Balance of State Regional NC HMIS and Coordinated Assessment
CLIENT RELEASE OF INFORMATION & SHARING PLAN

SECTION 1 - Identifying Information

Last Name:	First Name:	Middle Initial:
Provider Completing Assessment:	Date of Birth:	Date of Assessment:

Introduction: Many North Carolina shelters and helping programs use the North Carolina Homeless Management Information System (NC HMIS) to keep information about people they help. This form defines which client data is entered into NC HMIS and how those data are shared between NC HMIS and the local Balance of State Regional Coordinated Assessment group. A Balance of State Regional Coordinated Assessment group is a locally created group that meets regularly to identify homeless veterans and develop strategies for housing them.

The included agencies will collect personal information directly from you to provide the best service possible. They only collect personal information that is considered appropriate for getting you housed. The collection and use of all personal information is guided by strict standards of confidentiality.

Why do we collect information about you?

- To determine eligibility for benefits and services;
- To connect you with other helping agencies;
- To reduce the number of times you have to tell your story; and
- To prevent your information from being confused with someone else's.

The information shared within the Balance of State Regional Coordinated Assessment group will be used for the following purposes (see Section 2 for a full explanation of how information will be shared):

- To create a Veterans By-Name List and coordinate services for you.
- To identify veterans experiencing chronic homelessness to prioritize them for permanent housing.
- To help case managers and staff at participating agencies to work together to meet your needs including, but not limited to, housing, case management, and financial assistance.

Basic identifying information (name, year of birth, **partial** Social Security Number, gender and your veteran status) can be seen by all North Carolina agencies that use HMIS. This information allows us to select the correct record and to better coordinate services for you. All persons using HMIS are trained and certified in privacy.

If you have a specific privacy concern you can ask to close this information so that only our Agency can see this information. Please initial here to indicate understanding _____.

SECTION 2 – Coordination of Care and Coordinated Assessment Sharing Plan

Who will be disclosing information about the individual?
The following person(s) or entities may use or disclose the information:
All providers within the Balance of State Continuum of Care Region 1. Southwest Region who utilize the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) pre-screen assessment and/or Service Prioritization Decision Assistance Tool (SPDAT) and participate with the Coordinated Assessment group.

Who will be receiving information about the individual?
The information may be disclosed to:
All providers within the Balance of State Continuum of Care Region 1. Southwest Region who utilize the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) pre-screen assessment and/or Service Prioritization Decision Assistance Tool (SPDAT) and participate with the Coordinated Assessment group.

What information is shared about you?
From HMIS:

- Name
- Date of Birth
- Gender
- Race
- Ethnicity
- Social Security Number
- Veteran Status
- Homeless status
- Homeless benchmark dates
- VI-SPDAT assessment score

Additional information possibly included in case conferencing:

- Contact information
- Services provided
- Reasons for homelessness
- Income information
- Disability Information
- Family composition
- Coordinated assessment notes
- Homeless history
- All information in the VI-SPDAT assessment

Your Rights

Instructions: *Put your initials next to the statements that you understand and agree to:*

___ I have received a copy of this agency's Privacy Notice/script that explains NC HMIS and my rights and responsibilities associated with how information is kept and shared through this system.

___ I understand that my written consent allows the information listed in the Sharing Plan to be shared among the agencies discussed in the Sharing Plan. All sharing agencies where I am receiving services may update that information as I provide additional or new information. The purpose of sharing my information is to better coordinate care for me and my family.

___ I understand that the confidentiality of my records is protected by law. I understand that this agency will never give information about me to anyone outside the agency without my specific written consent through a Sharing Plan or as required by law (The regulations are the Federal Law of Confidentiality for Alcohol and Drug Abuse Patients, (42 CFR, Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CRF, Parts 160 & 164) and certain North Carolina laws.

___ I understand that Agencies included in my Sharing Plan must follow strict privacy guidelines.

___ I can withdraw my consent to share at any time by writing to Region 1. Southwest. Jill.Carter@abccm.org. However, any information already shared with another agency cannot be taken back. I also understand that the request to discontinue sharing will have to be coordinated between sharing partners. I should tell all agencies that I work with that are included on the Plan when I withdraw my consent.

___ I understand that I have the right to see my information, request to change it, and to have a copy of that information from the servicing agency by written request. An agency can refuse to change information in my record, but must provide me with a written explanation of the refusal within 60 days of the request. Agencies are allowed to charge for reproducing a record.

___ I understand that my refusal to share information in this system will not be used to deny me services such as emergency assistance, outreach, shelter, or housing assistance.

___ I understand that any information I provide related to race, color, religion, sex, national origin, disability, familial status, and actual or perceived sexual orientation, gender identity, or marital status will not be used in any way that would discriminate against me or prevent me from receiving services or housing assistance. I understand that I can file a complaint if I feel that I have been discriminated against.

___ I understand that some of my information may be disclosed for academic research purposes without identifying information included. My name and other identifying information may be used to match records but will not be released to be used directly in the research unless I sign a separate consent when identifying information is a requirement for the Study (example: so a researcher can contact me).

If you have any questions about anything on this form, or how to fill it out, we can help. Please call Jill Carter **at** 828-398-6785 or jill.carter@abccmorg.

Instructions: *Check the box next to the statement that you understand and agree to:*

I agree to have all of my information listed above to be visible to all helping agencies listed above.

__ Yes, I agree to share according to the Sharing Plan.

__ No, I do not agree to the Sharing Plan (Only our agency will able to see all your detailed information.)

SECTION 3 – Outreach Sharing Plan

Sharing Plan for the purpose of improving outreach to individuals who may qualify for benefits

If you have served in the military and been on active duty, the VA Medical Center would like to contact you about potential housing. With your permission, they will use the information you give this agency (recorded in the HMIS) to contact you.

Information that will be shared includes: Name, date of birth, homeless status, veteran status, housing history, contact information, chronically homeless status

I agree to share my NC HMIS data for Housing Prioritization with the VA Medical Center:
(Circle Response): ___Yes ___No _____ N/A

This Release is active for one year effective on the date of signature.

Client signature: _____, Date: _____,

Signature of guardian or authorized-representative (when required): _____

Relationship to client: _____ Date signed by guardian/authorized representative: _____

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.