Housing Authority of Grant County Central Intake Form

Section #1 - Head of Household Information

Social Security Number ______-______-______

Name First________________________ Last________________________

Date of Birth ____/____/____

Current Mailing Address:____

Telephone number where you can be reached: ________________________ Is this a message number? YES NO

Please tell us more about the Head of Household

Race (Check as Many As Apply)
- ☐ White
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ US Indian or Alaska Native
- ☐ Refused

Ethnicity
- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Non-Latino
- ☐ Refused

Gender
- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Don't Know
- ☐ Other
- ☐ Refused

Are you or any other household members pregnant?
☐ Yes ☐ No

What Non-Cash Benefits do you receive?
Check all that apply:
- ☐NONE
- ☐ Food Assistance
- ☐WIC
- ☐Other:__________

Do you have health insurance?
No or **Yes** (Check as many as apply)
- ☐Medicaid ☐Medicare
- ☐VA Medical ☐Employer Provided
- ☐State Health Insurance for adults
- ☐ Other:______________

Did/Do you serve in the military?
No *or* Yes – Branch __________

Office Use Only:

What is your current living situation?
- ☐ I have a pay or vacate notice from my landlord
- ☐ I have a termination notice from my landlord
- ☐ I am sleeping in my vehicle, RV, outdoors, etc
- ☐ I am staying at friends/family at: (address)________________
- ☐ Other:______________________________

Office use Only:
Approximate date homelessness started:
___/___/___

Who can we contact in case we are unable to get in touch with you? (Other than anyone in your household)

Name:______________________ Relationship:______________________ Phone:______________

Section #2 – Other Household Members

If there are other members in your household, please complete this section.

Other Household Member #1

SSN	First Name	Last Name	Date of Birth	Relation
_____-_____-_____			____/____/____	
Gender	**Race**	**Ethnicity**	**Insurance**	**Veteran**
☐ Male ☐ Female ☐ Transgender ☐ Don't Know ☐ Other ☐ Refused	☐ White ☐ Asian ☐ Black or African America ☐ Native Hawaiian/ Pacific Islander ☐ US Indian or Alaska Native ☐ Refused	☐ Hispanic/Latino ☐ Non-Hispanic/ Non-Latino ☐ Refused	No or Yes (Check as many as apply) ☐Medicaid ☐Medicare ☐VA Medical ☐ Employer Provided ☐State Health Insurance for adults ☐ Other:__________	No *or* Yes – Branch __________

Other Household Member #2

SSN	First Name	Last Name	Date of Birth	Relation
_____-_____-_____			____/____/____	
Gender	**Race**	**Ethnicity**	**Insurance**	**Veteran**
☐ Male ☐ Female ☐ Transgender ☐ Don't Know ☐ Other ☐ Refused	☐ White ☐ Asian ☐ Black or African America ☐ Native Hawaiian/ Pacific Islander ☐ US Indian or Alaska Native ☐ Refused	☐ Hispanic/Latino ☐ Non-Hispanic/ Non-Latino ☐ Refused	No or Yes (Check as many as apply) ☐Medicaid ☐Medicare ☐VA Medical ☐ Employer Provided ☐State Health Insurance for adults ☐ Other:__________	No *or* Yes – Branch __________

Other Household Member #3

SSN	First Name	Last Name	Date of Birth	Relation
_____-_____-_____			____/____/____	
Gender	**Race**	**Ethnicity**	**Insurance**	**Veteran**
☐ Male ☐ Female ☐ Transgender ☐ Don't Know ☐ Other ☐ Refused	☐ White ☐ Asian ☐ Black or African America ☐ Native Hawaiian/ Pacific Islander ☐ US Indian or Alaska Native ☐ Refused	☐ Hispanic/Latino ☐ Non-Hispanic/ Non-Latino ☐ Refused	No or Yes (Check as many as apply) ☐Medicaid ☐Medicare ☐VA Medical ☐ Employer Provided ☐State Health Insurance for adults ☐ Other:__________	No *or* Yes – Branch __________

