Introduction: This application will be used to help identify your needs and refer you to housing programs. Please understand that the information you provide will be input into the Homeless Management Information System (HMIS), which many homeless service providers in Indianapolis use to keep information about people that they help. Although we will share some of your information for the purposes of helping you connect to resources, we have strict rules about sharing and everyone using HMIS is trained to protect your information. If you do not want to share your information in HMIS, we can complete a confidential application and can still help you connect to resources.

SECTION 1 - Identifying Information in HMIS

This basic identifying information is collected about you and your family members and can be seen by all Indianapolis agencies that use HMIS:

- Name
- Gender
- Social security number
- Date of birth
- Race, ethnicity
- Marital status
- Veteran status
- Phone number, address

Why do we collect information about you?

- Work with other agencies to help you
- Help case managers work together for you
- Connect you with other helping agencies or benefits you may be eligible for
- Reduce the number of times you have to tell your story
- Identify where there are gaps in our community resources so we can work to fill them

SECTION 2 – Coordination of Care Sharing Plan for CES

Many Indianapolis agencies also use the Coordinated Entry System (CES) to improve services to you through coordination of care. If you receive services from multiple agencies that participate in CES, agreeing to the Sharing Plan defined below allows for these agencies to see your information.

The information shared about you and your family members through the Coordination of Care Sharing Plan includes the basic identifying information listed in Section 1 and:

- Homeless status and history
- Type of housing you are eligible for
- Domestic violence history
- Insurance information
- Income information
- Medical information including presence of mental or physical health conditions, disability, substance abuse, pregnancy status

I understand that:

∗ I can receive a copy of the Privacy Notice/script that explains HMIS and my rights and responsibilities associated with how information is kept and shared through this system, upon request.
∗ 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 Indiana

State laws.

∗I understand that the information I provide will be used to determine if I am eligible for partner agency housing, services, or related programs. I also understand that each agency may have different eligibility requirements.

∗ I understand that if I have a domestic violence history, details regarding specific incidents will NOT be shared nor will other housing agencies have access to this information unless I have given my consent.

∗ I understand that I am signing this consent as a release of information so that my information may be shared with housing providers at housing case conferencing for housing referral and placement purposes. Only relevant information that would impact eligibility will be discussed.

∗ I can withdraw my consent to share at any time; 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. If I withdraw my consent, I should tell any agencies that I see who are included on the Plan.

∗ I understand that the 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 can get a list of the partner agencies that will be able to see my information upon request.

∗ I understand that a copy of this authorization is as valid as the original.

SECTION 3 – Signatures

Instructions: By signing below you understand and agree to all your information being visible to all participating partner agencies according to the Sharing Plan.

This release is active until revoked.

Client signature: _____ Date signed: _____

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

Relationship to client: _____

Date signed by guardian/authorized representative: _____

Assessor signature: _____