Transitional Housing Program

Admissions Checklist and Instructions

A completed Admissions Packet is required for screening and acceptance to the Transitional Housing Program (THP). The willful withholding or the intentional falsification of information during the application and/or admissions process will render the applicant disqualified from program admission. Please compile the following documents for submission.

Fax or email completed document to:

Building 10 (Retsil)
WDVA THP Lead Case Manager, Bernice Petty
Fax: (360) 895-4451
Email: bernicep@dva.wa.gov
Cell: (360) 485-2705

Roosevelt Barracks (Orting)
WDVA THP Lead Case Manager, Melissa Frink
Fax: (360) 893-5623
Email: Melissa.Frink@dva.wa.gov
Cell: (360) 227-9575

☐ Initial Program Application (*attached)*

To be completed by the applicant with assistance from referral source.*

☐ Request for Conviction/Criminal History Record and Consumer Reports

To be completed and signed by applicant.

Applicants who receive income from work, benefits, or any other source must provide verification of income (ex. Award letter from VA, DSHS, Social Security; Proof of retirement income (DoD).

* "Referral source" is the social worker, case manager, provider or professional.

Transitional Housing Program Application

VETERAN INFORMATION

Veteran Name: _____ **Date of Birth:** _____

Full SSN:_____/___/_____ **Veteran Phone** _____-_____-_____ **No Phone** ☐

Veteran is enrolled in the VA Puget Sound Health Care System? Yes ☐ No ☐ Unknown ☐

Referent Information: (You agree to be contact on behalf of Veteran)

Staff:_____ Agency:_____

Staff phone: _____-_____-_____ email:_____

MILITARY HISTORY

Enlistment Date: _____

Discharge Date: _____

Type of Discharge:

☐ Honorable or General (Under Honorable Conditions)

☐ Other Discharge: _____

Branch of Service: _____

Military Era: *(check all that apply)*

☐ Vietnam ☐ Vietnam Era ☐ Peacetime

☐ Persian Gulf ☐ OIF/OEF *(9/11/2001 - present)*

Combat Experience: ☐ Yes ☐ No

If yes, explain: _____

_____

HOUSING STATUS

Where did the Veteran sleep last night? Outdoors (On street, in car) ☐ Shelter ☐ Hospital ☐ Housed-Fleeing Domestic Violence ☐

Other (Explain): _____

Is the Veteran able to live independently and manage self-care? YES ☐ NO ☐ (able to manage medication/hygiene/ADLs etc.) **If NO, STOP** and do not make a referral to GPD.

Please specify Veteran's treatment needs:

(Medical/Mental Health dx, Substance Use, assistive devices, aftercare follow up etc.)

Medical Diagnoses: _____

Mental Health Diagnoses: _____

Substance Use History: _____

Request for Conviction/Criminal History Record and Consumer Reports

Name: _____
(Please Print) (First) (Middle) (Last)

Social Security Number: _____

Date of birth*: _____ Place of birth: _____ (County and State, or Country)

DL#_____ State: _____

Height*: _____ Weight*: _____ Hair color*: _____ Eye color*: _____ Race*: _____
*Used for identification only, not required.

Other names used and dates of use (including maiden name): 1. _____

2. _____ 3. _____

Have you ever been convicted of a crime? _____ Yes _____ No

If yes, give details (date, crime, location). _____

Note: Disclosure of convictions does not automatically disqualify your application.

Current address: _____
Number, Street, Apartment # (if any), City, State, Zip Code

Previous address:_____ Dates:_____
Number, Street, Apartment # (if any), City, State, Zip Code

List addresses, cities, states and counties of residence you have lived for the past seven years.

Address	City	State	County	from	To

Signature below authorizes and requests any present or former employer, school, police department, financial institution, division of motor vehicles, or other persons or agencies having personal knowledge about me to furnish bearer with any and all information in their possession regarding me, in connection with a tenant application. I give permission that a photocopy of this authorization be accepted with the same authority as the original.

_____ _____

Signature Date

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release of information other than that specifically described below.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including the last four of your Social Security Number (SSN) and Date of Birth (used to locate records for release) is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10P2 "Patient Medical Record – VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

PURPOSE(S) OR NEED: Information is to be used by the individual for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☐ OTHER *(Please specify)* _____

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☐ HEALTH SUMMARY *(Prior 2 Years)*

☐ INPATIENT DISCHARGE SUMMARY *(Dates)*: _____

☐ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*: _____
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: _____
- ☐ DATE RANGE: _____

☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____

☐ LAB RESULTS:

- ☐ SPECIFIC TESTS *(Name & Date)*: _____
- ☐ DATE RANGE: _____

☐ RADIOLOGY REPORTS *(Name & Date)*: _____

☐ LIST OF ACTIVE MEDICATIONS: _____

☐ FLU VACCINATION *(Dose, Lot Number, Date & Location)*: _____

_____

☐ OTHER *(Describe)*: _____

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire.