Other Household Member #4

SSN	First Name	Last Name	Date of Birth	Relation
_____-_____-_____			____/____/____	
Gender	**Race**	**Ethnicity**	**Insurance**	**Veteran**
☐ Male ☐ Female ☐ Transgender ☐ Don't Know ☐ Other ☐ Refused	☐ White ☐ Asian ☐ Black or African America ☐ Native Hawaiian/ Pacific Islander ☐ US Indian or Alaska Native ☐ Refused	☐ Hispanic/Latino ☐ Non-Hispanic/ Non-Latino ☐ Refused	No or Yes (Check as many as apply) ☐Medicaid ☐Medicare ☐VA Medical ☐ Employer Provided ☐State Health Insurance for adults ☐ Other:__________	No *or* Yes – Branch __________

Section #3 – Household Income

Please tell us about the income you and the members of your household receive – wages, unemployment, DSHS benefits, child support, SSI, etc.

Household member name	Type of income	How much?	How often?
Example *John Smith*	*TANF*	*$470*	*monthly*
1.			
2.			
3.			
4.			

Does anyone in the household have a job they will be starting soon?

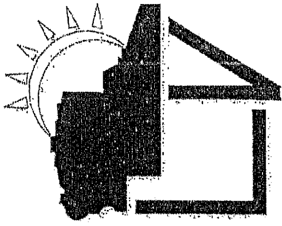
☐ No ☐ Yes, Who?__________________, Employer name?______________________, Start Date__________

Office Use Only:

Section 4:

	Comments
How many times have you slept on the street/in your vehicle or stayed in an emergency housing project in the past <u>3 years</u>? ☐ None ☐ I don't know ☐ I refuse to answer ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more	
How many total <u>months</u> have you been homeless in the past 3 years? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ more than 12 ☐ I don't know ☐ I refuse to answer	

Do you or a family member have a physical disability? ☐ No ☐ I don't know ☐ I refuse to answer ☐ Yes, Who?__________________ Are you currently receiving services for the disability? **Y / N** Is this a long-term disability? **Y / N**	
Have you or anyone in your family been diagnosed with a developmental disability? – any issues with reading, writing, walking, speaking, or hearing? ☐ No ☐ I don't know ☐ I refuse to answer ☐ Yes, Who?______________ Are you currently receiving services for the disability? **Y / N** Does it substantially impair your independence? **Y / N**	
Do you or a family member have any on-going health conditions? ☐ No ☐ I don't know ☐ I refuse to answer ☐ Yes, Who?__________________ Are you currently receiving services for the condition(s)? **Y / N** Is this a long-term condition? **Y / N**	
Do you or a family member have a mental health issue? ☐ No ☐ I don't know ☐ I refuse to answer ☐ Yes, Who?__________________ Are you currently receiving services for the condition(s)? **Y / N** Is this a long-term condition? **Y / N**	
Do you or a family member have an issue with drugs or alcohol? ☐ No ☐ I don't know ☐ I refuse to answer ☐ Alcohol, Who?_________________ ☐ Drug, Who?____________ ☐ Both, Who?______________ Are you currently receiving services for the issue(s)? **Y / N** Is this a long-term issue? **Y / N**	
Have you or a member of your family been a victim of domestic or intimate partner violence? ☐ No ☐ Yes, how long ago?__________ Currently fleeing? **Y / N** ☐ I don't know ☐ I refuse to answer ☐ In Services with New Hope? **Y / N**	



Housing Authority of Grant County

1139 Larson Blvd. • Moses Lake, WA 98837-3308
Phone: (509) 762-5541 • Fax: (509) 762-2202
Toll Free: (800) 747-9202 • TTY: (800) 833-6388
www.hagc.net

AUTHORIZATION FOR RELEASE FOR INFORMATION

I authorize and direct any federal, state, or local agency, organization, business, or individual to release to HOUSING AUTHORITY OF GRANT COUNTY any information or materials needed to complete and verify the information that I have given. I understand and agree that this authorization or the information obtained with its use may be given to and used by HAGC in administering and enforcing program rules and policies.

