

Home Stretch Referral Packet Fax Cover Sheet

FAX

TO: EveryOne Home – Home Stretch	FROM:
FAX: (855) 658-5466	FAX:
PHONE: (510) 891-8938	PHONE:
SUBJECT: Referral to Home Stretch	DATE:

Contact for Questions about Referral

Name: _____

Agency/Program: _____

Phone Number: _____

E-mail: _____

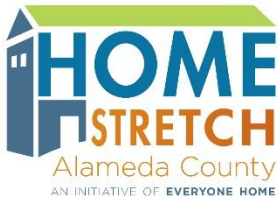
Are you the client’s Housing Navigator? Yes No

If not, please list Housing Navigator’s name, agency, and contact information (if known):

Please make sure you verify eligibility AND include all of the following with the referral (Complete Checklist):

Client HMIS ID# (if known): _____

- Completed and Signed Home Stretch Consent to Release of Information (ROI); AND,
- Completed InHOUSE Standard Intake Form OR updated data in HMIS for this client; AND,
- Home Stretch Contact Information Form OR updated contact information in HMIS for this client.
- Home Stretch High Service Need Verification Form and Supporting Documents OR updated VI-SPDAT in HMIS (if applicable).



Consent for the Release of Confidential Health, HIV/AIDS, Alcohol or Drug, Mental Health, and Housing Information to Alameda County Health Care Services Agency – Home Stretch

Home Stretch is a collaborative project of the Alameda County Health Care Services Agency and the members of its health, HIV/AIDS, alcohol or drug, mental health, and the InHOUSE housing, services, and program network. A list of current programs participating in Home Stretch is available upon request and at the following website: <http://everyonehome.org/our-work/home-stretch>

I, _____, authorize
(Print Name of participant/patient)

Home Stretch participating agencies to communicate with and disclose to one another the following information to help me obtain permanent housing and needed and desired services. *Information will only be shared with and used by people associated with the Home Stretch project that need and will use my information to help me obtain services and housing* [initial each category that applies]:

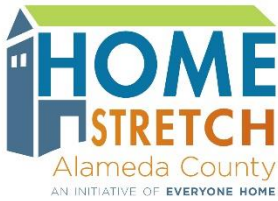
_____ **Data collected about me and entered into the InHOUSE (HMIS data) system** including intake, annual update, exit, program entry/exit, and services data. This data includes my name, age, date of birth, gender, race, ethnicity, marital status, veteran status, education, disability information, employment information, household relationships, living situation, income amount and type, benefits information, health insurance, income amount and type, benefits information, pregnancy status, legal information, programs and services needed and provided, and outcomes of services provided;

_____ Initial and subsequent evaluations of my service needs and health conditions by Home Stretch and its network members;

_____ Summaries of physical health, HIV/AIDS, alcohol/drug and mental health assessment results and service use history for the past 12 months.

_____ Other: _____

The purpose of the disclosures authorized in this consent is to enable Home Stretch and its network members to evaluate my need and desire for services, provide and coordinate services to me, determine my eligibility for specific service and housing programs, and to support me in obtaining permanent housing.



Consent for the Release of Confidential Health, HIV/AIDS, Alcohol or Drug, Mental Health, and Housing Information to Alameda County Health Care Services Agency – Home Stretch

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that records concerning mental health services I receive are protected by state law.

I understand that I may revoke or “take back” this consent at any time. If I “take back” my consent, however, this will only effect future sharing of information. Information shared prior to taking back my consent cannot be changed retroactively. This consent expires automatically 6 months after the date of my last services from a Home Stretch provider. Home Stretch services end after I obtain permanent housing. To revoke this consent, I must request in writing my wish to take back my consent with a designated Home Stretch provider OR with the Alameda County Health Care Services Agency – Home Stretch, P.O. Box 29172, Oakland, CA 94612; homestretch@acgov.org OR by FAX to (855) 658-5466. I have the right to receive a copy of all InHOUSE (HMIS) information collected about me and shared between participating agencies. I may also amend and correct InHOUSE (HMIS) information collected about me, which may be incorrect.

