Missouri Department of Mental Health
Shelter Plus Care Program
Application Information

GENERAL INFORMATION

- For help with this application, contact the DMH Housing Unit at housing@dmh.mo.gov or at **573-526-3125**.
- For application processing and wait list information, call **573-751-9206**.
- FAX completed applications to the DMH Housing Unit at **573-526-7797**.
- Download this form as a PDF file at http://dmh.mo.gov/housing/ShelterPlusCare.htm#ApplyingforSPCAssistance.

DETAILED PROGRAM INFORMATION

- For an overview of DMH's Shelter Plus Care programs, visit: http://dmh.mo.gov/housing/ShelterPlusCare.htm.
- For complete information, see the DMH *Housing Manual* at http://dmh.mo.gov/housing/ShelterPlusCare.htm#DMHHousingManual.

NOTICE OF CLIENT RIGHTS

The ***Notice of Client Rights***, located at the end of this application, applies only to Applicants applying for assistance in **non-metropolitan counties,** in the **Springfield** area (which includes Greene, Christian and Webster counties), and the **Joplin** area (Jasper and Newton counties). For those areas, both the Applicant and the Case Manager must sign this form. **Skip this form if** you are applying for assistance in the metro areas of St. Louis City, St. Louis County, Jackson County, or St. Joseph.

REQUIRED DOCUMENTS

Applicants and adults in the Applicant's household must have the following in order to receive assistance: a state-issued picture ID; proof of Social Security number; copy of birth certificate; and proof of income, if any. Minors must have a copy of their birth certificate and proof of Social Security number, if applicable. If any of these items are missing, you should begin to work on obtaining them immediately.

An incomplete application slows review time and delays assistance for your client.
For the fastest possible determination of eligibility:

- ***Be sure you have the most current version of the application before you begin.*** You can check for the latest version by visiting http://dmh.mo.gov/housing/ShelterPlusCare.htm#ApplyingforSPCAssistance.
- ***Read the instructions found throughout the application*** to be sure you are filling it out correctly. If you have a question or need help, it's better to contact DMH Housing first than to submit an application you're not sure is complete and correct.
- ***Know what your client's housing status is.*** The only persons who may be served by Shelter Plus Care are those who come from the streets, emergency shelters, Safe Havens, institutions, or transitional housing. If your client has not lived in one of these settings within the past 30 days, he or she is not eligible for Shelter Plus Care assistance (see Attachment C for further detail).
- ***Include documentation*** of the Applicant's homelessness (see Attachment C). ***This is required.*** No Applicant can be found eligible for assistance without this documentation.
- ***Fill out the Service Plan in detail*** (see Attachment B) if you are not submitting a copy of your agency's Service Plan or Treatment Plan. Include the names of all practitioners the applicant sees, how often he or she sees them, and all details relevant to the categories listed—even if they describe future plans of action rather than issues currently being worked on. Do not leave any sections blank unless they do not apply to the Applicant.
- ***Sign the form in all areas where required***. Both the Case Manager and the applicant must sign in multiple locations.
- ***Make sure the application is legible*** and will remain so after you fax it to us. **Use only dark-colored ink.**
- ***Save time and paper—don't fill out and fax us pages we don't need.*** Don't fax us these instructions or the Application Checklist. If you are a single individual applying, don't fill out or fax us the 'Other Adults' and 'Minors' pages in Sections 5 and 6. If you don't need to sign the ***Notice of Client Rights***, don't fax that page back to us—remove it from the application.

Missouri Department of Mental Health
Shelter Plus Care Program
Application Checklist

The purpose of this checklist is to help you complete an Application for Shelter Plus Care.
Please do not send this page with the application.

☐ Sections 1-13 of the Application are filled out completely. Skip Section 5 if there are no other adults in the household; skip Section 6 if there are no minors in the household.

☐ The Applicant has signed the Applicant Certifications (Section 12).

☐ Attachment A (Disability Verification) is completely filled out with ONE option checked and is signed by a person with the proper credentials.

☐ Attachment B (Service Plan) is completely filled out, if you choose not to submit a copy of your agency's original Treatment or Service Plan.

☐ Attachment C (Homelessness Verification) is completely filled out with ONE option checked and is signed by the Case Manager.

☐ Complete documentation of the applicant's homelessness is attached (*see Attachment C* for required documentation).

☐ Attachment D (Chronic Homelessness Verification) is filled out if the Applicant fits the definition of "chronic homelessness." You can omit this form from the application if the Applicant does not fit the definition of "chronic homelessness."

☐ Documentation of the Applicant's chronic homelessness is attached, if needed (*see Attachment D* for the definition of chronic homelessness).

☐ Attachment E—Consent for Disclosure of Applicant's Protected Health Information is completely filled out and signed by the Applicant and a witness.

☐ The *Notice of Client Rights* is signed by the Applicant and the Case Manager, if needed. Only Applicants in non-metropolitan counties, Joplin, and the Springfield areas need to sign this form (see instructions on previous page).

☐ A copy of the Applicant's documentation of legal non-citizen status is attached, if applicable.

☐ The Applicant has, or is working on obtaining all required forms of identification and proof of income, if any, for all members of the proposed household.

