question.

Participants should be informed that the questions are intended to determine appropriate and preferred housing connections.

When all data is collected, please scan, and send via secure/encrypted messaging to:

511CE@caresny.org / fax: 518-489-2237

HOUSEHOLD INFORMATION

*INTAKE DATE	*FIRST NAME	*LAST NAME
/ /		
*SOCIAL SECURITY NUMBER		
<i>(enter "9" for any missing numbers in an Approximate or Partial SSN)</i>		
- - - - -		
*GENDER (Please select all that apply)		
<input type="checkbox"/> Woman (Girl if child) <input type="checkbox"/> Man (Boy if child) <input type="checkbox"/> Transgender <input type="checkbox"/> Questioning <input type="checkbox"/> Culturally Specific Identity (e.g. Two-Spirit) <input type="checkbox"/> Non-binary <input type="checkbox"/> Different Identity		
*BIRTHDATE		
/ /		
*RACE (choose all that apply)		
<input type="checkbox"/> American Indian, Alaska Native, or Indigenous <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black, African American, or African <input type="checkbox"/> Hispanic/Latina/e/o <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White		
Would you like to add any additional information regarding your race/ethnic identity?		
APPLICANT PHONE NUMBER:		
() - -		
APPLICANT EMAIL ADDRESS:		
ALTERNATE CONTACT INFORMATION		
NAME:		RELATIONSHIP TO APPLICANT:
PHONE NUMBER:		

COUNTY OF RESIDENCY

- Delaware Otsego Broome Chenango Cortland
 Tioga

***PRIOR LIVING SITUATION**

Based on the client's living situation **the night before project entry**, where they slept last night.

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	
*APPROXIMATE DATE THIS EPISODE OF 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"/> 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	

OR

INSTITUTIONAL SITUATIONS:	
TYPE OF RESIDENCE (TONIGHT)	
<input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail , prison or juvenile detention facility	<input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance Abuse treatment facility or detox center
IS CLIENT GOING TO LEAVE WITHIN 14 DAYS?	IF YES, HAS A SUBSEQUENT RESIDENCE BEEN IDENTIFIED?
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Location Details:	Living Situation Verified by:

If yes is indicated for "Is Client Going to Leave Within 14 Days" respond to the three questions below:

DOES INDIVIDUAL OR FAMILY HAVE RESOURCES OR SUPPORT NETWORKS TO OBTAIN OTHER PERMANENT HOUSING?
<input type="checkbox"/> No <input type="checkbox"/> Yes
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
HAS THE CLIENT MOVED 2 TIMES OR MORE IN THE LAST 60 DAYS?
<input type="checkbox"/> No <input type="checkbox"/> Yes

OR

TEMPORARY HOUSING SITUATIONS:	
TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)	
<input type="checkbox"/> Hotel or Motel paid for without emergency shelter voucher <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)	
Location Details:	Living Situation Verified by:
IS CLIENT GOING TO LEAVE THEIR CURRENT LIVING SITUATION WITHIN 14 DAYS?	IF YES, HAS A SUBSEQUENT RESIDENCE BEEN IDENTIFIED?
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

If yes is indicated for "Is Client Going to Leave Within 14 Days" respond to the three questions below:

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

No Yes

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

No Yes

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

No Yes

OR

PERMANENT HOUSING SITUATIONS:

TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)

- Owned by client, **no** ongoing subsidy
- Owned by client **WITH** ongoing subsidy
- Rental by client, **no** ongoing subsidy
- Rental by client with ongoing housing subsidy

IF RENTAL OR OWNED WITH ONGOING SUBSIDY WAS SELECTED CHOOSE SUBSIDY TYPE BELOW:

- GPD TIP Housing subsidy
- HCV Voucher
- Family Unification Program Voucher
- Other permanent housing dedicated to formerly homeless persons
- VASH housing subsidy
- Public Housing Unit
- Foster Youth to Independence Initiative
- RRH or equivalent subsidy
- Emergency Housing Voucher
- Permanent Supportive Housing
- Rental by client, other ongoing subsidy

Location Details:

Living Situation Verified by:

IS CLIENT GOING TO LEAVE THEIR CURRENT LIVING SITUATION WITHIN 14 DAYS?

No Yes

IF YES, HAS SUBSEQUENT RESIDENCE BEEN IDENTIFIED?