I also consent for HAGC to release information from my file about any related history to any state, federal, agency, or program that may assist a client with their social or legal needs as determined by HAGC.

INFORMATION COVERED

I understand that, depending on program and requirements, previous or current information regarding my household or me may be needed. Verifications and inquires that may be requested include but are not limited to:

- Identity and Martial Status
- Medical and Child Care Allowances
- Residences and Rental activity
- Employment, Income, and Assets
- Credit and Criminal Activity
- Citizenship or eligibility Immigration Status

I understand that this authorization cannot be used to obtain any information about me that is NOT pertinent to the programs that HAGC works with.

GROUPS OR INDIVIDUALS THAT MAY BE ASKED

The groups or individuals that may be asked to release the above information (depending on program requirements) includes but not limited to:

- Current & Previous Landlord
- Public Housing Agencies
- Courts and Post Offices
- Support and Alimony Providers
- Utility Companies
- Medical Providers
- Retirement Systems
- Past and present Employers
- State Unemployment Agencies
- Schools and Colleges
- Immigration and Naturalization
- Services Providers
- Childcare Providers
- Welfare Agencies
- Law Enforcement Agencies
- Veterans Administrations
- Banks and Financial Institutions
- Credit Providers
- Credit Bureaus

CONDITIONS

I agree that a photocopy of this authorization may be used for the purpose as stated above. The original of this authorization is on file with HAGC and will stay in effect for a year and one month from the date signed. I understand I have a right to review my file and correct any information that I can prove incorrect.

SIGNATURES

Head of Household	Print Name	Date
Spouse/Partner	Print Name	Date
Other Adult over 18	Print Name	Date

The Housing Authority of Grant County, Washington is an equal opportunity provider and employer and does not discriminate on the basis of race, color, national origin, religion, sex, physical or mental disability, or familial status. The Housing Authority of Grant County's policies and practices are designed to provide assurances that persons with disabilities will be given reasonable accommodations, upon request, so that they may fully access and utilize the housing programs and related services.

Client Release of Information and Informed Consent

IMPORTANT: Do not enter personally identifying information into HMIS for clients who are: 1) in DV agencies or; 2) currently fleeing or in danger from a domestic violence, dating violence, sexual assault or stalking situation; 3) are being served in a program that requires disclosure of HIV/AIDS status (i.e.; HOPWA); or 4) under 13 with no parent or guardian available to consent to enter the minor's information in HMIS.
If this applies to you, STOP- Do not sign this form.

This agency participates in the Washington State Homeless Management Information System (HMIS) by collecting information, over time, about the characteristics and service needs of people facing homelessness. **RCW 43.185C.180 and RCW 43.185C.030**

- 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 Washington State. In order to insure that clients are not counted twice, we need to collect four pieces of personally identifying information. Specifically, we collect: **name, birth date, and race/ethnicity.** You may also choose to provide your social security number. However, signing this form does not require you to do so. Your information will be stored in our database for 7 years after the last date of service. If you have questions about collection of data or your rights regarding your personally identifying information, contact the HMIS System Administrator at: (360) 725-3028
- 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 two-factor authentication 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 the HMIS System Administrator at: (360) 725-3028
- The data you provide may be combined with data from the Washington State Department of Social and Health Services (DSHS) and Education Research and Data Center for the purpose of further analysis. Your name and other identifying information will not be included in any reports or publications. Only a limited number of staff members, who have signed confidentiality agreements, will be able to see this information. Your information will not be used to determine eligibility for DSHS programs. Washington State HMIS system administrators have full access to all information in HMIS. This includes the Department of Commerce staff, designated HMIS system administrators, and the software vendor.
- By signing this form, you acknowledge and allow Department of Commerce staff to obtain additional records of information from other state agencies with which there is a data sharing agreement (DSA) on file between Commerce and the other agency. Our DSA guides data transfer and storage security protocols. If DSAs are in place, Commerce is authorized by you to obtain, add to HMIS, and use for evaluation purposes any other data you have provided to other Washington state agencies.
- 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. However, if you do choose to participate, services in the region may improve if we have accurate information about homeless individuals and the services they need. Furthermore, some funders MAY require that you consent to provide your personally identifying information in HMIS in order for you to receive services from that funding source.