Application for Shelter Plus Care

DMH Housing Unit | 1706 E. Elm Street | Jefferson City MO 65101
573-751-9206 | FAX 573-526-7797 | housing@dmh.mo.gov | http://dmh.mo.gov/housing/

➢SECTION 1. APPLICANT INFORMATION

Applicant Name:

First: ______________________ **Middle** ___________________________ **Last:** _______________________________

Social Security Number: _________ - _________ - _________ **Date of Birth:** _________ / _________ / _________

➢SECTION 2. CASE MANAGER CONTACT

Case Manager Name:

____

Agency: ____ **City:** __________________________________

Office Phone: (________) ___________________________ **Fax:** (________) _______________________________

Alternate Phone: (________) _____________________________

Email Address: _____________________________________ @ ____

➢SECTION 3. EMERGENCY CONTACT

Name: ____ **Relationship:** ___________________________

Address: ____ **Apt. #:** ______________

City: ____ **State:** ________ **Zip:** ___________

Phone: (________) _________________________ **Other Contact Info:** ___________________________________

DMH Housing Use Only				
Jackson County ☐	St. Louis City ☐	Bootheel ☐	Jefferson-Franklin ☐	Rolla ☐
Jackson Co. Chronic ☐	St. Louis County ☐	Branson ☐	Kirksville ☐	Springfield ☐
Joplin ☐	St. Louis City Chronic ☐	Central Missouri ☐	Nevada ☐	West Central ☐
Joplin Chronic ☐	St. Louis Co. Chronic ☐	Farmington ☐	Outer KC Metro ☐	West Plains ☐
St. Joseph ☐		Hannibal ☐	Poplar Bluff ☐	

Forms:	Applicant ☐	Other Adults ☐	Minors ☐	Disability ☐	Service Plan ☐	Homeless ☐	Chronic ☐	HIPAA ☐
Eligibility:	Disabled ☐	Homeless ☐	Income ☐					
Disability:	SMI ☐	CSA ☐	SMI/CSA ☐	PWA ☐	PWOD ☐			
Chronic:	Yes ☐	No ☐						
HMIS:	Notice of Client Rights (BOS and Springfield only) ☐							
Referral:	*Processing Center*	*Grant Code*	MO *HUD Grant Number*	*Date Referred*				

➢SECTION 4. APPLICANT'S INFORMATION

Applicant Name:

____

☐ **U.S citizen** ☐ **Eligible non-citizen**

Applicant's primary language: ____________________

If the primary language is not English, can the Applicant speak limited English? ☐ Yes ☐ No

Country of origin if not U.S.: ____________________

Race:
☐ American Indian/Alaska Native
☐ Asian
☐ Black/African-American
☐ Native Hawaiian/Other Pacific Islander
☐ White
☐ Multi-Racial (*specify by checking additional boxes above*)

Ethnicity:
☐ Hispanic
☐ Non-Hispanic

Gender:
☐ Male
☐ Female
☐ Transgender, male to female
☐ Transgender, female to male

Marital Status:
☐ single
☐ married
☐ separated
☐ widowed
☐ divorced
☐ same-sex couple

Are you pregnant? ☐ Yes ☐ No No. of months: _____
Delivery date: _________ / _________ / _________

Temporary Address/Location:
Where do you currently live? Provide at least a city and zip code.

Street address ____________________ Apt. ________

City ____________________

Zip Code ____________________

Telephone ____________________

Last Permanent Address/Location:
Where did you last live for at least 90 days where you paid rent or had a mortgage? Provide at least a city and zip code.

Street address ____________________ Apt. ________

City ____________________

Zip Code ____________________

Where did you spend the night before filling out this application?
☐ Emergency shelter (includes a motel or hotel room paid for by an emergency shelter voucher; and a respite bed)
☐ Transitional housing program
☐ A place not meant for human habitation (car, park, etc.)
☐ Jail, prison or juvenile detention center
☐ Substance abuse treatment facility/detox center
☐ Safe Haven
☐ Hospital (non-psychiatric)
☐ Psychiatric hospital or similar facility
☐ Other

How long did you stay in the above situation?
☐ One week or less
☐ More than one week but less than one month
☐ 1-3 months
☐ 4-6 months
☐ 7-12 months
☐ 1-2 years
☐ 2-4 years
☐ Four or more years
☐ Don't know

Do you have health insurance? Check all that apply.
☐ Medicare
☐ Medicaid (aka Missouri HealthNet)
☐ VA Medical
☐ private insurance
☐ medication assistance
☐ no insurance

What is the primary reason for your homelessness? Check one.

☐ stranded/transient	☐ relocating
☐ physical abuse	☐ loss of income
☐ insufficient income	☐ fire
☐ kicked out of house	☐ housing condemned
☐ substandard housing	☐ no power
☐ no water	☐ eviction
☐ building sold	☐ spousal desertion
☐ mental health issues	☐ Section 8 violation
☐ drug/alcohol issues	☐ never lived independently
☐ high-risk neighborhood	☐ 2005 disaster victim (Katrina, etc.)
☐ marriage/separation	☐ victim of crime
☐ displaced	☐ institution discharge
☐ shelter termination	☐ employment situation
☐ domestic violence	☐ disaster
☐ mental/emotional abuse	
☐ release from incarceration	

Have you ever been a victim of domestic violence?
☐ Yes ☐ No ☐ Don't Know ☐ Refuse to Answer

If yes, how long in the past did this occur?
☐ Within past three months
☐ 3-6 months ago
☐ 6-12 months ago
☐ More than one year ago
☐ Don't Know
☐ Refused to Answer

Are you currently in school and/or working on any degree or certificate? ☐ Yes ☐ No

Have you received vocational training or been in a trade apprenticeship? ☐ Yes ☐ No

➢SECTION 4—Continued

What is the highest grade you've completed?
☐ no school completed
☐ nursery school to 4th grade
☐ 5th grade to 6th grade
☐ 7th grade to 8th grade
☐ 9th grade
☐ 10th grade
☐ 11th grade
☐ 12th grade, no diploma
☐ high school diploma
☐ GED
☐ Associates degree
☐ some college, no degree
☐ Bachelors degree
☐ Masters degree
☐ doctorate
☐ other graduate or post-secondary education
☐ Certificate of advanced training or skilled artisan
☐ Don't Know

