Dear Potential Participant,

Attached you will find an application for the Continuum of Care (CoC) HUD funded program to be completed by you and the agency that is referring you to our program. In addition to completing this application, you will also need to provide:

- Documentation of a serious mental health disability [verification of disability form must be completed by a professional who, under the scope of their license, is able to diagnose]
- Authorization to Obtain and Release information (must be signed by referral party and applicant)
- A letter from referring party confirming homelessness according to HUD definition
- HALS CoC Funded Housing Programs Self Sufficiency Matrix

HUD Definition of Homeless – A person is considered homeless only when he/she resides in one of the places described below:

- Has a primary nighttime residence that is a public or private place not meant for human habitation. (ex: car, park, abandoned building, bus or train station, airport, camp ground)
- Is living in a publicly or privately-operated shelter designated to provide temporary living arrangements (including congregate shelters, **transitional housing for the homeless**, and hotels and motels **paid for by charitable organizations or by federal, state, and local government programs); or**
- Is exiting an institution, where he/she has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

Any individual or family who:

- Is fleeing, or is attempting to flee, domestic violence;
- Has no other residence; and
- Lacks the resources or support networks to obtain other permanent housing.

If you are still interested in this program it is important that we have all of these items as soon as possible.

We are considering several individuals for one opening. Therefore, it is important that each step of the process be handled in a thorough and efficient manner. **Please note that only mailed application will be accepted.**

Please submit the application was completed to Teresa Fryer at teresa.fryer1@maryland.gov

Sincerely,

Shannon Frey

Continuum of Care (CoC) Lead

HALS COC FUNDED HOUSING PROGRAM INTAKE AND ASSESSMENT FORM

Date of Application: _________________

Client Demographics: please note that bolded questions are required to be answered:

First Name: _____________________________ MI: ___ **Last Name**: ______________________________ Suffix: ____

Name Data Quality (all clients) ◌ Full name ◌ Partial, street name or code name reported
◌ Client doesn't know ◌ Client refused

Social Security #: _____ - ____-_______ **Date of Birth**: ____/____/______

◌ Full SSN reported
◌ Approx. or partial SSN reported
◌ Client doesn't know
◌ Client refused

◌ Full date of birth reported
◌ Approx. or partial date of birth reported
◌ Client doesn't know
◌ Client refused

Veteran Status (all adults) ◌ No ◌ Yes ◌ Client doesn't know ◌ Client refused

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Primary & Secondary Race: (use P or S)

◌ American Indian/Alaska Native
◌ Asian
◌ Black/African American
◌ Native Hawaiian/Other Pacific Islander
◌ White
◌ Client doesn't know ◌ Client refused

Ethnicity (Check One):

◌ Hispanic/Latino
◌ Non-Hispanic/Non-Latino
◌ Client doesn't know
◌ Client refused

Gender (Check One):

◌ Male
◌ Female
◌ Transgender Male to Female
◌ Transgendered Female to Male
◌ Other ________________ ◌ Client doesn't know ◌ Client refused

Does the client have a disabling condition? (Check One): ◌ Yes ◌ No

Residence Prior to Project Entry (Head of household and adults) (Check One):

◌ Emergency Shelter & motel paid by others
◌ Foster Care Home or group home
◌ Hospital (non-psychiatric)
◌ Hotel/Motel (w/o emergency shelter voucher)
◌ Jail, prison or juvenile detention fac.
◌ Long Term care facility/nursing home
◌ Owned by Client, no ongoing subsidy
◌ Owned by Client, with ongoing subsidy
◌ Permanent housing (CoC project)
◌ Place not meant for Habitation
◌ Psychiatric hospital or other Psyc. Fac.
◌ Rental by client, no ongoing subsidy
◌ Rental by client w/ VASH subsidy
◌ Rental by client,w /GPD TIP subsidy
◌ Rental by client,w/other ongoing housing subsidy
◌ Residential /halfway house w/no homeless criteria
◌ Safe Haven
◌ Staying or living in family's room, apt. or house
◌ Staying or living in friend's room, apt. or house
◌ Substances abuse treatment facility or detox center
◌ Transitional homeless housing (incl. unacc. youth)
◌ Other (Describe) ___________________________
◌ Client doesn't know
◌ Client refused