I understand the potential for information shared about me under this authorization to be redisclosed or shared again by the recipient and not necessarily protected by this authorization. I understand that the purpose of Home Stretch is the coordination of care and improved access to services and permanent housing resources. I understand that I will not be able to participate in coordinated care if I do not sign this Authorization, but individual service providers and government agencies listed may not deny me services if I refuse to sign this authorization. *I have been provided a copy of this form.*

_____ Date _____ Signature of Client

_____ Signature of person signing form if *not* client

Describe authority to sign on behalf of client: _____

Agency Representative MUST sign this consent form:

_____ Print Agency Representative Name _____ Agency Name

_____ Signature of Agency Representative

Project Name: _____ **Start:**

		/			/		
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ServicePoint ID:

--	--	--	--	--	--

Entry Type: HUD VA PATH

First: _____ **Middle:** _____

Full name reported Partial, Street or Code Name

Last: _____ **Suffix:** _____

Client doesn't know Client refused

Alias: _____

Social Security Number:

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Date of Birth:

		/			/		
--	--	---	--	--	---	--	--

Full SSN Approximate or Partial SSN
 Client doesn't know Client refused

Full DOB reported Approx or Partial DOB
 Client doesn't know Client refused

Household Information

What kind of household do you have?

- Single adult, no children Female single parent Male single parent Couple with no children
 Two parent family with children Couple (parent and friend) and children Foster parent(s) and children Grandparent(s) and children
 Non-custodial caregiver(s) Other: _____

Relationship to Head of Household:

- Self (Head of Household) HoH's **child** HoH's **spouse or partner**
 HoH's other relation member Other: non-relation member

Race

(Select all that apply—up to five responses)

- American Indian or Alaska Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander White Client doesn't know Client refused

Veteran Status

- No Yes

Gender

- Female
 Male
 Transgender male to female
 Transgender female to male
 Client doesn't know
 Client refused
 Other: _____

Ethnicity

- Non-Hispanic/Non-Latino
 Hispanic/Latino
 Client doesn't know
 Client refused

Residence Prior to Project Entry (Where did you stay last night?)

- | | | |
|---|--|---|
| <input type="checkbox"/> Emergency Shelter (including hotel or motel paid for with an emergency shelter voucher) | <input type="checkbox"/> Transitional Housing for homeless persons (including homeless youth) | <input type="checkbox"/> Place not meant for habitation (e.g. vehicle, abandoned building, bus/train/subway station/airport or anywhere outside) |
| <input type="checkbox"/> Hotel or motel paid for <u>without</u> emergency shelter voucher | <input type="checkbox"/> Rental by client, <u>no</u> ongoing housing subsidy | <input type="checkbox"/> Rental by client, with <u>VASH</u> subsidy |
| <input type="checkbox"/> Rental by client, with <u>GPD TIP</u> (transition-in-place) subsidy | <input type="checkbox"/> Rental by client, with <u>other ongoing subsidy</u> | <input type="checkbox"/> Residential project or halfway house with <u>no homeless criteria</u> |
| <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility | <input type="checkbox"/> Psychiatric hospital or other psychiatric facility | <input type="checkbox"/> Jail, prison or juvenile detention facility |
| <input type="checkbox"/> Staying or living in a <u>FAMILY</u> member's room, apartment or house | <input type="checkbox"/> Staying or living in a <u>FRIEND'S</u> room, apartment or house | <input type="checkbox"/> Substance abuse treatment facility or detox center |
| <input type="checkbox"/> Owned by client, <u>no</u> ongoing housing subsidy | <input type="checkbox"/> Owned by client, <u>with</u> ongoing housing subsidy | <input type="checkbox"/> Permanent housing for formerly homeless persons (CoC project; HUD legacy programs; or HOPWA PH, or Rapid Re-housing) |
| <input type="checkbox"/> Long-term care facility or nursing home | <input type="checkbox"/> Safe Haven (note: none in Alameda Co.) | <input type="checkbox"/> Foster care home or foster care group home |
| <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Client refused | <input type="checkbox"/> Other: _____ |