Are you employed? ☐ Yes ☐ No

If yes, what type of employment is it?
☐ Permanent ☐ Temporary ☐ Seasonal

How many hours did you work last week? __________

If not employed, are you looking for work?
☐ Yes ☐ No

What is your general physical health status?
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Do you have a mental illness?
☐ Yes ☐ No
If yes, is the mental illness a disabling condition?*
☐ Yes ☐ No
[*If Attachment A, "Disability Verification," indicates a mental illness or a dual diagnosis, you must answer "yes" to the above.*]
Are you receiving services or treatment for the mental illness? ☐ Yes ☐ No

Do you have a substance abuse disorder?
☐ yes, alcohol abuse ☐ yes, drug abuse
☐ yes, both alcohol and drug abuse
☐ No
If yes, is the substance abuse disorder a disabling condition?
☐ Yes ☐ No
[*If Attachment A, "Disability Verification," indicates a substance abuse disorder, you must answer "yes" to the above.*]
Are you receiving services or treatment for the substance abuse disorder?
☐ Yes ☐ No

Do you have HIV or AIDS?
☐ Yes ☐ No
If yes, is this a disabling condition?
☐ Yes ☐ No
[*If Attachment A, "Disability Verification," indicates a diagnosis of HIV or AIDS, you must answer "yes" to the above.*]
If yes, are you receiving services or treatment for HIV or AIDS?
☐ Yes ☐ No

Do you have a developmental disability?**
☐ Yes ☐ No
If yes, is the developmental disability a disabling condition?
☐ Yes ☐ No
[*If Attachment A, "Disability Verification," indicates a developmental disability diagnosis, you must answer "yes" to the above.*]
If yes, are you receiving services or treatment for the developmental disability?
☐ Yes ☐ No

Do you have a chronic health condition*?**
☐ Yes ☐ No ☐ Don't Know
If yes, please specify what the condition is:

____

If yes, is the chronic health condition a disabling condition?
☐ Yes ☐ No
If yes, are you receiving services or treatment for the chronic health condition?
☐ Yes ☐ No

Do you have a physical disability?
☐ Yes ☐ No ☐ Don't Know
If yes, please specify what the disability is:

____

If yes, is the physical disability a disabling condition?
☐ Yes ☐ No
Are you receiving services or treatment for the physical disability?
☐ Yes ☐ No

* **"Disabling condition"** means a condition that is expected to be of long-continued and indefinite duration and is expected to substantially impede a person's ability to live independently.

** **"Developmental disability"** includes mental retardation, cerebral palsy, head injuries, autism, epilepsy, and some learning disabilities. Such conditions must have occurred before age 22 and be expected to continue indefinitely.

*** **Chronic health conditions** include, but are not limited to, heart disease, including coronary heart disease, angina, heart attack and any other kind of heart condition or disease; severe asthma; diabetes; arthritis-related conditions including arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia; adult-onset cognitive impairments including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive-related conditions; severe headache/migraine; cancer; chronic bronchitis; liver condition; stroke; or emphysema.

➢ SECTION 5. INFORMATION ABOUT OTHER ADULTS IN HOUSEHOLD (ANYONE 18+ YEARS OLD)

Use additional copies of Section 5 if the Applicant's household has more than one adult aside from the Applicant. Omit this section if there are no other adults in the household.

Other Adult's Name:

____

Social Security Number: _________ - _________ - _________

Date of Birth: _________ / _________ / _________

Race:
☐ American Indian/Alaska Native
☐ Asian
☐ Black/African-American
☐ Native Hawaiian/Other Pacific Islander
☐ White
☐ Multi-Racial (*specify by checking additional boxes above*)

Ethnicity:
☐ Hispanic
☐ Non-Hispanic

Gender:
☐ Male
☐ Female
☐ Transgender, male to female
☐ Transgender, female to male

What is this adult's relationship to the Applicant?

☐ spouse	☐ significant other/partner	
☐ parent	☐ step-parent	☐ grandparent
☐ aunt	☐ uncle	
☐ brother	☐ sister	
☐ son	☐ daughter	☐ step-child
☐ niece	☐ nephew	
☐ roommate	☐ other	

Is this adult pregnant? ☐ Yes ☐ No No. of months: _____

Temporary Address/Location:
☐ Check here if this adult currently lives at the same location as the Applicant; if the location is different, fill it in below. Please provide at least a city and zip code.

Street address ____________________ Apt. ________

City ______________________________

Zip Code ______________________________

Telephone ______________________________

Last Permanent Address/Location:
☐ Check here if this adult's last permanent address was the same as the Applicant's; if it was different, fill it in below. Please provide at least a city and zip code.

Street address ____________________ Apt. ________

City ______________________________

Zip Code ______________________________

Where did this adult spend the night before this application was filled out?
☐ Emergency shelter (includes a motel or hotel room paid for by an emergency shelter voucher; and a respite bed)
☐ Transitional housing program
☐ A place not meant for human habitation (car, park, etc.)
☐ Jail, prison or juvenile detention center
☐ Substance abuse treatment facility/detox center
☐ Safe Haven
☐ Hospital (non-psychiatric)
☐ Psychiatric hospital or similar facility
☐ Other

How long did this adult stay in the above situation?
☐ One week or less
☐ More than one week but less than one month
☐ 1-3 months
☐ 4-6 months
☐ 7-12 months
☐ 1-2 years
☐ 2-4 years
☐ Four or more years
☐ Don't know

Has this adult ever been a victim of domestic violence?
☐ Yes ☐ No ☐ Don't Know ☐ Refuse to Answer

If yes, how long in the past did this occur?
☐ Within past three months
☐ 3-6 months ago
☐ 6-12 months ago
☐ More than one year ago
☐ Don't Know
☐ Refused to Answer