Length of Stay in Previous Place (head of household and adults):

- One day or less
- Two day to one week
- More than one week, but less than 1 month
- One to three months, but less than 1 year
- One year or longer
- Client doesn't know
- Client Refused

Relationship to Head of Household (all clients)

- Self (head of household)
- Head of Household Child
- Head of Household's spouse or partner
- Head of Household's other relative member (other relation to head of household)
- Other – non-relation member

Client Location (Head of Household) HUD assigned CoC Code - select MD-513

NEW QUESTIONS BELOW THAT REPLACE PREVIOUS QUESTIONS ON CHRONIC HOMELESSNESS

Length of Time on Street, in an Emergency shelter (ES), or Safe Haven (SH) (head of household and adults)
Client entering from Streets, ES or SH: No Yes Client doesn't know Client refused
If yes, for Client Entering from Streets, ES or SH, Approx. date started: _______________

Regardless of where they stayed last night - # of times client has been on streets, ES or SH in past 3 years, including today: 0 1 2 3 4 5 6 7 8 9 10 11 12 More than 12 Client doesn't know Client refused
Total Number of Months homeless on the street, in ES or SH in the past 3 years? __________
Status Documented: No Yes

Total Monthly Income _________________
Income And Sources (head of households and adults): No Yes Client doesn't know Client refused
Income**:** Source of Income (Check All that Apply) and list amounts for each :

- Alimony/Spousal Support ____________
- Child support ______________________
- Earned income from job ______________
- General Assistance (GA) _______________
- Other specify source & amount ____
- Pension/Retirement from Former Job __________
- Private Disability Insurance ________________
- Retirement Income from Social Security _______
- SSDI___________________
- SSI ____________________
- TANF/TCA/TDAP______________
- Unemployment Insurance
- VA Non-Service Conn. Diab.Pension______
- VA Service Conn Disab. Penson__________
- Workers Compensation ________________

Non Cash benefits (head of household and adults): No Yes Client doesn't know Client refused
Non Cash Benefits (Check Yes on HMIS to all that apply. Answer No for benefits that have been terminated, even if they were received in the past). Amount of Non Cash Benefits $________________

- SNAP - Food Stamps
- Special Supplemental Nutritional Program for WIC
- TANF Child Care Services
- TANF Transportation Services
- Other TANF-Funded Services
- Section 8 Public Housing or Rental Assist.
- Temporary Rental Assistance, specify ____
- Other Source: ___________________________

Health Insurance (all clients) – Covered by health Insurance**:** No Yes Client doesn't know Client refused
Health Insurance Benefits: (Check Yes on HMIS to all that apply. Answer No for benefits that have been terminated, even if they were received in the past).

- Medicaid
- Medicare
- State Children's Health Insurance Programs
- VA Medical Services
- Employer-Provided Health Insurance
- Health Insurance obtained through COBRA
- Private Pay Health Insurance
- State Health Insurance for Adults

Disability Type (Check All that Apply):

( ) **Alcohol Abuse** ( ) No ( ) Yes ( ) Client doesn't know ( ) Client refused

If Yes, - Expected to be of long, continued, indefinite duration and substantially impairs ability to live independently

( ) No ( ) Yes ( ) Client doesn't know ( ) Client refused

If Yes – Documentation of Disability and severity on file ( ) No ( ) Yes

( ) **Both Alcohol & Drug Abuse** ( ) No ( ) Yes ( ) Client doesn't know ( ) Client refused

If Yes, - Expected to be of long, continued, indefinite duration and substantially impairs ability to live independently

( ) No ( ) Yes ( ) Client doesn't know ( ) Client refused

If Yes – Documentation of Disability and severity on file ( ) No ( ) Yes

( ) **Chronic Health Condition** ( ) No ( ) Yes ( ) Client doesn't know ( ) Client refused