Last night's location

- Alameda
 Albany
 Berkeley
 Castro Valley
 Dublin
 Emeryville
 Fremont
 Hayward
 Livermore
 Newark
 Oakland
 Piedmont
 Pleasanton
 San Leandro
 San Lorenzo
 Sunol
 Union City
 Other unincorporated Alameda County
 Other California County
 Other State
 Other Country

Length of stay in Residence prior to entry

- One day or less Two days to one week More than one week, but less than a month One to three months
 More than three months, but less than one year One year or longer Client doesn't know Client refused

Standard Intake

Length of Time on Street, or in Emergency Shelter

Client entering from the streets, shelter or safe haven? No Client doesn't know Yes Client doesn't know

➔ If **Yes**, Approximate date started: ___/___/___

Number of **times** homeless (on the streets or in an emergency shelter, or safe haven) in the past three years including today: Never in the 3 years Four or more times
 One time Client doesn't know
 Two times Client refused
 Three times

Total number of **months** homeless on the street, in emergency shelter, or safe haven in the past three years: One month (this time is the first month) Client doesn't know
 2-12 months (___ months) Client refused
 More than 12 months

Domestic Violence

Are you, or have you been a survivor of domestic or intimate partner violence?

No Yes
 Client doesn't know Client refused

➔ If **YES**, how long ago did you have this experience?

Within the past 3 months One year ago or more
 3 to 6 months ago 6 months to 1 year ago
 Client doesn't know Client refused

➔ If **Yes**, are you currently fleeing?

No Yes
 Client doesn't know Client refused

Housing Status

Homeless and At-Risk of Homelessness Status

Category 1 - Homeless **Category 4** – Fleeing domestic violence
 Category 2 - At imminent risk of losing housing At-risk of homelessness
 Category 3 - Homeless only under other federal statutes Stably housed

CoC Location

CA-502

In permanent housing

No
 Yes (complete **Housing Assessment** form)

Move-in date: ___/___/___

Education

What is the highest level of school that you have completed?

Less than Grade 5 Grades 5-6 Grades 7-8 Grades 9-11
 Grade 12 School program does not have grade levels GED Some college
 Client doesn't know Client refused

Employment

Are you presently employed?

No Yes Client doesn't know Client refused

If employed, is this permanent, temporary or seasonal work?

Full-time Part-time Seasonal Client doesn't know

City/State Info

Answer the questions below, using the values at right:

What is the City, State of your last permanent housing where you lived for 90 days or more?

What is the City, State of the high school you last attended? (child: blank)

What is the City, State of your family residence when you were born?

Alameda County:	10 Newark	Other County:
1 Alameda	11 Oakland	19 Contra Costa
2 Albany	12 Piedmont	20 Marin
3 Berkeley	13 Pleasanton	21 San Francisco
4 Castro Valley	14 San Leandro	22 San Mateo
5 Dublin	15 San Lorenzo	23 Santa Clara
6 Emeryville	16 Sunol	24 Other California County
7 Fremont	17 Union City	25 Other State
8 Hayward	18 Other unincorporated	26 Other Country
9 Livermore	Alameda County	

Standard Intake

Income

- No/None at all **Yes** (Identify source and amounts)
 Client doesn't know Client refused