Is this adult currently in school and/or working on any degree or certificate? ☐ Yes ☐ No

Has this adult received vocational training or been in a trade apprenticeship? ☐ Yes ☐ No

What is the highest grade completed by this adult?
☐ no school completed
☐ nursery school to 4th grade
☐ 5th grade to 6th grade
☐ 7th grade to 8th grade
☐ 9th grade
☐ 10th grade
☐ 11th grade
☐ 12th grade, no diploma
☐ high school diploma
☐ GED
☐ Associates degree
☐ some college, no degree
☐ Bachelors degree
☐ Masters degree
☐ doctorate
☐ other graduate or post-secondary education
☐ Certificate of advanced training or skilled artisan
☐ Don't Know

➢SECTION 5—Continued

Other Adult's Name:

____

Is this adult employed? ☐ Yes ☐ No

If yes, what type of employment is it?
☐ Permanent ☐ Temporary ☐ Seasonal

How many hours did this adult work last week? __________

If not employed, is this adult looking for work?
☐ Yes ☐ No

What is this adult's general physical health status?
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Does this adult have a mental illness?
☐ Yes ☐ No
If yes, is the mental illness a disabling condition?*
☐ Yes ☐ No
If yes, is this adult receiving services or treatment for the mental illness? ☐ Yes ☐ No

Does this adult have a substance abuse disorder?
☐ yes, alcohol abuse ☐ yes, drug abuse
☐ yes, both alcohol and drug abuse
☐ No
If yes, is the substance abuse disorder a disabling condition?
☐ Yes ☐ No
If yes, is this adult receiving services or treatment for the substance abuse disorder?
☐ Yes ☐ No

Does this adult have HIV or AIDS?
☐ Yes ☐ No
If yes, is this a disabling condition?
☐ Yes ☐ No
If yes, is this adult receiving services or treatment for HIV or AIDS?
☐ Yes ☐ No

Does this adult have a developmental disability?**
☐ Yes ☐ No
If yes, is the developmental disability a disabling condition?
☐ Yes ☐ No
If yes, is this adult receiving services or treatment for the developmental disability?
☐ Yes ☐ No

Does this adult have a chronic health condition*?**
☐ Yes ☐ No ☐ Don't Know
If yes, please specify what the condition is:

____

If yes, is the chronic health condition a disabling condition?
☐ Yes ☐ No
If yes, is this adult receiving services or treatment for the chronic health condition?
☐ Yes ☐ No

Does this adult have a physical disability?
☐ Yes ☐ No ☐ Don't Know
If yes, please specify what the disability is:

____

If yes, is the physical disability a disabling condition?
☐ Yes ☐ No
If yes, is this adult receiving services or treatment for the physical disability?
☐ Yes ☐ No

* **"Disabling condition"** means a condition that is expected to be of long-continued and indefinite duration and is expected to substantially impede a person's ability to live independently.

** **"Developmental disability"** includes mental retardation, cerebral palsy, head injuries, autism, epilepsy, and certain learning disabilities. Such conditions must have occurred before age 22 and be expected to continue indefinitely.

*** **Chronic health conditions** include, but are not limited to, heart disease, including coronary heart disease, angina, heart attack and any other kind of heart condition or disease; severe asthma; diabetes; arthritis-related conditions including arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia; adult-onset cognitive impairments including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive-related conditions; severe headache/migraine; cancer; chronic bronchitis; liver condition; stroke; or emphysema.

➢SECTION 6. INFORMATION ABOUT MINORS IN HOUSEHOLD (ANYONE 17 YEARS OLD OR YOUNGER)

Fill out one Section 6 per minor that will live in the Applicant's household. Omit this section if there are no minors in the household.

Minor's Name:

____

Social Security Number: _________ - _________ - _________

Date of Birth: _________ / _________ / _________

Does the Applicant have legal custody of this minor?
☐ Yes ☐ No

Race:
☐ American Indian/Alaska Native
☐ Asian
☐ Black/African-American
☐ Native Hawaiian/Other Pacific Islander
☐ White
☐ Multi-Racial (*specify by checking additional boxes above*)

Ethnicity:
☐ Hispanic
☐ Non-Hispanic

Gender:
☐ Male
☐ Female
☐ Transgender, male to female
☐ Transgender, female to male

What is this minor's relationship to the Applicant?
☐ brother ☐ sister
☐ son ☐ daughter ☐ step-child
☐ niece ☐ nephew ☐ grandchild
☐ other

Is this minor pregnant? ☐ Yes ☐ No No. of months: _____

Temporary Address/Location:
☐ Check here if this minor currently lives at the same location as the Applicant; if the location is different, fill it in below. Provide at least a city and zip code.

Street address ____________________________ Apt. ________

City ____

Zip Code ____

Telephone ____

Last Permanent Address/Location:
☐ Check here if this minor's last permanent address was the same as the Applicant's; if it was different, fill it in below. Provide at least a city and zip code.