I understand the above statements and consent to the inclusion of personally identifying information in HMIS about me and any dependents listed below, and authorize information collected to be shared with partner agencies. I understand that my personally identifying information will not be made public and will only be used with strict confidentiality. I also understand that I may withdraw my consent at any time by filing a 'Client Revocation of Consent' form with this agency. I understand that I may obtain a copy of my signed consent form from this Agency (including forms signed electronically).

Dependent children under 18 in household, if any (Please print first and last names):

____________________ ____________________

____________________ ____________________

Client Signature (Parent/Guardian) Date

Client Name (Print clearly) Agency Staff Name (Print clearly) Initials

Client refused consent __________ (Agency Staff Initials) **HMIS Unique Identifier (optional) ____________**

This form may not be amended except by approval of the Washington State Department of Commerce
Approved as to form by Sandra Adix, Assistant Attorney General, 6/5/2018

Washington State Department of Social & Health Services
Transforming lives

Consent

NOTICE TO CLIENTS: The Department of Social and Health Services (DSHS) can help you better if we are able to work with other agencies and professionals that know you and your family. By signing this form, you are giving permission for DSHS and the agencies and individuals listed below to use and share confidential information about you. DSHS cannot refuse you benefits if you do not sign this form unless your consent is needed to determine your eligibility. If you do not sign this form, DSHS may still share information about you to the extent allowed by law. If you have questions about how DSHS shares client confidential information or your privacy rights, please consult the DSHS Notice of Privacy Practices or ask the person giving you this form.

CLIENT IDENTIFICATION:

NAME	DATE OF BIRTH	IDENTIFICATION NUMBER	
ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NUMBER (INCLUDE AREA CODE)	OTHER INFORMATION		

CONSENT:

I consent to the use of confidential information about me within DSHS to plan, provide, and coordinate services, treatment, payments, and benefits for me or for other purposes authorized by law. I further grant permission to DSHS and the below listed agencies, providers, or persons to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or by computer data transfer, mail, or hand delivery.

Please check all below who are included in this consent in addition to DSHS and identify them by name and address:

- ☐ Health care providers: ______
- ☐ Mental health care providers: ______
- ☐ Substance use disorder service providers: ______
- ☐ Other DSHS contracted providers: ______
- ☒ Housing programs: **Housing Authority of Grant County 1139 Larson Blvd. Moses Lake WA 98837**
- ☐ School districts or colleges: ______
- ☐ Department of Corrections: ______
- ☐ Employment Security Department and its employment partners: ______
- ☐ Social Security Administration or other federal agency: ______
- ☐ See attached list
- ☐ Other:

I authorize and consent to sharing the following records and information (check all that apply):

☒ All my client records ☐ Records on attached list

☒ Only the following records

- ☐ Family, social and employment history ☐ Health care information ☐ Treatment or care plans
- ☐ Payment records ☐ Individual assessments ☐ School, education, and training
- ☒ Other (list): **Child support (DCS) Child Support Payment Records for the past 12 months**

PLEASE NOTE: If your client records include any of the following information, you must also complete this section to include these records.
I give my permission to disclose the following records (check all that apply):
☐ Mental health ☐ HIV/AIDS and STD test results, diagnosis, or treatment ☐ Substance Use Disorder