If Yes, - Expected to be of long, continued, indefinite duration and substantially impairs ability to live independently

( ) No ( ) Yes ( ) Client doesn't know ( ) Client refused

If Yes – Currently receiving services/treatment for this condition: ( ) No ( ) Yes ( ) Client doesn't know ( ) Client refused

( ) **Developmental** ( ) No ( ) Yes ( ) Client doesn't know ( ) Client refused

If Yes, - Expected to be of long, continued, indefinite duration and substantially impairs ability to live independently

( ) No ( ) Yes ( ) Client doesn't know ( ) Client refused

If Yes – Documentation of Disability and severity on file ( ) No ( ) Yes

If Yes – Currently receiving services/treatment for this condition: ( ) No ( ) Yes ( ) Client doesn't know ( ) Client refused

( ) **Drug Abuse** ( ) No ( ) Yes ( ) Client doesn't know ( ) Client refused

If Yes, - Expected to be of long, continued, indefinite duration and substantially impairs ability to live independently

( ) No ( ) Yes ( ) Client doesn't know ( ) Client refused

If Yes – Documentation of Disability and severity on file ( ) No ( ) Yes

If Yes – Currently receiving services/treatment for this condition: ( ) No ( ) Yes ( ) Client doesn't know ( ) Client refused

( ) **HIV/AIDS** ( ) No ( ) Yes ( ) Client doesn't know ( ) Client refused

If Yes, - Expected to be of long, continued, indefinite duration and substantially impairs ability to live independently

( ) No ( ) Yes ( ) Client doesn't know ( ) Client refused

If Yes – Documentation of Disability and severity on file ( ) No ( ) Yes

If Yes – Currently receiving services/treatment for this condition: ( ) No ( ) Yes ( ) Client doesn't know ( ) Client refused

( ) **Mental Health Problem** ( ) No ( ) Yes ( ) Client doesn't know ( ) Client refused

If Yes, - Expected to be of long, continued, indefinite duration and substantially impairs ability to live independently

( ) No ( ) Yes ( ) Client doesn't know ( ) Client refused

If Yes – Documentation of Disability and severity on file ( ) No ( ) Yes

If Yes – Currently receiving services/treatment for this condition: ( ) No ( ) Yes ( ) Client doesn't know ( ) Client refused

( ) **Physical** ( ) No ( ) Yes ( ) Client doesn't know ( ) Client refused

If Yes, - Expected to be of long, continued, indefinite duration and substantially impairs ability to live independently

( ) No ( ) Yes ( ) Client doesn't know ( ) Client refused

If Yes – Documentation of Disability and severity on file ( ) No ( ) Yes

If Yes – Currently receiving services/treatment for this condition: ( ) No ( ) Yes ( ) Client doesn't know ( ) Client refused

Is Client Domestic Violence Victim/Survivor? (Head of household and adults) ( ) No ( ) Yes ( ) Client doesn't know ( ) Client refused

If yes, when did the experience occur?

( ) Within 3 months ( ) One year ago or more
( ) 3-6 months ( ) Client Doesn't Know
( ) 6 -12 months ( ) Client refused

If yes for domestic violence victim/survivor, are you currently fleeing?

( ) No ( ) Yes ( ) Client doesn't know ( ) Client refused ( ) Data not collected

Household Information (children & spouse/significant others)

1.Name:____________________________________ DOB:_________________ SS#:___________________
Gender: _______ Race:________ Relationship to Applicant:____
2.Name:____________________________________ DOB:_________________ SS#:___________________
Gender: _______ Race:________ Relationship to Applicant:____
3.Name:____________________________________ DOB:_________________ SS#:___________________
Gender:________ Race:_______ Relationship to Applicant:____
4.Name:____________________________________ DOB:_________________ SS#:___________________
Gender:________ Race:_______ Relationship to Applicant:____

For any adults living in the household, complete the following:
Income And Sources (head of households and adults) : ⚬ No ⚬ Yes ⚬ Client doesn't know ⚬ Client refused
Income**:** Source of Income (Check All that Apply) and list amounts for each:

⚬ Alimony/Spousal Support ____________ ⚬ SSDI___________________
⚬ Child support ______________________ ⚬ SSI ____________________
⚬ Earned income from job ______________ ⚬ TANF/TCA/TDAP______________
⚬ General Assistance (GA) _______________ ⚬ Unemployment Insurance
⚬ Other specify source & amount ____
⚬ Pension/Retirement from Former Job __________ ⚬ VA Non-Service Connected Diab. Pension__________
⚬ Private Disability Insurance ________________ ⚬ VA Service Connected Disab. Pension_____________
⚬ Retirement Income from Social Security ⚬ Workers Compensation _______________________

Non Cash benefits (head of household and adults): ⚬ No ⚬ Yes ⚬ Client doesn't know ⚬ Client refused
Non Cash Benefits (Check Yes on HMIS to all that apply. Answer No for benefits that have been terminated, even if they were received in the past). Amount of Non Cash Benefits $________________

⚬ SNAP - Food Stamps ⚬ Other TANF-Funded Services
⚬ Special Supplemental Nutritional Program for WIC ⚬ Section 8 Public Housing or Rental Assist.
⚬ TANF Child Care Services ⚬ Temporary Rental Assistance, specify _______
⚬ TANF Transportation Services ⚬ Other Source: ____________________________

Health Insurance (all clients) – Covered by health Insurance**:** ⚬ No ⚬ Yes ⚬ Client doesn't know ⚬ Client refused
Health Insurance Benefits: (Check Yes on HMIS to all that apply. Answer No for benefits that have been terminated, even if they were received in the past).

⚬ Medicaid ⚬ Employer-Provided Health Insurance
⚬ Medicare ⚬ Health Insurance obtained through COBRA
⚬ State Children's Health Insurance Programs ⚬ Private Pay Health Insurance
⚬ VA Medical Services ⚬ State Health Insurance for Adults

Disability ⚬ No ⚬ Yes ⚬ Client doesn't know ⚬ Client refused If adult, list disability type_______________________
Is Client Domestic Violence Victim/Survivor? (Head of household and adults) ⚬ No ⚬ Yes ⚬ Client doesn't know
⚬ Client refused If yes, are you currently fleeing? ⚬ No ⚬ Yes
If yes, when did the experience occur? ⚬ Within 3 months ⚬ 3-6 months ⚬ 6 -12 months ⚬ One year ago or more
⚬ Client refused ⚬ Client doesn't know

Mental Health:

Are you currently in treatment for mental health? ☐ Yes ☐ No
Treatment Start Date:______________________ Treatment End Date: __________________

If yes, list diagnosis. ____
Where are you currently being treated? ____

Have you ever been hospitalized for mental health issues? ☐ Yes ☐ No

If yes, please list location and date.

Location	*Treatment Start Date*	*Treatment End Date*

Are you currently on medication? ☐ Yes ☐ No Do you take them as prescribed? ☐ Yes ☐ No

Please list any current medications:	*Dosage*	*Frequency*
1. ______	______	______
2. ______	______	______
3. ______	______	______
4. ______	______	______
5. . ______	______	______

Medical History:

Current Medical Issues: ______

Name of Primary Care Provider: ______

Address:______ Phone: ______

Please list any current medications:	*Dosage*	*Frequency*
1. ______	______	______
2. ______	______	______
3. ______	______	______
4. ______	______	______
5. ______	______	______

Substance Abuse:

Do you have a substance abuse history? ☐ Yes ☐ No

If yes, list drug(s) of choice: ______

How long were you actively engaged in substance abuse? ______ Months ______ Years

Substance Abuse Treatment History: ***(List Dates & Locations)***
Treatment Start Date: Treatment End Date:

	Location	***Date***	***Location***	***Date***
A.A.				
N.A.				
Detox				
Inpatient				
Outpatient				

Has the applicant(s) ever been arrested for drug possession or distribution? ☐ Yes ☐ No
If yes, when? ____