Street address ____________________________ Apt. ________

City ____

Zip Code ____

Where did this minor spend the night before this application was filled out?
☐ Emergency shelter (includes a motel or hotel room paid for by an emergency shelter voucher; and a respite bed)
☐ Transitional housing program
☐ A place not meant for human habitation (car, park, etc.)
☐ Jail, prison or juvenile detention center
☐ Substance abuse treatment facility/detox center
☐ Safe Haven
☐ Hospital (non-psychiatric)
☐ Psychiatric hospital or similar facility
☐ Other

How long did this minor stay in the above situation?
☐ One week or less
☐ More than one week but less than one month
☐ 1-3 months
☐ 4-6 months
☐ 7-12 months
☐ 1-2 years
☐ 2-4 years
☐ Four or more years
☐ Don't know

Is this minor currently enrolled in school?
☐ Yes ☐ No ☐ the minor is not old enough

If yes, please give the name of the school:

____

If enrolled, is this minor connected with the school district's official homelessness coordinator?
☐ Yes ☐ No ☐ Don't Know

If enrolled, what type of school does the minor attend?
☐ public (includes charter schools)
☐ parochial or private
☐ don't know

If not enrolled, give the most recent date of enrollment:

_________ / _________ / _________

If the minor is old enough to attend school but is not enrolled, please identify any problems or obstacles to enrollment:
☐ none
☐ residency requirements
☐ availability of school records
☐ birth certificate
☐ legal guardianship requirements
☐ transportation
☐ lack of available preschool programs
☐ immunization requirements
☐ physical examination records
☐ other ☐ don't know

Has this minor ever been a victim of domestic violence?
☐ Yes ☐ No ☐ Don't Know ☐ Refuse to Answer

If yes, how long in the past did this occur?
☐ Within past three months
☐ 3-6 months ago ☐ 6-12 months ago
☐ More than one year ago
☐ Don't Know ☐ Refused to Answer

SECTION 6.—Continued

Minor's name:

____

What is the minor's general physical health status?
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Does the minor have a mental illness?
☐ Yes ☐ No
If yes, is the mental illness a disabling condition?*
☐ Yes ☐ No
If yes, is the minor receiving services or treatment for the mental illness? ☐ Yes ☐ No

Does the minor have a substance abuse disorder?
☐ yes, alcohol abuse ☐ yes, drug abuse
☐ yes, both alcohol and drug abuse
☐ No
If yes, is the substance abuse disorder a disabling condition?
☐ Yes ☐ No
If yes, is the minor receiving services or treatment for the substance abuse disorder?
☐ Yes ☐ No

Does the minor have HIV or AIDS?
☐ Yes ☐ No
If yes, is this a disabling condition?
☐ Yes ☐ No
If yes, is the minor receiving services or treatment for HIV or AIDS?
☐ Yes ☐ No

Does the minor have a developmental disability?**
☐ Yes ☐ No
If yes, is the developmental disability a disabling condition?
☐ Yes ☐ No
If yes, is the minor receiving services or treatment for the developmental disability?
☐ Yes ☐ No

Does the minor have a chronic health condition*?**
☐ Yes ☐ No ☐ Don't Know
If yes, please specify what the condition is:

____

If yes, is the chronic health condition a disabling condition?
☐ Yes ☐ No
If yes, is the minor receiving services or treatment for the chronic health condition?
☐ Yes ☐ No

Does the minor have a physical disability?
☐ Yes ☐ No ☐ Don't Know
If yes, please specify what the disability is:

____

If yes, is the physical disability a disabling condition?
☐ Yes ☐ No
If yes, is the minor receiving services or treatment for the physical disability?
☐ Yes ☐ No

* **"Disabling condition"** means a condition that is expected to be of long-continued and indefinite duration and is expected to substantially impede a person's ability to live independently.

** **"Developmental disability"** includes mental retardation, cerebral palsy, head injuries, autism, epilepsy, and certain learning disabilities. Such conditions must have occurred before age 22 and be expected to continue indefinitely.

*** **Chronic health conditions** include, but are not limited to, heart disease, including coronary heart disease, angina, heart attack and any other kind of heart condition or disease; severe asthma; diabetes; arthritis-related conditions including arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia; adult-onset cognitive impairments including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive-related conditions; severe headache/migraine; cancer; chronic bronchitis; liver condition; stroke; or emphysema.

➢SECTION 7. INCOME

CASH INCOME

Have you or anyone who will live with you received cash income from any source in the past 30 days? ☐ Yes ☐ No

If yes, please check the boxes next to all sources of **CASH** income in the list below received by all household members (do not include food stamps); indicate which household member actually receives the income; and state the amount received per month.

Type	Name of Person Who Has the Cash Income	Amount/Month
☐ Employment income	______________	$ ________
☐ Child support	______________	$ ________
☐ Social Security Disability (SSDI)	______________	$ ________
☐ Supplemental Security Income (SSI)	______________	$ ________
☐ Social Security retirement	______________	$ ________
☐ TANF	______________	$ ________
☐ Veteran's pension	______________	$ ________
☐ Veteran's disability payment	______________	$ ________
☐ Unemployment Insurance	______________	$ ________
☐ Alimony/other spousal support	______________	$ ________
☐ Pension from a former job	______________	$ ________
☐ Worker's Compensation	______________	$ ________
☐ Private disability insurance	______________	$ ________
☐ Other sources of income	______________	$ ________

Specify any other sources of cash income, amount, and who has the income, below:

____

____

____

NON-CASH INCOME

Have you or anyone who will live with you received non-cash benefits or services in the past 30 days? ☐ Yes ☐ No

Please check the boxes next to all sources of **NON-CASH** benefits and services, and give the name of the household member who has or receives the benefits/services. For food stamps/SNAP, provide the amount received per month.

Type	Name of Person Who Has the Non-Cash Assistance	Amount/Month
☐ Food stamps/EBT/SNAP	______________	$ ________
☐ Medicaid/MO HealthNet	______________	
☐ Medicare	______________	
☐ WIC	______________	
☐ TANF childcare services	______________	
☐ TANF transportation services	______________	
☐ Other TANF-funded services	______________	
☐ Children's Health Insurance Program	______________	
☐ VA Medical Services	______________	
☐ Other assistance source	______________	

➢SECTION 8. ASSETS INFORMATION

Assets: please list all checking, savings, and investment accounts below for all persons that will be living in your household.

