

Homeless Preference Voucher Document Checklist

Today's date: _____ HMIS ID# _____

Confirmation # _____

Please copy all documentation and attach with this checklist.

Program Participant Name / Phone Number: _____

Requested from Program Participant:

- | Has | Needs | N/A | Document |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Driver's license or State ID with Oakland County address – or |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Driver's license or State ID with Verification of Employment in Oakland County |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Social Security Card |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Birth Certificate |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Homeless Verification |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Consent for Release of Information |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Coordinated Service Agreement |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Proof of Income (Pay stubs, W-2, SSI letter, etc.) or Written/signed "No Income" statement. |

Contacts:

	First Name	Last Name	Entity/Relationship	Contact Number
Secondary Contact				
Tertiary Contact				

Mailing Address			
	Street	City	Zip Code

Email Address _____ @ _____

Gender: M F T Social Security: _____ DOB: ___ / ___ / ___

Race: _____ | Hispanic/Latino? Yes No | Served in the Armed Forces? Yes No

Disability: Yes No

Income (Calculate ANNUAL income) \$ _____

Case Manager Name (please print) _____

Provider _____

**Consent for the Release of Confidential Information
For the HCV Homeless Preference**

Referring Agency: _____

Referring Agency Contact Name: _____

Contact's Phone Number: _____

I, _____,
(Name of Applicant)

authorize _____,
(Name of HARA agency)

and the Michigan Coalition Against Homelessness
(CoC Homeless Management Information System Administrator)

permission to disclose information or communicate with the Michigan State Housing Development Authority (MSHDA)-Assigned Housing Agent regarding:

1. Homeless Certification Information;
2. Applicant Profile Information (locations, address and/or other contact information);
3. Changes in voucher status notification, including reasons for change.

The purpose of the disclosure authorized in this consent is to:

- Assist the MSHDA-assigned Housing Agent in locating or assisting an applicant when their name has been selected from the waiting list;
- I understand that there may have been information shared based on this consent when it was in effect. Ending this consent cannot change that;
- I understand that I may end this consent with a notice in writing;
- I understand that my treatment records are protected under state and federal regulations governing confidentiality of patient records;
- The regulations are the Federal Law of Confidentiality for Alcohol and Drug Abuse Patients, (42 DFR, Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CFR, Parts 160 and 164;
- These records cannot be shared without my written consent except as provided for in the regulations;
- I understand that my treatment will not change based on whether I sign this consent form.

Signature of Applicant

Date

Signature of Guardian, or authorized representative (if required)

Date



Oakland County Alliance
Client Release of Information
Coordinated Services

This release of information is for the network of providers in Oakland County that work together through, the Alliance for Housing, providing services and supports to program participants in a variety of capacities.

Through a coordinated services agreement, the following agencies work together to coordinate services and supports for housing related assistance and documentation. You may be working with one or more of these organizations currently, or may be connected to them, through the course of developing a plan to resolve your current housing crisis.

In order to best serve you, we would like permission to share information, as needed, through this network.

What helping agencies share information to coordinate your services?

Catholic Community Response Team (CCRT)	Michigan Department of Health and Human Services (MDHHS)
Common Ground	MSHDA Housing Agents
Community Housing Network (CHN)	Oakland County Community Mental Health Authority (OCCMHA) and Core Provider Network
Community Network Services (CNS)	Oakland County Health Division
Disability Network of Michigan (DNOM)	Oakland County Sheriff's Office – Program Services Unit
Easter Seals Michigan	Oakland County Veteran's Services
HAVEN	Oakland Family Services (OFS)
Hope Network/New Passages	Oakland Integrated Health Network (OIHN)
HOPE, Inc.	Oakland Livingston Human Services Agency (OLHSA)
Jewish Family Service	Rochester Area Neighborhood House
Legal Aid and Defender Association (LADA)	South Oakland Shelter (SOS)
Lighthouse of Oakland County	Training and Treatment Innovations
Macomb Oakland Regional Center (MORC)	Welcome Inn/South Oakland Citizens for the Homeless

The information you give:

- May be used by other helping agencies in Oakland County.
- Will help reduce the paperwork you would have to fill out at other agencies.
- Will allow agencies to work together to better help you.
- Allow for agencies to verify homelessness.
- To let members of the Alliance know the current location of a client and provide contact information to an agency/organization when a housing program may be available





Client Informed Consent and Release of Information Authorization
Coordinated Services
SECTION 2

Please read the statements below and place your signature on the Client Signature line below.

I have received a copy of this agreement for my reference.

I understand that this written consent allows the servicing agency share and update information about my family and me to coordinate services. I understand that specific information about other adults in my family will require that a separate agreement be filled out by the individual.

I understand that the confidentiality of my records is protected by law. I understand that the partnering Alliance for Housing agency will never give information about me to anyone outside the agency without my written consent 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 (HIPAA), 45 CFR, Parts 160 & 164).