No Yes

If yes is indicated for "Is Client Going to Leave Within 14 Days" respond to the three questions below:

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

No Yes

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

No Yes

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

No Yes

***CURRENT LIVING SITUATION**

Based on where a household will sleep tonight.

HOMELESS SITUATIONS:	
TYPE OF RESIDENCE (TONIGHT)	
<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	
Location Details:	Living Situation Verified by:

OR

INSTITUTIONAL SITUATIONS:	
TYPE OF RESIDENCE (TONIGHT)	
<input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail , prison or juvenile detention facility	
<input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance Abuse treatment facility or detox center	
IS CLIENT GOING TO LEAVE WITHIN 14 DAYS?	IF YES, HAS A SUBSEQUENT RESIDENCE BEEN IDENTIFIED?
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Location Details:	Living Situation Verified by:

If yes is indicated for "Is Client Going to Leave Within 14 Days" respond to the three questions below:

DOES INDIVIDUAL OR FAMILY HAVE RESOURCES OR SUPPORT NETWORKS TO OBTAIN OTHER PERMANENT HOUSING?
<input type="checkbox"/> No <input type="checkbox"/> Yes
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
HAS THE CLIENT MOVED 2 TIMES OR MORE IN THE LAST 60 DAYS?
<input type="checkbox"/> No <input type="checkbox"/> Yes

OR

TEMPORARY HOUSING SITUATIONS:	
TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)	
<input type="checkbox"/> Hotel or Motel paid for without emergency shelter voucher <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)	
Location Details:	Living Situation Verified by:
IS CLIENT GOING TO LEAVE THEIR CURRENT LIVING SITUATION WITHIN 14 DAYS?	IF YES, HAS A SUBSEQUENT RESIDENCE BEEN IDENTIFIED?
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p>If yes is indicated for "Is Client Going to Leave Within 14 Days" respond to the three questions below:</p>	
DOES INDIVIDUAL OR FAMILY HAVE RESOURCES OR SUPPORT NETWORKS TO OBTAIN OTHER PERMANENT HOUSING?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	
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	
HAS THE CLIENT MOVED 2 OR MORE TIMES IN THE LAST 60 DAYS?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	

OR

PERMANENT HOUSING SITUATIONS:	
TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)	
<input type="checkbox"/> Owned by client, no ongoing subsidy <input type="checkbox"/> Owned by client WITH ongoing subsidy <input type="checkbox"/> Rental by client, no ongoing subsidy <input type="checkbox"/> Rental by client with ongoing housing subsidy	
IF RENTAL OR OWNED WITH ONGOING SUBSIDY WAS SELECTED CHOOSE SUBSIDY TYPE BELOW:	
<input type="checkbox"/> GPD TIP Housing subsidy <input type="checkbox"/> HCV Voucher <input type="checkbox"/> Family Unification Program Voucher <input type="checkbox"/> Other permanent housing dedicated to formerly homeless persons <input type="checkbox"/> VASH housing subsidy <input type="checkbox"/> Public Housing Unit <input type="checkbox"/> Foster Youth to Independence Initiative <input type="checkbox"/> RRH or equivalent subsidy <input type="checkbox"/> Emergency Housing Voucher <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Rental by client, other ongoing subsidy	
Location Details:	Living Situation Verified by:
IS CLIENT GOING TO LEAVE THEIR CURRENT LIVING SITUATION WITHIN 14 DAYS?	IF YES, HAS SUBSEQUENT RESIDENCE BEEN IDENTIFIED?
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes is indicated for "Is Client Going to Leave Within 14 Days" respond to the three questions below:	
DOES INDIVIDUAL OR FAMILY HAVE RESOURCES OR SUPPORT NETWORKS TO OBTAIN OTHER PERMANENT HOUSING?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	
HAS THE CLIENT HAD A LEASE OR OWNERSHIP INTEREST IN A PERMANENT HOUSING UNITY WITHIN THE LAST 60 DAYS?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	
HAS THE CLIENT MOVED 2 OR MORE TIMES IN THE LAST 60 DAYS?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	