Household Member's Name	Bank/Institution Name	Account Number	Type of Account (checking, savings, investment)	Current Balance

List the value of all stocks, bonds, trusts, pension contributions or other assets: ______________________________

Have you sold or given away any real property or assets in the past two years? ☐ Yes ☐ No

If yes, what is the current market value of the asset: ______________________________

➢SECTION 9. EXPENSES

Expenses: please provide the information requested below. These answers may help reduce the amount of rent for which you'll be responsible in DMH's Shelter Plus Care program.

Do you pay for childcare that enables you or another household member to work or go to school?
☐ Yes ☐ No

If yes, give the name and address of the childcare provider, weekly cost and the name of the household member working or in school:

Provider Name & Address:

____

____

____

Name of household member who works or goes to school:

____

Weekly Cost: ______________________________

Do you pay for a care attendant or for any equipment for a disabled member of the household necessary to permit that person or someone else in the household to work?
☐ Yes ☐ No

If yes, give the name of the household member who works because of this expense:

____

Do you incur unreimbursed medical expenses on a regular basis? ☐ Yes ☐ No **If yes, amount per month: $________**

Do you owe money on back rent? ☐ Yes ☐ No

If yes, amount: $____________________

Do you owe money on past utility bills? ☐ Yes ☐ No

If yes, amount: $____________________

➢SECTION 10. ZERO INCOME DECLARATION

Complete this section only if the Applicant has NO cash income.

➢*APPLICANT*: If you have no cash income, please read the statement below, then print your name, sign your name, and fill in the date. *Please be aware that falsification of this statement is grounds for denial or termination of housing assistance.*

To the best of my knowledge and belief, I have no income at the time of making this application.

➢______________________________
(Print Applicant Name)

➢______________________________
(Sign Applicant Name)

➢_________ / _________ / _________
(Date)

➢*CASE MANAGER*: If the Applicant has no cash income, please read the statement below, then print your name, sign your name, and fill in the date.

To the best of my knowledge and belief,

______________________________ *(print applicant name)* ***has no income at the time of making this application.***

➢______________________________
(Print Case Manager Name)

➢______________________________
(Sign Case Manager Name)

➢_________ / _________ / _________
(Date)

➢SECTION 11. VETERAN STATUS

Is anyone in this household a veteran? ☐ Yes ☐ No

If yes, name: ______________________________

<u>If no, skip the rest of this section.</u>

What date did the veteran begin military service?

_________ / _________ / _________

What branch was served in?
☐ Army ☐ Air Force ☐ Navy ☐ Marines
☐ Other ☐ Don't Know

When was the service? Choose one; if the service dates overlap two choices, choose the one containing most of the service time.

☐ Post-September 11th (September 11, 2001-present)

☐ Persian Gulf (August 1991-September 10, 2001)

☐ Post-Vietnam (May 1975-July 1991)

☐ Vietnam (August 1964-April 1975)

☐ Between Korea and Vietnam (Feb. 1955-July 1964)

☐ Korea (June 1950-January 1955)

☐ Between WW2 and Korea (August 1947-May 1950)

☐ WW2 (September 1940-July 1947) ☐ Don't know

Duration of Active Duty: ______ Enter months served

Was the service in a war zone? ☐ Yes ☐ No ☐ Don't Know

If yes, which one?

☐ Europe ☐ North Africa ☐ Vietnam

☐ Laos and Cambodia ☐South China Sea

☐ China, Burma, India ☐ Korea ☐ South Pacific

☐ Persian Gulf ☐ Afghanistan ☐ Don't know

Number of months in war zone: __________________

Did the veteran receive fire, either hostile or friendly?
☐ Yes ☐ No ☐ Don't Know

Discharge Status: ☐ Honorable ☐ General

☐ Medical ☐ Bad Conduct ☐ Dishonorable

☐ Other ☐ Don't Know ☐ Refused to Answer

(*Please continue to Section 12, on the next page.*)

➢SECTION 12. APPLICANT CERTIFICATIONS

Applicant: please read the paragraphs below and then sign to show that you have read the information, understand it and agree to it.

- ✓ I understand that if I am approved to receive assistance from the Department of Mental Health's Shelter Plus Care program, I agree to follow all of the rules of the Shelter Plus Care program.
- ✓ I understand that I must report all increases and decreases in my income to my local processing center agency within 30 days of the change in income;
- ✓ I understand that I must adhere to the Service Plan that I established with the agency that is referring this application to the Department of Mental Health;
- ✓ I understand that if my referring agency can no longer provide case management or supportive services, I will help to identify a new agency of my choice to provide those services.
- ✓ I understand that if I change supportive service agencies I must notify my local processing center agency of the change within 30 days.
- ✓ I understand that as a Shelter Plus Care participant I am required to obey the rules and restrictions of my lease, including paying my share of rent on time, not disturbing fellow tenants, and keeping my unit clean and free of damages.
- ✓ I certify that all information given on this application by me or other parties is accurate and complete to the best of my knowledge and belief. I also understand that making false statements or providing false information is grounds for denial or termination of rental assistance.

➢ ____
(*Print Name of Applicant, or of Parent, Guardian or Legal Representative of Applicant*)

➢ ____
(*Signature of Applicant, or of Parent, Guardian or Legal Representative of Applicant*)

➢ _________ / _________ / _________
(*Date*)

SECTION 13. CASE MANAGER CERTIFICATIONS

Case Manager: please read the following and indicate your understanding and agreement by signing below.

