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

InHOUSE Standard Intake Form v. 5.4 Effective 10/01/2015

Project Name: _____ **Start:** ☐☐/☐☐/☐☐ **ServicePoint ID:** ☐☐☐☐☐

Entry Type: ☐ HUD ☐ VA ☐ PATH

First: _____ **Middle:** _____

Last: _____ **Suffix:** _____

Alias: _____

Social Security Number: ☐☐☐☐☐☐☐☐☐

☐ Full name reported ☐ Partial, Street or Code Name

☐ Client doesn't know ☐ Client refused

Date of Birth: ☐☐/☐☐/☐☐

☐ Full DOB reported ☐ Approx or Partial DOB

☐ Client doesn't know ☐ Client refused

☐ Full SSN ☐ Approximate or Partial SSN

☐ 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

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

☐ **Emergency Shelter** (including hotel or motel paid for with an emergency shelter voucher) ☐ **Transitional Housing** for homeless persons (including homeless youth) ☐ **Place not meant for habitation** (e.g. vehicle, abandoned building, bus/train/subway station/airport or anywhere outside)

☐ Hotel or motel paid for without emergency shelter voucher ☐ Rental by client, no ongoing housing subsidy ☐ Rental by client, with VASH subsidy

☐ Rental by client, with GPD TIP (transition-in-place) subsidy ☐ Rental by client, with other ongoing subsidy ☐ Residential project or halfway house with no homeless criteria

☐ Hospital or other residential non-psychiatric medical facility ☐ Psychiatric hospital or other psychiatric facility ☐ Jail, prison or juvenile detention facility

☐ Staying or living in a FAMILY member's room, apartment or house ☐ Staying or living in a FRIEND'S room, apartment or house ☐ Substance abuse treatment facility or detox center

☐ Owned by client, no ongoing housing subsidy ☐ Owned by client, with ongoing housing subsidy ☐ Permanent housing for formerly homeless persons (CoC project; HUD legacy programs; or HOPWA PH, or Rapid Re-housing)

☐ Long-term care facility or nursing home ☐ Safe Haven (note: none in Alameda Co.) ☐ Foster care home or foster care group home

☐ Client doesn't know ☐ Client refused ☐ Other: _____

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

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

InHOUSE Standard Intake Form

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 ☐ One time ☐ Two times ☐ Three times	☐ Four or more times ☐ Client doesn't know ☐ Client refused
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) ☐ 2-12 months (___ months) ☐ More than 12 months	☐ Client doesn't know ☐ Client refused

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

Standard Intake

InHOUSE Standard Intake Form v. 5.4

Income

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

Source:	Amount:
☐ Earned income **(i.e., employment income)**	$ __ __ __ __ . 00
☐ Unemployment Insurance	$ __ __ __ __ . 00
☐ Supplemental Security Income **(SSI)**	$ __ __ __ __ . 00
☐ Social Security Disability Income **(SSDI)**	$ __ __ __ __ . 00
☐ Retirement Income from Social Security	$ __ __ __ __ . 00
☐ VA Service-Connected Disability Compensation	$ __ __ __ __ . 00
☐ VA Non-Service-Connected Disability Pension	$ __ __ __ __ . 00
☐ Worker's Compensation	$ __ __ __ __ . 00
☐ Temporary Assistance for Needy Families **(TANF)**	$ __ __ __ __ . 00
☐ General Assistance **(GA)**	$ __ __ __ __ . 00
☐ Private disability Insurance	$ __ __ __ __ . 00
☐ Pension or retirement income from a former job	$ __ __ __ __ . 00
☐ Child Support	$ __ __ __ __ . 00
☐ Alimony or other spousal support	$ __ __ __ __ . 00
☐ 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:

☐ MEDICAID/MediCal ☐ MEDICARE
☐ State Children's Health Insurance Program **(SCHIP)** ☐ Veteran's Administration **(VA)** Medical Services
☐ Employer-Provided Health Insurance ☐ Health Insurance obtained through COBRA
☐ Private Pay Health Insurance ☐ 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

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