- **This consent is valid for ☒ one year ☐ as long as DSHS needs records, or ☐ until ______ (date or event).**
- **I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared.**
- **I understand that records shared under this consent may no longer be protected under the laws that apply to DSHS.**
- **A copy of this form is valid to give my permission to share records.**

SIGNATURE	DATE	WITNESS / NOTARY (SIGN AND PRINT NAME, IF APPLICABLE)	DATE
PARENT OR OTHER REPRESENTATIVE'S SIGNATURE (IF APPLICABLE)		TELEPHONE NUMBER (INCLUDE AREA CODE)	DATE

If I am not the subject of the records, I am authorized to sign because I am the: (attach proof of authority)
☐ Parent ☐ Legal Guardian (attach court order) ☐ Personal representative ☐ Other:

NOTICE TO RECIPIENTS OF INFORMATION: **If these records contain information about HIV, STDs, or AIDS, you may not further disclose that information without the client's specific permission.** If you have received information related to **drug or alcohol abuse** by the client, you must include the following statement when further disclosing information as required by 42 CFR 2.32:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medial or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

ASSETS

An asset is cash or items that could be converted to cash quickly and includes the real or personal property and investments that a household may possess, including assets that are owned by more than one person, but allow unrestricted access to the applicant. Please mark all that apply and provide documentation showing the asset(s). If you have no assets, please mark "None" at the bottom of the page. Assets include:

Cash on hand $___________

___Checking Account ___Saving Account ___Stocks

___Bonds ___Saving Certificates ___IRA

___Trust Account ___Keogh ___Inheritances

___Capital gains ___Lottery Winnings ___Money Market Fund

___Insurance Settlements ___Real Estate ___Other Investments

___Personal Property

___None

______________________________ ______________________________

Signature Date

You Have Rights as a Tenant!

Fair Housing Laws

The Fair Housing Act protects people from discrimination when they are renting, buying, or securing financing for any housing. The prohibitions specifically cover discrimination because of race, color, national origin, religion, gender, disability and the presence of children.

Washington State Residential Landlord-Tenant Act (RLTA)

The WA State Residential Landlord Tenant Act specifies the rights and responsibilities of tenants and landlords. Generally the State law requires landlords and tenants to act in good faith toward one another.

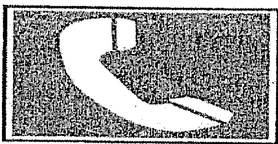
- To learn more about Your Rights as a Tenant in Washington State: http://www.commerce.wa.gov/Documents/Tenants%20Rights%20and%20Responsibilities.pdf Includes information about Landlord and Tenant Responsibilities, requirements around repairs, moving out and when a unit can be considered abandoned.

- To learn more about Eviction and your Defense: http://www.washingtonlawhelp.org/resource/eviction-and-your-defense?ref=4mm2N

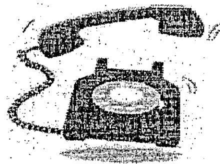
- Landlord Tenant Issues for Survivors of Domestic Violence, Sexual Assault and/or Stalking http://www.washingtonlawhelp.org//resource/landlordtenant-issues-for-survivors-of-domest

CLEAR Legal Assistance Hotline

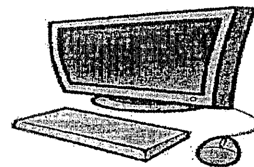
Call the CLEAR Hotline for Legal Assistance related to landlord-tenant issues. Generally, callers are screened for income eligibility and type of legal problem. CLEAR gets many calls. It may take a while to speak to someone. Please be patient.



CLEAR* Senior Hotline
Age 60 and Better
1-888-387-7111
(M-F 9:15 am to 12:15 pm)



Call NJP's **CLEAR Hotline**
at **1-888-201-1014**
(M-F 9:15 am to 12:15 pm)



Share your situation on-line
and get legal advice.
https://nwjustice.org/get-legal-help

Ask your housing case manager for hard copies of any documents that may be helpful.

I have received a copy of this flier ______________________________ ____________________
Signature Date