- ✓ I understand that by referring this Applicant to the Shelter Plus Care program, my agency is committing to providing case management and/or other supportive services for the Applicant for as long as the Applicant continues to qualify for such services.
- ✓ I will ensure that all children in this household are properly enrolled in school and are connected to the appropriate services within the community, including early childhood education programs.
- ✓ I will attend the initial Shelter Plus Care orientation with the Applicant at the local housing processing center agency, once the applicant has been approved to receive Shelter Plus Care assistance.
- ✓ I will assist the Applicant in his or her housing search once the Applicant is approved for Shelter Plus Care assistance.
- ✓ I will ensure that this Applicant for Shelter Plus Care receives case management services consistent with the Service Plan included in this application, and that those services will be adequate to help him or her maintain stable independent housing. DMH Housing strongly recommends at least one visit per quarter to the Participant's home.
- ✓ I understand that if I leave my position or if this Applicant is assigned to a different Case Manager, I am responsible for ensuring that DMH Housing and the Applicant's local Shelter Plus Care Processing Center are notified of the change in case management and for facilitating the transfer of services to another person or agency.
- ✓ I understand that making false statements or providing false information is grounds for denial or termination of the Applicant's rental assistance.
- ✓ I certify that all information provided on this application is accurate and complete to the best of my knowledge and belief.

➢ ____
(*Print Name of Case Manager*)

➢ ____
(*Signature of Case Manager*)

➢ ____
(*Name of Agency Employing Case Manager*)

➢ _________ / _________ / _________
(*Date*)

➢ATTACHMENT A. VERIFICATION OF DISABILITY

INSTRUCTIONS: This form identifies the Applicant's primary disability that is of long and continuing duration and impedes his or her ability to work and live independently. If the Applicant has multiple disabilities, please choose only the one that most substantially impedes his or her ability to work and live independently.

This form may be filled out only by a person who is licensed by the State of Missouri to make one of the diagnoses listed below. The agency must maintain appropriate documentation related to the diagnosis. Please indicate your professional licensure by checking a box below, and provide your license number.

- ☐ **Advanced Practice Registered Nurse**
- ☐ **Licensed Clinical Social Worker**
- ☐ **Licensed Professional Counselor**
- ☐ **Physician**
- ☐ **Psychiatrist**
- ☐ **Psychologist**

License number (*required*): ____

APPLICANT'S NAME: ____

☐ The Applicant has been diagnosed with **a serious mental illness.**

☐ The Applicant has been diagnosed with **both a serious mental illness** and **a chronic alcohol or drug abuse disorder.**

☐ The Applicant has **a chronic alcohol abuse disorder and/or a chronic drug abuse disorder.**

☐ The Applicant has **a severe and chronic developmental disability** that**:**

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
2. Manifested before the individual attained the age of 22;
3. Is likely to continue indefinitely;
4. Results in substantial functional limitations in three or more of the following areas of major life activity (*please check three or more of the following*):
   - ☐ Self-care
   - ☐ Receptive and expressive language
   - ☐ Learning
   - ☐ Mobility
   - ☐ Self-direction
   - ☐ Capacity for independent living
   - ☐ Economic self-sufficiency; and
5. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

☐ The Applicant has **a diagnosis of HIV and/or AIDS.**

I have personally made the diagnosis specified above. The above individual has a disability that is expected to be of long-continued and indefinite duration; is expected to substantially impede this person's ability to live independently; and is of such a nature that it could be improved by more suitable housing conditions.

➢____ ➢____

(Print Name of Person Verifying Disability) ***(Signature of Person Verifying Disability)***

➢_________ / _________ / _________

(Date)

➢ATTACHMENT B. SERVICE PLAN

OPTION 1: Use this form to identify the service plan that will help the Applicant achieve stable housing and increase his or her self-sufficiency and job skills. For all types of services that apply, list both the name of the provider and the frequency with which the Applicant receives or attends the service. Please provide as much detail as possible.

OPTION 2: Attach to this application a copy of your agency's Assessment, Service Plan or Treatment Plan and skip this form.

APPLICANT'S NAME: ______________________________

- ☐ **Mental Health Services**
  - ☐ Doctor, Psychologist or Psychiatrist visits: ______________________________
  - ☐ Therapist visits: ______________________________
  - ☐ Group therapy: ______________________________
  - ☐ Case management: ______________________________
- ☐ **Substance Abuse Treatment and Aftercare**
  - ☐ Treatment services: ______________________________
  - ☐ Aftercare: ______________________________
  - ☐ Case management: ______________________________
  - ☐ AA/NA meetings: ______________________________
  - ☐ Relapse plan and sponsor: ______________________________
- ☐ **Developmental Disability Services**
  - ☐ Doctor visits: ______________________________
  - ☐ Therapist visits: ______________________________
  - ☐ Case management: ______________________________
- ☐ **HIV/AIDS Services**
  - ☐ Doctor visits: ______________________________
  - ☐ Case management: ______________________________
- ☐ **Employment and Training**
  - ☐ Vocational rehabilitation: ______________________________
  - ☐ Supported employment: ______________________________
  - ☐ Case management follow-ups: ______________________________
  - ☐ Employment and training goals: ______________________________
- ☐ **Income and Benefits**
  - ☐ Applied for benefits: ______________________________
  - ☐ Appeals for benefits: ______________________________
  - ☐ Benefits goals: ______________________________
  - ☐ Case management follow-ups: ______________________________
- ☐ **Housing**
  - ☐ Other forms of housing assistance applied for:
    - ☐ Section 8 ☐ Subsidized/project-based rental unit ☐ DMH Rental Assistance Program (RAP)
    - ☐ DMH Supportive Community Living (SCL) ☐ Other rental assistance or voucher program
  - ☐ Housing search & moving assistance: ______________________________
  - ☐ Furniture & household Items: ______________________________
  - ☐ Schedule of case management home visits: ______________________________

➢______________________________ ➢_______ / _______ / _______

(Signature of Applicant) ***(Date)***

➢______________________________ ➢_______ / _______ / _______

(Signature of Case Manager) ***(Date)***

➢ATTACHMENT C. VERIFICATION OF HOMELESSNESS

DEFINITION: The only persons who may be served by Shelter Plus Care are those who come from the streets, emergency shelters, Safe Havens, institutions, or transitional housing. "Safe Haven" is HUD's term for certain HUD-funded apartment-based programs for chronically homeless disabled individuals; persons living in Safe Havens are considered homeless. There are three Safe Havens in Missouri: Access House in Kansas City; The Haven in St. Joseph; and the Safe Haven in Dunklin County.

