



Vermont Coalition to End Homelessness (VCEH) Coordinated Entry Partnership

PERMISSION TO SHARE PERSONAL & HEALTH INFORMATION TO SECURE HELP WITH HOUSING

A staff member will review this form with you. Signing is voluntary.

Each adult in a household must sign their own permission form.

Name of Individual: _____ DOB: _____ Last 4 of SSN: _____

A Parent/Legal Guardian may complete a release for one or more children at a time.

Name of Child (if applicable): _____ DOB: _____ Last 4 of SSN: _____

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Name of Parent/Legal Guardian (if applicable): _____

_____ <Agency Name> _____ has agreed to participate in the VCEH Coordinated Entry Partnership. The VCEH Coordinated Entry Partnership includes organizations that provide homeless and housing assistance. As part of the VCEH Coordinated Entry Partnership, agencies agree to share information about individuals and families with other agencies in the Partnership in order to help a household to find or keep housing as quickly as possible.

_____ <Agency Name> _____ also participates in the Vermont's Homeless Management Information System (VTHMIS), ServicePoint. Agencies that participate in VTHMIS belong to an internet-based network. You have the option to share your information in VTHMIS with other agencies from whom you might be seeking housing help. With your permission, information you provide will be shared with this agency, the agencies participating in the VTHMIS data sharing agreement, and limited staff of the Institute for Community Alliances, administrators of the database. Information collected is housed in a secure server located at Mediarware Information Systems in Shreveport, Louisiana.

HOW IT CAN HELP YOU WHEN YOU LET AGENCIES SHARE YOUR INFORMATION

Reduces the amount of time spent answering basic questions about your situation	Reduces the amount of times you have to tell your story to service providers
Faster access to services and housing help	Allows agencies to focus on meeting your unique needs
Eliminates duplicate intake paperwork	Multiple services can be better coordinated

I give my permission for the following homeless and housing service agencies (check all that apply):

- Agencies participating in the VTHMIS data sharing agreement of < Local Area Name > Coordinated Entry Partnership, except for the following:

The list of agencies participating in this VTHMIS sharing agreement can be accessed at www.icalliances.org/vermont-documents. This list may change.

- Agencies participating in the <Local Area Name > Coordinated Entry Partnership, except for the following:

The list of participating agencies is attached.

To communicate with and disclose to one another the following information (check all that apply):

- Personal Identifying Information: Name (First, Middle and Last), Social Security Number, Date of Birth, Ethnicity, Gender, Last Residence Information, Military Status
- Information about my housing status and barriers to stable housing, including income, non-cash income, history of domestic violence, evictions, debt, legal issues, etc.
- Information about my enrollment in services related to housing or other homeless assistance programs
- Information about the services my household receives from housing or homeless assistance programs: referrals, assessments
- Information about my physical and/or mental health condition(s), such as any disabilities or chronic medical conditions
- Information about my alcohol/drug related diagnosis, treatment or referral for treatment, and HIV status (as limited as possible), no information about a child's substance use disorder will be shared
- Other _____

The purpose(s) of the disclosure authorized is:

- To determine the services that are necessary for me
- To facilitate obtaining resources to support my housing and related needs
- To coordinate services on my behalf and prevent duplication
- Other _____

By signing this form, I understand:

- The reason(s) I am being asked to release information.
- Signing this authorization is voluntary. I understand that ability to receive services or support is not conditioned upon authorizing this disclosure. However, by not giving authorization to share information, I may not be able to access housing help as quickly as possible. Also, some agencies may require that you answer certain questions to make sure that you are eligible for services.
- While _____<agency>_____ will take every precaution to protect my personal and health information, once it is released pursuant to this authorization, it may be subject to re-disclosure by other parties.
- My drug and alcohol treatment records are protected by Federal confidentiality rules (42 CFR Part 2) and cannot be disclosed or re-disclosed without my express written consent or as allowed by the regulation. If applicable, I am I am not authorizing subsequent or re-disclosure about my alcohol or drug related diagnosis, treatment or referral for treatment and HIV status among the homeless and housing service agencies named in this release.
- I may revoke this authorization at any time by contacting _____<name>_____ at _____<phone>_____, except to the extent that it has been acted upon.
- If I do not revoke or update this authorization, it will be in effect for one year from the date below.
- I will be provided a copy of this form.
- All items on this form have been completed and my questions about this form have been answered.

Signature of Individual or Parent/Legal Representative	Date<date>
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Name of Person Explaining Authorization Process	Organization / Position	Date <date>
	<Organization/Position>	