Legal Information:
Are you on Probation? ☐ Yes ☐ No If yes, Probation Officer's Name:_________________________________

Are you on Parole? ☐ Yes ☐ No If yes, Parole Officer's Name: _________________________________

Current Warrant Issued? ☐ Yes ☐ No

Arrest Record:

Arrest Charge: ____Were you convicted? ☐ Yes ☐ No

Arrest Date:________________________ Did you serve time? ☐ Yes ☐ No
If yes, Prison or Jail? ☐ Jail ☐ Prison

Arrest Charge:____ Were you convicted? ☐ Yes ☐ No

Arrest Date:________________________ Did you serve time? ☐ Yes ☐ No
If yes, Prison or Jail? ☐ Jail ☐ Prison

Arrest Charge: :____Were you convicted? ☐ Yes ☐ No

Arrest Date:________________________ Did you serve time? ☐ Yes ☐ No
If yes, Prison or Jail? ☐ Jail ☐ Prison

Are you a Convicted Sex Offender? ☐ Yes ☐ No

Additional Comments to Support Application

____

____

____

Emergency Contact: (Relative or friend's name and number who we can contact in the case of any emergency.)

Name:__________________________ Phone: __________________________

Referral Source: Must be completed.

Referring Party: ____ Date: ______________________

Agency: ____

Type of Program: ____

Agency Address: ____

Agency Phone: ______________________________________ FAX: ____

Client's Statement:

All information that I have provided on this application is complete, truthful, and I have answered all questions to the best of my ability.

____ _____________________________

Client's Signature ***Date***

Referral Checklist: ***(Documentation below must be attached for completion of referral process.)***

☐ Documentation of Homelessness (Letter from referring agency stating homeless status of the client, or, if applicable, a letter from the Shelter.)

☐ Documentation of Disability (Letter from a doctor or other qualified professional that states this person has a disability.)

☐ Current Entitlements (Proof of any current entitlements being received, i.e. pay stubs, award letters, bank statements)

☐ Dually executed Consent to Release Information

☐ Self Sufficiency Matrix form

As the information contained in this application contains protected health information, please <u>mail</u> this form to:

Shannon Frey, CoC Lead
Homeless Alliance for the Lower Shore Continuum of Care
Somerset County Health Department
8928 Signpost Road
Westover, MD 21871

Phone: (443) 523-1815

HALS CoC Funded Housing Programs
Verification of Disability
Authorization to Release Information

Continuum of Care Applicant: ____

I hereby authorize the release of the information requested below to the HALS CoC Funded Housing Program for the purpose of determining my eligibility for the Continuum of Care Housing Program.

CoC Applicant's Signature ____________________________ Date ________________
___________________________, has applied for housing through the HALS CoC Funded Housing Program. The Department of Housing and Urban Development's regulations governing the Continuum of Care Program requires verification of disability as a condition of participation in the program.

This release authorizes you to provide information regarding the physical/mental condition on the above applicant as follows:

1. Does the applicant have a diagnosis of Schizophrenia (DSM V 295.90, 295.40, 295.70, 295.80), Major Affective disorders (DSM V 296.33 and 296.34), Bipolar disorders (DSM V 296.43, 296.44, 296.53, 296.54, 296.40, 296.7, and 296.89), Delusional disorder (DSM V 297.1), Psychotic disorder (DSM V 298.8 and 298.9), Schizotypal Personality disorder (DSM V 301.22), and Borderline Personality disorder (DSM V 301.83), Post Traumatic Stress disorder (DSM V 309.81)
Yes: No: _____ Diagnosis and DSM V Code: _______________________

2. Has the applicant had the disability for two years or longer?
Yes: ______ No: _______ Date of Disability: _________________________

3. Is the disability expected to be of long- continued and indefinite duration?
Yes: No: ___________

4. Would the nature of the applicant's disability be improved by more suitable housing conditions? Yes: _______ No: ________

Physician's Name: ____
Street Address: ____
City: State: ______________ Zip Code: ________________