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

*INCOME FROM ANY SOURCE	
<input type="checkbox"/> No <input type="checkbox"/> Yes (SEE BELOW)	
IF YES: CHECK & FILL IN MONTHLY AMOUNT FOR ALL THAT APPLY	
<input type="checkbox"/> Earned Income \$ _____ <input type="checkbox"/> SSI \$ _____ <input type="checkbox"/> VA Service-Connected Disability Compensation \$ _____ <input type="checkbox"/> Private Disability Insurance \$ _____ <input type="checkbox"/> TANF \$ _____ <input type="checkbox"/> Retirement from SSA \$ _____ <input type="checkbox"/> Child Support \$ _____ <input type="checkbox"/> Other \$ _____	<input type="checkbox"/> Unemployment Insurance \$ _____ <input type="checkbox"/> SSDI \$ _____ <input type="checkbox"/> VA Non-Service Connected Disability Pension \$ _____ <input type="checkbox"/> Worker's Compensation \$ _____ <input type="checkbox"/> General Public Assistance \$ _____ <input type="checkbox"/> Pension or Retirement from former job \$ _____ <input type="checkbox"/> Alimony or Other Spousal Support \$ _____
*NON-CASH BENEFITS FROM ANY SOURCE	
<input type="checkbox"/> No <input type="checkbox"/> Yes	
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 Source <input type="checkbox"/> TANF Child Care Services <input type="checkbox"/> TANF Transportation Service <input type="checkbox"/> Other TANF-funded Services	

***HEALTH INSURANCE / DISABLING CONDITIONS**

*COVERED BY HEALTH INSURANCE	
<input type="checkbox"/> No <input type="checkbox"/> Yes	
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	Veteran's Health Administration <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	Other..... <input type="checkbox"/> No <input type="checkbox"/> Yes
*PHYSICAL DISABILITY	IF YES: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
<input type="checkbox"/> No <input type="checkbox"/> Yes (SEE RIGHT)	<input type="checkbox"/> No <input type="checkbox"/> Yes
*DEVELOPMENTAL DISABILITY	
<input type="checkbox"/> No <input type="checkbox"/> Yes	
*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"/> No <input type="checkbox"/> Yes
*HIV/AIDS	
<input type="checkbox"/> No <input type="checkbox"/> Yes	
*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"/> No <input type="checkbox"/> Yes
*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"/> Yes, Drug (SEE RIGHT) <input type="checkbox"/> Yes, Both (SEE RIGHT)	<input type="checkbox"/> No <input type="checkbox"/> Yes

*** DV STATUS**

*DOMESTIC ABUSE VICTIM/SURVIVOR	
<input type="checkbox"/> No <input type="checkbox"/> Yes (SEE BELOW)	
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"/> 3 to 6 months ago <input type="checkbox"/> More than a year ago	<input type="checkbox"/> No <input type="checkbox"/> Yes

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

VETERAN STATUS

*Have you ever served in the United States Military?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	
IF YES: SELECT BRANCH	<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"/> Space Force <input type="checkbox"/> Other

Questions below are relevant to: 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"/> No <input type="checkbox"/> Yes	
DEVELOPMENTAL DISABILITY			
<input type="checkbox"/> No <input type="checkbox"/> Yes			
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"/> No <input type="checkbox"/> Yes	
HIV/AIDS			
<input type="checkbox"/> No <input type="checkbox"/> Yes			
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"/> No <input type="checkbox"/> Yes	
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"/> Yes, Drug (SEE RIGHT) <input type="checkbox"/> Yes, Both (SEE RIGHT)		<input type="checkbox"/> No <input type="checkbox"/> Yes	

Questions below are relevant to: 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"/> No <input type="checkbox"/> Yes	
DEVELOPMENTAL DISABILITY			
<input type="checkbox"/> No <input type="checkbox"/> Yes			
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"/> No <input type="checkbox"/> Yes	
HIV/AIDS			
<input type="checkbox"/> No <input type="checkbox"/> Yes			
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"/> No <input type="checkbox"/> Yes	
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"/> Yes, Drug (SEE RIGHT) <input type="checkbox"/> Yes, Both (SEE RIGHT)		<input type="checkbox"/> No <input type="checkbox"/> Yes	

CONSENT TO RELEASE PERSONAL INFORMATION

Signing this consent allows Coordinated Entry-participating programs in the NY-511 STHC Continuum of Care to review 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 NY-511 STHC Coordinated Entry Committee.

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 judicial system involvement (if any), and accommodations required (if any).

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 NY-511 STHC 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:** _____