Page 1 of this document lists the partners that share information under a Coordinated Services Agreement. All of the sharing agencies must follow strict privacy laws. The sharing agencies may change from time to time.

I understand that the information provided and shared will be used to coordinate services, link with other available programs, and help to document homelessness history.

I understand that generally my services/treatment will not change based on whether I sign a consent form, but in certain limited circumstances I may be denied services/treatment if I do not sign a consent form. I understand this consent is voluntary and may be revoked in writing at any time, except to the extent that action has been taken relying on this authorization. Unless otherwise revoked, this authorization will expire one year from the signed date.

Client signature: _____ Date: _____

Guardian or authorized representative signature (if required): _____

Relationship to client: _____

Guardian/authorized representative signature date: _____



Homeless Preference Voucher Self-Certification of Missing Birth Certificate

Today's date: _____

HMIS ID #: _____

Program Participant Name/Phone Number: _____

Proof of Age is required for all family members

Proof of Age for Adults and Children

Listed in order of preference:

- A birth certificate or other official record of birth
- For elderly individuals, an original document that provides evidence of the receipt of social security retirement benefits is acceptable, if the individual's date of birth is on the document.

If neither of the above documents can be provided, one of the following documents can be accepted:

- Driver's license or State ID, if the individual's birth year is on the document
- School records, if the individual's birth year is on the document

Explanation as to why the household cannot produce the birth certificate(s):

Program Participants Signature: _____ Date: _____

Staff Signature: _____ Date: _____

MICHIGAN STATE HOUSING DEVELOPMENT AUTHORITY

VERIFICATION TRACKING OF INCOME

****Household member 18 or older with zero income must complete Step 5**

Each Household member 18 or older: _____ Date _____

- Intake/Screening 3-month Certification

Agencies must record all attempts to obtain required verifications in the order specified:

Step 1. Third Party Source: Were verification documents provided by the client?

- Yes – Complete calculation worksheet (Form No. 10 to determine eligibility).
 No – Proceed to Third Party Written. (Provide explanation). **Go to Step 2 if income could not be verified in Step 1.** _____

Step 2. Third Party Written: Send ESG Form No. 9, Verification of Income, to Income Source(s).

Date Form(s) sent/faxed: _____ (Retain copy of form(s) in client file)

- Documents received within 10 business days – Complete calculation worksheet (Form No. 10).
 Documents not received within 10 business days – Proceed to Third Party Oral. **Go to Step 3 if income could not be verified in Step 2.**

Step 3. Third Party Oral: Intake staff contacts third-party sources identified by the household.

Record date, source(s) contacted and income information or reason(s) for not obtaining information:

If sufficient income information is provided, complete Calculation Worksheet (Form No. 10) to determine eligibility; otherwise, **proceed to Step 4, Self-Certification.**

- I certify, under penalty of perjury, this information is true and correct to the best of my knowledge.

Intake Staff Signature: _____ **Date:** _____

Step 4. Self-Certification: ONLY use Step 4 to verify income after attempting and documenting Steps 1, 2 & 3.

- I certify, under penalty of perjury, that the information I have provided on this form is true and correct, to the best of my knowledge.

Source: _____ Amt. _____ Frequency: _____
 Source: _____ Amt. _____ Frequency: _____
 Source: _____ Amt. _____ Frequency: _____

Step 5. Zero Income: (Each household member 18 or older with zero income must sign)

- I certify, under penalty of perjury, that I do not have income from any source at this time. This is true and correct to the best of my knowledge.

Client Signature: _____ **Date:** _____

Oakland County HMIS Client Release of Information (ROI)

This release of information is for the Michigan Statewide Homeless Management Information System (MSHMIS). Many shelters and agencies use the system to store information about clients that get help.

The information you give:

- May be used by other helping agencies in Oakland County.
- Will help reduce the paperwork you would have to fill out at other agencies.
- Will allow agencies to work together to better help you.

SECTION 1: Basic Identifying Information

Your information will be entered into the system, as this is our internal record keeping tool. All persons using the system are trained and certified in privacy. Your basic information (name, year of birth, partial SSN, gender, veteran status, and photo) is searchable in the system by all HMIS licensed users.

SPECIAL NOTICE**

If you have a **specific** privacy concern, such as fleeing domestic violence, you may elect to close the search screen by initialing here: _____ PLEASE TALK TO YOUR CASE MANAGER FOR MORE INFORMATION.

If you have initialed above, please understand that your information will still be entered into the system but will not be searchable to other agencies. If you choose this option and have already received services from an agency in Oakland County, we will need to coordinate a discussion with those agencies to determine the most appropriate way to lock down the search screen.

SECTION 2: Oakland County Sharing Plan

What helping agencies share information in the system?