___________________________________ ________________ __________________
Signature of Physician, Psychiatrist or Licensed Professional | Phone Number | Date Completed

Homeless Alliance for the Lower Shore (HALS) Continuum of Care (CoC) Funded Projects

AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION

Homeless Clients' Personal Identifying Information:

Name: Birth Date: SSN:

Phone: Sex: Race:

Present Address:

Former Name (if applicable): ____

I authorize the following to obtain my personal information:

Name	Address	Phone Number
HALS CoC Funded Permanent Supportive Housing Programs (Tri-County Alliance for the Homeless PSH Programs and Wicomico, Somerset & Worcester County Shelter Plus Care Programs), City of Salisbury Housing Program, SSVF		

____

I request and authorize that the following personal information be provided:

☐**Mental Health** ☐**Substance Related Abuse Treatment Information**

☐**Communicable Disease information** ☐**Disability Information** ☐**X-Ray Reports**

☐**Discharge Summary** ☐**Shelter Stay** ☐**Hospitalizations**

☐**Other Health Care Information (Specify) Continuity of Care**

☐ **Other Personal (e.g. income, financial) information (Specify): program issues and emergency contact**

____

Except for the following which expressly may NOT be disclosed (If none, write "NONE"):

If the information which a program has includes records or information from another entity, I ☒ DO or ☐ DO NOT wish to have that information released under this authorization. No service will be withheld if you do not authorize release of information attained by a program from another agency.

Conditions for Exchange of Authorized Information

Expiration: This authorization will expire two years from date below unless revoked in writing: DATE ☐☐/☐☐/☐☐☐☐

RIGHT TO REVOKE: I understand that I may revoke this authorization at any time by giving written notice in good faith. **(CRIMINAL JUSTICE SYSTEM REFERRALS – RULES:** "Revocation of consent" An individual whose release from confinement, probation, or parole is conditioned upon his participation in a treatment program may not revoke a consent given by him in accordance with paragraph (a) of this section until there has been a formal and effective termination or revocation of such release from confinement, probation or parole." FEDERAL REGISTER, VOL 40, No 127, TUESDAY, July 1, 1975.)

USE SPACE BELOW ONLY IF CLIENT REVOKES CONSENT

☐☐/☐☐/☐☐☐☐ ____________________________________

Date Consent Revoked by Client Signature of Applicant

CONFIDENTIALITY: If the request for information concerns a person's treatment of alcohol or drug abuse, the confidentiality of this information is protected by federal law: (42CFR Part 2) which prohibits any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A General Authorization for the release of medical or other information is NOT sufficient for this purpose.

REDISCLOSURE: Any individual or agency receiving Homeless Alliance for the Lower Shore (HALS) CoC Funded Program applicant information is prohibited from making further disclosure of the medical record based on this authorization. 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.

____ ______________________

Signature of Applicant Date

____ ______________________

Signature of Guardian or Legal Representative Date

Relationship to Client: ________________________

(Attach copy of document granting legal authority)

____ ______________________

Signature of Witness Date

____ ______________________

Signature of Counselor (if applicable) Date

HALS CONTINUUM OF CARE HOUSING PROGRAM

Documentation of Homelessness

Please use the following space to have the applicant describe his or her current living situation. If currently in the detention center, please have them describe their living situation prior to incarceration. Their living situation prior to incarceration is required. Please use an additional sheet of paper as necessary.

Also, the referring agency must attach verification of current, or a history within the past 3 years or more of, applicant's homelessness from either the referring agency and/or a third party source if practical such as from an emergency shelter, emergency feeding program, DSS, HMIS, etc.

____

____

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____

** Verification of homelessness documentation must also be provided, using letterhead.

Date: ______________ Signed: ____

Date: ______________ Witness: ____

HALS CoC Funded Housing Programs Self Sufficiency Matrix

Name: ________________________ **Referring Agency: _____________________________**

Shelter/Housing ○ Not Applicable
○ 1. Homeless or threatened with eviction.
○ 2. In transitional, temporary, or substandard housing; and/or current rent/mortgage payment is unaffordable (over 30% of income).
○ 3. In stable housing that is safe but only marginally adequate,
○ 4. Household is in safe, adequate, subsidized housing.
○ 5. Household is in safe, adequate, unsubsidized housing.

