MARYLAND HOMELESS I.D. PROJECT

Documentation of Homelessness

Please use the following space to describe the applicant's current living situation. If the applicant is currently in the detention center, please describe their living situation prior to incarceration. <u>If the applicant is currently</u> <u>residing in a shelter, transitional housing program, or other temporary housing facility additional</u> <u>documentation of homelessness, i.e. letter on agency letterhead must be included with this form.</u>

Self-Verification (Brief statement from client saying he/she is homeless or at-risk of losing his/her housing):

_____

_____

_____

_____

_____

_____

_____

<u>(Please ask the Applicant these questions):</u>

1. Where do you typically stay at night? _____

2. Do you know the name of the shelter or housing program where you stay?

_____

3. Do you work with any of the outreach teams or case management programs? If Yes, do you know the name of the agency or the worker you see?

I certify that the information provided regarding my homeless status is accurate and true.

Date: _____ **Signed:** _____ (Applicant)

Date: _____ **Witness:** _____

Public Health
Prevent. Promote. Protect.
Somerset County Health Department

Somerset County Health Department

8928 Sign Post Road, Suite 2, Westover, Maryland 21871
443.523.1700 • Fax 410.651.5680 • TDD 1-800-735-2258

Health Officer: Danielle Weber, MS, RN

BEHAVIORAL HEALTH ADMINISTRATION

Homeless I.D. Project FY 2018 APPLICATION/ INTAKE

Client Name: _____ D.O.B.* _____ Phone number: _____

*If Client is under age 18, is he/she under the care of an adult that is homeless/imminent risk of homelessness AND has a mental illness or co-occurring substance use disorder: ___Yes ___No

Client MA #, Gray Zone # or Medicare #: _____ Social Security #_____
Current Living Situation: __ Emergency Shelter __Transitional Housing __ Hospital __ Hotel/Motel __ Jail ___ Street, Park, Car, Bus Station, Bridge, etc. ___ Living with Relatives/Friends
Other: _____ Zip Code of Last residence: _____

Chronically Homeless (homelessness for a year or longer, or at least four episodes of homelessness in the last three years): ___Yes ___No
Housing Status: ___ Literally Homeless ___ Imminently Losing Housing
Veteran: ___Yes __No Gender: __ Male __ Female Race:_____ Ethnicity:_____

Disability: Mental Illness _____ Co-occurring_____
Person completing form: _____
Phone #_____
Agency & Address: _____
Documentation of Homelessness Received: ____ Yes ____ No
*SBHA will maintain file applications

Request: (Please check all that apply) ____ State Identification Card **OR** ____ Drivers License Renewal
_____Birth Certificate Which state: _____

FOR SBHA OFFICE USE ONLY: Provider Making the Request: _____
Requesting SBHA has verified that this is not a duplicate request for funding for this individual within the past 6 months: ___Yes ___ No *Note: There is a maximum of 2 IDs or Birth Certificates

FOR ID:

Check payee:_____
AMOUNT: _____
Phone #:_____
Payee address:_____
Tax ID #:_____
Account # if applicable: _____

For Birth Certificate:
Check payee:_____
AMOUNT: _____
Phone #:_____
Payee address:_____
Tax ID #:_____
Account # if applicable: _____ Total

Amount Approved by SBHA: _____ Amount Denied by SBHA _____
Approved SBHA Director or Designee _____ Date _____
WBHA Fiscal Officer _____ Date _____
Date Approved YTD _____

Revised 4/10/18 Date
ID paid: _____ Date Birth Certificate Paid: _____
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Health Officer Danielle Weber, MS, RN

Authorization for the Release of Confidential Information

Client Name: _____ DOB: _____
Patient ID# _____
Street Address: _____
Phone Number: _____
City, State, Zip: _____

I hereby authorize the Somerset County Health Department to: X Obtain X Release information to / from:

_____

_____

The following information from my records (specify extent or nature of the information to be obtained

or released):

_____
_____
_____
_____

The purpose of this authorized disclosure:

_____
_____
_____

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality 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 and 164. These regulations prohibit you from making further disclosure of it without the specific written consent to whom it pertains or as otherwise specified by regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules may restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

Conditions for Exchange of Authorized Information

Expiration: This authorization will expire one year from the date signed unless specified below by date or event less than one year:

Date: _____/_____/_____

Event or Condition:

_____

RIGHT TO REVOKE: I understand that I may revoke this authorization at any time by giving written notice, but not retroactive to release of information already made in good faith. USE SPACE BELOW ONLY IF CLIENT WITHDRAWS CONSENT.

Date Authorization Revoked by Client: _____/_____/_____

Signature of Client: _____

REDISCLOSURE: Any individual or agency receiving Somerset County Health Department client information is prohibited from making further disclosure of the medical record. This is prohibited as provided by the Annotated Code of Maryland 4-303(b)(5)(ii).

PHOTOSTAT/FACSIMILE: A photostat or facsimile of this authorization is considered as effective and valid as the original.

Date: _____

Signature of Client: _____