**Balance of State Regional Coordinated Assessment**

**CLIENT RELEASE OF INFORMATION & SHARING PLAN– DV Agencies**

**READ FIRST:** Before you decide whether or not to let [Program/Agency Name] share some of your confidential

information with another agency or person, an advocate at [Program/Agency Name] will discuss with you all

alternatives and any potential risks and benefits that could result from sharing your confidential information. If you

decide you want [Program/Agency Name] to release some of your confidential information, you can use this form to

choose what is shared and how it's shared.

This agency and many others who help people experiencing homelessness participate in Coordinated Assessment. Coordinated Assessment is a locally created group that meets regularly to identify homeless persons and develop strategies for housing them. This form defines how your information is shared with the local Balance of State Regional Coordinated Assessment group. Sharing your personal information with this group is completely voluntary and you will not be refused housing or services if you choose not to share your information with this group.

The included agencies will discuss the information you share 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.

Please Note: there is a risk that a release of information can potentially open up access by others to all of your

confidential information held by [Program/Agency Name].

**SECTION 1 - Identifying Information**

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

**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 regional list of people who need housing and coordinate services for you.
* To identify people 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, gender, type of disability, current location, Veteran status). You have three options for how your personal information could be shared with the coordinated assessment group. 1) You may share information about your housing and services needs but NO identifying information. 2) You may share your personally identifying information as well. 3) You may choose not to share any information with the group. [Provider/agency] will discuss with you which of these options is safest for you and how they may affect the coordination of your housing and services.

*Please initial here to indicate choice: \_\_\_\_\_ De-identified sharing \_\_\_\_\_Identified sharing \_\_\_\_ No sharing*

**SECTION 2 – Coordination of Care and Coordinated Assessment Sharing Plan**

The Coordinated Assessment Sharing Group uses the information, listed below, to help connect people to housing and services that they are eligible for and meet their needs. You may choose whether to share all, some, or none of this information.

**If you allow all the following information to be shared about you with the coordinated assessment group, please initial here: \_\_\_\_\_\_\_\_\_\_**

**If you would like to only share some of the information below to the coordinated assessment group, please initial here and check the data elements you would like shared: \_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Entry/Exit dates  |  |  | Family Composition  |  |
| Lengths of Stay in project(s)  |  |  | Contact information |  |
| VI-SPDAT score  |  |  | Date removed from By-Name-List |  |
| All other information in the VI-SPDAT |  |  | Services provided |  |
| Chronically Homeless status |  |  | Reasons for homelessness |  |
| Length of time homeless |  |  | Household type  |  |
| Homeless history |  |  | Whether you have a disability |  |
| Case conference date |  |  | Income information |  |
| Referral dates to housing providers |  |  | Coordinated assessment notes |  |

**Your Rights**

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

|  |  |
| --- | --- |
| \_\_\_ | I understand that I do not have to sign this release form. I do not have to allow [agency] to share my information. Signing this release form is completely voluntary. My decision to not share information with the Coordinated Assessment Group will not be used to deny me services such as emergency assistance, outreach, shelter, or housing assistance.  |
| \_\_\_ | I understand that releasing information about me could give another agency or person information about my location and wouldconfirm that I have been receiving services from [Program/Agency Name]. |
| \_\_\_ | I understand that [Program/Agency Name] and I may not be able to control what happens to my information once it has beenreleased to the above person or agency, and that the agency or person getting my information may be required bylaw or practice to share it with others. |
| \_\_\_ | I have received a copy of this agency’s Privacy Notice/script that explains Coordinated Assessment and my rights and responsibilities associated with how information is shared with the Coordinated Assessment Group. |
| \_\_\_ | I understand that my written consent allows the information listed in this release of information to be shared among the agencies discussed in this release. 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 this agency or Teresa Robinson at Community Link. 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 in the Coordinated Assessment Group 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 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. |

**If you have any questions about anything on this form, or how to fill it out, we can help. Please call Melissa Eastwood at Trillium Health Resources at 866-998-2597**

**SECTION 3 – Veterans Sharing Plan**

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 to the Coordinated Assessment Group 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 information for Housing Prioritization with the VA Medical Center:**

**(Check Response): \_\_\_Yes \_\_\_No \_\_\_\_ N****/A**

|  |
| --- |
| **This Release is active for 90 days unless you specify a different time period. If you would like this release to expire in more or less than 90 days, please write the expiration date here: \_\_\_\_\_\_\_\_\_\_**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.