Employment ○ Not Applicable
○ 1. No job.
○ 2. Temporary, part-time or seasonal; inadequate pay, no benefits.
○ 3. Employed full time; inadequate pay; few or no benefits.
○ 4. Employed full time with adequate pay and benefits.
○ 5. Maintains permanent employment with adequate income and benefits.

Income ○ Not Applicable
○ 1. No income.
○ 2. Inadequate income and/or spontaneous or inappropriate spending.
○ 3. Can meet basic needs with subsidy; appropriate spending.
○ 4. Can meet basic needs and manage debt without assistance
○ 5. Income is sufficient, well managed; has discretionary income and is able to save.

Food and Nutrition ○ Not Applicable
○ 1. No food or means to prepare it. Relies to a significant degree on other sources of free or low-cost food.
○ 2. Household is on food stamps.
○ 3. Can meet basic food needs, but requires occasional assistance.
○ 4. Can meet basic needs without assistance.
○ 5. Can choose to purchase any food household desires.

Child Care ○ Not Applicable
○ 1. Needs childcare, but none is available/ accessible and/or child is not eligible.
○ 2. Childcare is unreliable or unaffordable, inadequate supervision is a problem for childcare that is available.
○ 3. Affordable subsidized childcare is available, but limited.
○ 4. Reliable, affordable childcare is available, no need for subsidies.
○ 5. Able to select quality childcare of choice.

Children's Education ○ Not Applicable
○ 1. One or more school-aged children not enrolled in school.
○ 2. One or more school-aged children enrolled in school, but not attending classes.
○ 3. Enrolled in school, but one or more children only occasionally attending.
○ 4. Enrolled in school and attending classes most of the time.
○ 5. All school-aged children enrolled and attending on a regular basis.

Adult Education ○ Not Applicable
○ 1. Literacy problems and/or no high school diploma/GED are serious barriers to employment.
○ 2. Enrolled in literacy and/or GED program and/or has sufficient command of English to where language is not a barrier to employment.
○ 3. Has high school diploma/GED.
○ 4. Needs additional education/training to improve employment situation and/or to resolve literacy problems to where they are able to function effectively in society.
○ 5. Has completed education/training needed to become employable. No literacy problems.

Health Care Coverage ○ Not Applicable
○ 1. No medical coverage with immediate need.
○ 2. No medical coverage and great difficulty accessing medical care when needed. Some household members may be in poor health.
○ 3. Some members (e.g. Children) on Public Health Plan.
○ 4. All members can get medical care when needed, but may strain budget.
○ 5. All members are covered by affordable, adequate health insurance.

Life Skills ○ Not Applicable
○ 1. Unable to meet basic needs such as hygiene, food, activities of daily living.,
○ 2. Can meet a few but not all needs of daily living without assistance.
○ 3. Can meet most but not all daily living needs without assistance.
○ 4. Able to meet all basic needs of daily living without assistance.
○ 5. Able to provide beyond basic needs of daily living for self and family.

Family Relations ○ Not Applicable
○ 1. Lack of necessary support from family or friends; abuse (DV, child) is present or there is child neglect.
○, 2. Family/friends may be supportive, but lack ability or resources to help; family members do not relate well with one another; potential for abuse or neglect.
○ 3. Some support from family/friends; family members acknowledge and seek to change negative behaviors; are learning to communicate and support.
○ 4. Strong support from family or friends. Household members support each other's efforts. ○ 5. Has healthy/expanding support network; household is stable and communication is consistently open.

Mobility ◌ Not Applicable

◌ 1. No access to transportation, public or private; may have car that is inoperable.,
◌ 2. Transportation is available, but unreliable, unpredictable, unaffordable; may have car but no insurance, license, etc.
◌ 3. Transportation is available and reliable, but limited and/or inconvenient; drivers are licensed and minimally insured.
◌ 4. Transportation is generally accessible to meet basic travel needs.
◌ 5. Transportation is readily available and affordable, car is adequately insured.