- Blue Water Center for Independent Living (BWCIL) (limited to SSVF)
- Common Ground (limited to GAP)
- Community Housing Network (CHN)
- Catholic Community Response Team (CCRT)
- HOPE
- Lighthouse of Oakland County
- Oakland Livingston Human Service Agency (OLHSA) (limited to SSVF and Veteran Program)
- South Oakland Shelter (SOS)
- Training and Treatment Innovations (TTI)
- South Oakland Citizens for the Homeless (SOCH)/Welcome-Inn

Detailed Information

Specific details about what is shared and who can see your information is in the attached [Oakland County Sharing Plan](#) document. Do you want to share your detailed information with the helping agencies? Please initial the appropriate box.

	Yes, I agree to share according to the Oakland County Sharing Plan.
	No. I want help, but I don't want my info shared. Only our agency will be able to see your detailed information.

If No, your detailed information will not be shared but your basic information (name, year of birth, partial SSN, gender, veteran status, and photo) will still be searchable in the system search screen. If you choose this option and have already received services from an agency in Oakland County, only the information from this date forward will not be shared with the other helping agencies.

Homeless History Search (Optional):

The Michigan Coalition Against Homelessness may need to document your homeless history to see if you are eligible for specific community programs. Your case manager may contact a Representative from the Michigan Coalition against Homelessness (MSHMIS lead agency) to view data recorded in HMIS in order to complete a housing history document. With your permission, these representatives will complete the document and give it to your case manager. I give consent for the sharing agencies to be the recipients of this information by initialing here: _____

SECTION 3: Acknowledgment of Rights

Please read the statements below and place your signature on the Client Signature line below.

- I have received a copy of this Agency’s Privacy Notice/script that explains MSHMIS and my rights and responsibilities associated with how information is kept and shared through this system.
- I understand that the confidentiality of my records is protected by law. I understand that the servicing agency will never give information about me to anyone outside the agency without my written consent through Oakland County Sharing Plan or as required by law (The regulations are Federal Law of Confidentiality for Alcohol and Drug Abuse Patients, (42 CFR, Part 2), the Health Insurance Portability and Accountability Act of 1996 (HIPAA, 45 CFR, Parts 160 & 164 as revised by the Health Information Technology for Economic and Clinical Health Act of 2009 aka the HITECH Act), and certain Michigan laws.)
- I can withdraw my consent to share at any time, but any information already shared with another agency cannot be taken back. If sharing information on the system poses an imminent health or safety risk I will talk with my case manager.
- I understand that I have the right to see my information, request changes, and to get a copy of my information by written request. An agency can refuse to change my record but must provide a written explanation of why they refuse the change within 60 days. Agencies may charge for reproducing a record.
- I understand that agencies included in the Oakland County Sharing Plan must follow strict privacy guidelines.
- I understand that my written consent allows the information listed in Section 3 - Coordination of Care Sharing Plan to be shared among the agencies listed in the sharing plan. All sharing agencies where I am receiving services will update that information as I provide new or additional information. The purpose of sharing my information is to better coordinate care for me and my family.
- I understand that I will not be denied services (emergency assistance, outreach, shelter, housing assistance, etc.) if I refuse to share information in this system.
- I understand that my name and other identifying information may be used to match records through a trusted partner for academic research purposes or to determine eligibility for other resources. If I am eligible to receive additional resources, my case manager may contact me. None of my additional identifying information outside of my name will be shared with other organizations unless I sign an additional release of information. Prior to academic research being done, my identifying information will be removed, before data analysis takes place

This release is active for one year effective the date of signature.

Client signature (head of household): _____, Date: ____/____/____

Adult Household Member signature: _____, Date: ____/____/____

Adult Household Member signature: _____, Date: ____/____/____

Adult Household Member signature: _____, Date: ____/____/____

Guardian or authorized representative signature (if required): _____

Relationship to client: _____, Date: ____/____/____

Oakland County Sharing Plan

This document was developed to help explain what information is shared in HMIS and which agencies can see your information. This document accompanies the signed ROI and is provided to the client prior to requested signature. Agencies and projects that share my information:

Blue Water Center for Independent Living (BWCIL)

Common Ground

Community Housing Network (CHN)

Catholic Community Response Team (CCRT)

HOPE

Lighthouse of Oakland County

Oakland Livingston Human Service Agency (OLHSA)

South Oakland Shelter (SOS)

South Oakland Citizens for the Homeless/Welcome-Inn

Training and Treatment Innovations (TTI)

The basic information that is shared (a complete list varies by assessment and is available upon request):

Date of Birth	Race and Ethnicity	Household income and benefits
Household members and relationship	Housing status, homeless history, and move-in date	Additional assessment responses
Physical, developmental, and/or mental disability	HIV/AIDS	Type of health insurance and/or medical assistance
General health status	Chronic health conditions	Alcohol and/or drug abuse
Military service information	Employment	Education level
Domestic violence history	Project exit and destination	Exit housing assessment
Services and financial assistance with dates	Referrals and service connections	Location (city, county) and last permanent address
Eviction/loss of subsidy	Eligibility documentation	Contact information
Case plans, goals and notes	VI-SPDAT Housing Screening Tools	Registered sex offender
Danger Assessment		

Please note this document is subject to change and if you have concerns regarding the sharing of your information please contact your case manager.