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON _____ *(enter a future date other than date signed by patient)*

☐ UNDER THE FOLLOWING CONDITION(S): _____

_____

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE (*if applicable) (Sign in ink*)	DATE *(mm/dd/yyyy)*

PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED	RELEASED BY:

Client Release of Information and Informed Consent

For Pierce County ServicePoint Homeless Management Information System (HMIS)

IMPORTANT: <u>DO NOT CONSENT</u> to share personally identifying information in HMIS if you are:

- **Participating in a Domestic Violence agency program or shelter**
- **Currently fleeing or in danger from a domestic violence, dating violence, sexual assault or stalking situation**
- **Being served in a program that requires disclosure of HIV/AIDS status (i.e. HOPWA)**
- **Under 18 years of age with no parent/guardian available to consent to sharing the minor's information in HMIS**

*If one or more of these applies to you, **<u>skip to the back of this form, check the DO NOT CONSENT option and sign</u>.***

Agency Name: _____ is a Participating Agency in the Pierce County ServicePoint Homeless Management Information System (HMIS) and collects information, over time, about the characteristics and service needs of people experiencing homelessness. RCW 43.185C.180.

If you consent, your name and other personally identifying information will be available to Partner Agencies, Pierce County Community Connections and the Washington State HMIS for seven (7) years.

Please read the following Frequently Asked Questions and Answers, and make sure to discuss this and any other questions you have prior to signing this form.

Q: *Do I have to sign this form in order to get help?*

A: <u>Your decision to participate in the HMIS will not affect the quality or quantity of services you are eligible to receive from this agency and will not be used to deny outreach, assistance, shelter or housing.</u> (Please note: You cannot receive financial assistance from a Supportive Services for Veteran Families project without the eligible veteran's consent to enter their full social security number into the HMIS).

Q: *Why does my information need to be collected or put into a database?*

A: To provide the most effective services in moving people from homelessness to permanent housing, we need an accurate count of all people experiencing homelessness in Pierce County. In order to ensure that clients are not counted twice, we need to collect personally identifying information. Specifically, we ask for **name, date of birth, social security number, demographics, contact information, and last and future permanent addresses.**

⇨ Please ask the staff person you are working with all your questions about collection of data or your rights regarding your personally identifying information, so that you clearly understand what you are signing, what is being collected, and why.

Q: *If my personally identifying information is entered into a database, how will I know that it is safe and confidential?*

A: We use strict security policies designed to protect your privacy. Our computer system is highly secure and uses up-to-date protection features such as data encryption, passwords, and identity checks required for each system user. There is a small risk of a security breach, and someone might obtain and use your information inappropriately. If you ever suspect the data in HMIS has been misused, immediately contact agency staff or the HMIS System Administrator at (253) 798-6936.

Q: *What happens with my information once it is entered into this database?*

A: As you receive services, information will be collected about you, the services provided to you, and the outcomes these services helped you to achieve. This information will be collected so that the agency and community can monitor the outcomes of services that are provided to you, improve the quality of care and services for homeless individuals and families, and **ensure that your information is not duplicated in the system by Partner Agencies.**

The agency listed above is asking your permission to collect and share information with other Partner Agencies—such as other homeless service, employment, education, social service, or basic needs service providers, etc.— Pierce County Community Connections and the Washington State Homeless Management Information System (HMIS) in the planning and delivery of services to you. A list of Partner Agencies will be made available upon request.

You may revoke your consent at any time, in writing. However, information already entered into the system cannot be removed. If you revoke your consent, no new information about you will be entered and current information will be hidden. (Note: this does not include any historical data.)

Do you consent to allow the inclusion of personally identifying information into the HMIS, including name, social security number, date of birth, demographics, and last and future permanent addresses?

☐ **I DO consent** to the inclusion of personally identifying information about me and my dependents (listed below) and authorize information collected to be shared in the Pierce County HMIS. Personally identifying information includes name, social security number, date of birth, demographics, and last and future permanent addresses.

OR

☐ **I do NOT consent** to the inclusion of personally identifying information about me and my dependents (listed below) for use in the Pierce County HMIS. Personally identifying information includes name, social security number, date of birth, demographics, and last and future permanent addresses. Non-identifying information will still be collected and shared only as needed and required by funders.

List dependent children under the age of 18 in the household, if any. (Please print first and last names.)

_____

_____

_____

_____ _____

Client Signature (Parent/Guardian) Staff Witness Signature

_____ _____

Client Name (Print clearly) Date Signed Staff Witness Name (Print clearly) Date Signed

Staff Use Only:

HMIS ID #: _____

☐ Client Refused to Sign (Staff Initials: _____ Date: _____)