Community Involvement ◌ Not Applicable

◌ 1. Not applicable due to crisis situation; in "survival" mode.
◌ 2. Socially isolated and/or no social skills and/or lacks motivation to become involved.
◌ 3. Lacks knowledge of ways to become involved.
◌ 4. Some community involvement (advisory group, support group), but has barriers such as transportation, childcare issues.
◌ 5. Actively involved in community.

Parenting Skills ◌ Not Applicable

◌ 1. There are safety concerns regarding parenting skills.
◌ 2. Parenting skills are minimal.
◌ 3. Parenting skills are apparent but not adequate.
◌ 4. Parenting skills are adequate.
◌ 5. Parenting skills are well developed.

Legal ◌ Not Applicable

◌ 1. Current outstanding tickets or warrants.
◌ 2. Current charges/trial pending, non-compliance with probation/parole.
◌ 3. Fully compliant with probation/parole terms.
◌ 4. Has successfully completed probation/parole within past 12 months, no new charges filed.
◌ 5. No active criminal justice involvement in more than 12 months and/or no felony criminal history.

Mental Health ◌ Not Applicable

◌ 1. Danger to self or others; recurring suicidal ideation; experiencing severe difficulty in day-to-day life due to psychological problems.,
◌ 2. Recurrent mental health symptoms that may affect behavior, but not a danger to self/others; persistent problems with functioning due to mental health symptoms.,
◌ 3. Mild symptoms may be present but are transient; only moderate difficulty in functioning due to mental health problems.
◌, 4. Minimal symptoms that are expectable responses to life stressors; only slight impairment in functioning.
◌ 5.Symptoms are absent or rare; good or superior functioning in wide range of activities; no more than everyday problems or concerns.

Substance Abuse ◯ Not Applicable

◯ 1. Meets criteria for severe abuse/dependence; resulting problems so severe that institutional living or hospitalization may be necessary.

◯ 2. Meets criteria for dependence; preoccupation with use and/or obtaining drugs/alcohol; withdrawal or withdrawal avoidance behaviors evident; use results in avoidance or neglect of essential life activities.

◯ 3. Use within last 6 months; evidence of persistent or recurrent social, occupational, emotional or physical problems related to use (such as disruptive behavior or housing problems); problems have persisted for at least one month.

◯ 4. Client has use during last 6 months, but no evidence of persistent or recurrent social, occupational, emotional, or physical problems related to use; no evidence of recurrent dangerous use.

◯ 5. No drug use/alcohol abuse in last 6 months.

Safety ◯ Not Applicable

◯ 1. Home or residence is not safe; immediate level of lethality is extremely high; possible CPS involvement.

◯ 2. Safety is threatened/temporary protection is available, level of lethality is high.

◯ 3. Current level of safety is minimally adequate; ongoing safety planning is essential.

◯ 4. Environment is safe, however, future of such is uncertain; safety planning is important.

◯ 5. Environment is apparently safe and stable.

Credit ◯ Not Applicable

◯ 1. Bankruptcies/Foreclosures/Evictions

◯ 2. Outstanding Judgements/Garnishments

◯ 3. Needs a Credit Repair Plan

◯ 4. Moderate Budgeting Skills

◯ 5. Manageable Budget and Ability to Save

Disabilities ◯ Not Applicable

◯ 1. In crisis - acute or chronic symptoms affecting housing, employment, social interactions, etc. always.

◯ 2. Vulnerable- sometimes has acute or chronic symptoms affecting housing, employment, social interactions, etc.

◯ 3. Safe - rarely has acute or chronic symptoms affecting housing, employment, social interactions, etc.,

◯ 4. Building Capacity - asymptomatic - condition may be controlled by services and/or medication.

◯ 5. Thriving - No identified disability.

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

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: ______________________

Date: ______________________ Signature of Parent or Guardian: ______________________

Date: ______________________ Witness to Signature: ______________________