Child Household Member Assessment

NCCEH Back@Home North Carolina
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 a Homeless Management Information System (HMIS) to keep information about people they help. This form defines which client data is entered into HMIS and how those data are shared between HMIS and the Back@Home NC group. The Back@Home NC group is a group that was created in response to recent disaster and works to identify households who need assistance in finding a housing solution 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 Back@Home NC group will be used for the following purposes (see Section 2 for a full explanation of how information will be shared):

- To assess persons for eligibility.
- To identify people impacted by the disaster and get them housed as quickly as possible.
- 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.

SECTION 2 – Coordination of Care and Back@Home NC Sharing Plan

Who will be sharing information about the individual?
The following person(s) or entities may use or disclose the information: All agencies involved in the Back@Home NC disaster rehousing program. The list of providers can be found at www.backathome.org/partners.

What information is shared about you?

- Name
- Date of Birth
- Gender
- Race
- Ethnicity
- Social Security Number
- Contact information
- Services provided
- Reasons for homelessness
- Income information
- Disability Information
- Legal history
- Veteran Status
- Homeless Status
- Needs and Services
- Entry/Exit assessment information
- Contact information
- Family composition
- Homeless history
- Benefits received
- FEMA registration information
- Employment history
- Back@Home assessment information

Your Rights

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

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

___ If I have a specific privacy concern I can ask to close this information so that only Back@Home NC can see this information.

___ I understand that Agencies included in this sharing plan must follow strict privacy guidelines.

___ I understand that my written consent allows the information listed above to be shared among the agencies discussed in this sharing agreement. 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 can withdraw my consent to share at any time by writing to the agency listed at the top of this document. 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).

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 this sharing plan.

__ No, I do not agree to this 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

Veterans Administration:

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

Transitions to Community Living Initiative

If you have lived in an adult care home the North Carolina Transitions to Community Living Initiative 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, housing history, contact information, health status, disability status.*

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

This Release is active for 1 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: _____

DRH Assessment – Child Household Member

Date of Assessment: _____ Shelter Name: _____

Assessment Location: _____ County: _____

HMIS #: _____ Assessor Name: _____

A. Identification Data

1. First Name	Last Name	Middle Initial

2. Gender: ☐ Male ☐ Female ☐ Trans Female ☐ Trans Male ☐ Gender Non-Conforming

☐ Client does not know ☐ Client refused

3. Social Security Number:

4. Date of Birth: _____/_____/_____ Age: _____

5. Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Client does not know

☐ Client refused

6. Race:

☐ American Indian/Alaskan Native ☐White

☐ Asian ☐ Client does not know

☐ Native Hawaiian or Other Pacific Islander ☐ Client refused

☐ Black/African American

7. Are you a US Citizen? ☐Yes ☐No ☐ Client does not know ☐Client refused

B. Health History

1. Are you currently covered by health insurance? ☐Yes ☐No (go to E4)

☐Client does not know (go to E4) ☐Client refused (go to E4)

2. If you have health insurance, what type is it? _____

3. If Medicaid, what is your managed care organization? _____

4. Do you have a disabling condition?

☐Yes ☐No ☐Client does not know (go to F1) ☐Client refused (go to F1)

5. If yes, select all that apply:

☐Physical ☐Developmental ☐Chronic Health Condition ☐HIV/AIDS

☐Mental Health Diagnosis

6. Do you currently use alcohol or other substances on a daily basis?

☐Yes ☐No ☐Client does not know ☐Client refused

7. Are any of these conditions expected to be long-continued or indefinite in duration?

☐Yes ☐No ☐Client does not know ☐Client refused

8. Do any of these conditions make it substantially difficult to live independently?

☐Yes ☐No ☐Client does not know ☐Client refused

C. Service Needs

1. After being housed can you use any of the following services:

☐Mental health ☐Medicaid ☐Employment

☐Childcare ☐Substance Use ☐Social Security Benefits

☐Food stamps ☐Child care ☐Legal

☐Domestic Violence Services ☐Health Services

Assessor: _____	Signature: _____
Guardian: _____	Guardian Signature: _____