Source:	Amount:
<input type="checkbox"/> Earned income (i.e., employment income)	\$ _____ .00
<input type="checkbox"/> Unemployment Insurance	\$ _____ .00
<input type="checkbox"/> Supplemental Security Income (SSI)	\$ _____ .00
<input type="checkbox"/> Social Security Disability Income (SSDI)	\$ _____ .00
<input type="checkbox"/> Retirement Income from Social Security	\$ _____ .00
<input type="checkbox"/> VA Service-Connected Disability Compensation	\$ _____ .00
<input type="checkbox"/> VA Non-Service-Connected Disability Pension	\$ _____ .00
<input type="checkbox"/> Worker's Compensation	\$ _____ .00
<input type="checkbox"/> Temporary Assistance for Needy Families (TANF)	\$ _____ .00
<input type="checkbox"/> General Assistance (GA)	\$ _____ .00
<input type="checkbox"/> Private disability Insurance	\$ _____ .00
<input type="checkbox"/> Pension or retirement income from a former job	\$ _____ .00
<input type="checkbox"/> Child Support	\$ _____ .00
<input type="checkbox"/> Alimony or other spousal support	\$ _____ .00
<input type="checkbox"/> Other source: _____	\$ _____ .00
Total Monthly Income:	\$ _____ .00

Non-Cash Benefits

- No/None at all **Yes** (Identify source below)
 Client doesn't know Client refused

Source:

Supplemental Nutrition Assistance Program (SNAP/CalFresh)

Special Supplemental, Nutrition Program for Women, Infants, and Children (WIC)

TANF Child Care services

TANF transportation services

Other TANF-funded services

Section 8, public housing, or other ongoing rental assistance

Temporary rental assistance

Other: _____

Health Insurance

- Covered by Health Insurance:**
- No **Yes** (Identify source below)
 Client doesn't know Client refused

Source:

<input type="checkbox"/> MEDICAID/MediCal	<input type="checkbox"/> MEDICARE
<input type="checkbox"/> State Children's Health Insurance Program (SCHIP)	<input type="checkbox"/> Veteran's Administration (VA) Medical Services
<input type="checkbox"/> Employer-Provided Health Insurance	<input type="checkbox"/> Health Insurance obtained through COBRA
<input type="checkbox"/> Private Pay Health Insurance	<input type="checkbox"/> State Health Insurance for Adults

Disability

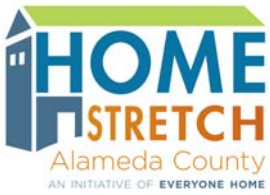
Do you have a physical, mental or emotional impairment, a post-traumatic stress disorder, or brain injury; a developmental disability, HIV/AIDS, or a diagnosable substance abuse problem?

- No **Yes** (Indicate type(s) below) Client doesn't know Client refused

	<input type="checkbox"/> Physical	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Chronic Health Condition	<input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs <input type="checkbox"/> Both	<input type="checkbox"/> Developmental	<input type="checkbox"/> HIV/AIDS
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	N/A	N/A
Expected to substantially impair ability to live independently:	N/A	N/A	N/A	N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Documentation of the disability and severity on file:	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Currently receiving services/treatment for this disability:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused

Staff Completing (Printed Name): _____ **Date:** _____

Standard Intake



Contact Information

Client Name: _____

Client HMIS ID# (if known): _____

Client Phone Number (if available): _____

Client Mailing Address (if available): _____

Client Email Address (if available): _____

Alternative Contact Name #1: _____

Alternative Contact #1 Phone Number (if available): _____

Alternative Contact #1 Email Address (if available): _____

Alternative Contact #1 Relationship to Client Description:
(please note if this person will be acting as the client's Housing Navigator):

Alternative Contact Name #2: _____

Alternative Contact #2 Phone Number (if available): _____

Alternative Contact #2 Email Address (if available): _____

Alternative Contact #2 Relationship to Client Description:
(please note if this person will be acting as the client's Housing Navigator):

Contact **HOME STRETCH**

fax: 1 (855) 658-5466, email: HomeStretch@acgov.org, phone: (510) 891-8938

mail: Post Office Box 29172, Oakland, CA 94612