INSTRUCTIONS: Check ONE option below that best describes the Applicant's homelessness situation immediately prior to the date this application is submitted to DMH. The Applicant must be literally homeless as defined by HUD.

DOCUMENTATION: You must include the documentation described below for the situation checked. No Applicant can be found eligible for assistance without this required documentation.

APPLICANT'S NAME: ____

CHOOSE ONLY ONE: The Applicant is literally homeless as defined by HUD because he or she is:

☐ **An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground**

➲ You must attach a written observation from a case manager, outreach worker or other homeless services worker able to personally verify the applicant's street homelessness. Describe in as much detail as possible: include locations, dates, and in what way the situation constitutes a place not meant for human habitation. This document must be on agency letterhead, and must be signed and dated by the author.

☐ **An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, Safe Havens, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals).**

➲ You must attach a letter from the shelter facility verifying the date(s) of entry and/or exit and that the Applicant currently resides there; **or** a printout from a Homeless Management Information System (HMIS) showing recorded shelter stays.

and

➲ You must attach a written observation by the case manager or homeless outreach worker verifying the shelter stay(s). This document must be on agency letterhead, and must be signed and dated by the author.

➲ For Applicants living in transitional housing programs, you must attach a letter from the transitional program verifying the date of entry and current residence; **and** documentation that the Applicant's housing immediately prior to the transitional program was either emergency shelter or living in a place not meant for human habitation (shelter letter, HMIS printout, or written observation of Applicant's former street homelessness).

☐ **An individual who is exiting an institution where he or she 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.**

An **institution** includes a medical or psychiatric hospital, an in-patient treatment program, a nursing home or other congregate setting, and jail.

➲ You must attach a signed and dated verification from the institution staff that the applicant has resided there for ninety days or less and is about to exit the institution; **and** documentation that the Applicant's housing immediately prior to the institutional facility was either emergency shelter or living in a place not meant for human habitation (shelter letter, HMIS printout, or written observation of Applicant's former street homelessness).

➢____________________________ ➢____________________________

(Print Name of Case Manager) ***(Signature of Case Manager)***

➢____________________________________ ➢______ / ______ / ______

(Name of Agency Employing Case Manager) ***(Date)***

***Please Note:* Eligibility for Shelter Plus Care cannot be determined without the documentation described above; failure to attach it will *significantly* delay application processing. The Applicant will not be placed on a wait list until determined to be eligible.**

➢ATTACHMENT D. VERIFICATION OF CHRONIC HOMELESSNESS

APPLICANT'S NAME: ____

INSTRUCTIONS: THIS FORM IS OPTIONAL. If the Applicant might qualify as chronically homeless, read the information below for guidance, and then complete the form and include the requested documentation. Most Applicants are not chronically homeless, so please read the information below before proceeding. DMH has several grants that serve chronically homeless Applicants only, so those who qualify as chronically homeless may receive assistance more quickly. HUD has set a goal of ending chronic homelessness by 2015, so identifying all Applicants who do meet the definition of chronic homelessness will help achieve that goal.

DEFINITION: A chronically homelessness Applicant is a disabled individual, or a family with a disabled head of household, who is currently living in a place not meant for human habitation, an emergency shelter, or a Safe Haven. The Applicant must have experienced one or more of those types of homelessness continuously for at least one year, or at least four separate episodes of homelessness in the last three years.

An individual currently living in an institutional setting (such as a jail, drug treatment facility or hospital) for fewer than 90 days, and who otherwise has the homelessness history described above, is also chronically homeless. An individual or family currently residing in a transitional housing program is **not** chronically homeless.

DOCUMENTATION: To verify chronic homelessness, this Application must include written documentation that shows the Applicant household lived in the homeless settings described above for the required time periods. Documentation can come from three general areas, listed in order of preference:

- **Primary** Documents (*most preferred*): letters from emergency shelters or Safe Havens documenting residence dates; or letters from homeless service providers or homeless outreach workers documenting eye-witness accounts of "street" homelessness; or printouts from Homeless Management Information Systems (HMIS; in Missouri these are MAACLink and ROSIE) showing recorded shelter stays. All letters must be on agency letterhead, and signed and dated. HMIS printouts must be clearly identifiable as originating from an HMIS program.
- **Secondary** Documents: letters from other health or human services providers such as food pantries, social workers, outreach workers, health workers, law enforcement, hospitals, medical clinics, and churches, when the staff of these agencies have interacted with the Applicant and can personally verify the Applicant's homelessness. All letters must be on agency letterhead, and signed and dated.
- **Tertiary** Documents (*least preferred*): a statement written or dictated by the Applicant describing when and where the Applicant experienced homelessness. Both the Applicant and the Case Manager submitting this Application must sign and date the statement. In general, these documents may only be used to fill in gaps in the documentation and may not be used as the sole source of homelessness documentation.

"EPISODES" OF HOMELESSNESS: HUD has not defined how long an episode must be, but has described them as "separate, distinct, and sustained" stays in shelters or on the street. DMH Housing evaluates each application individually.

SAFE HAVENS: "Safe Haven" does not refer to a domestic violence shelter; it is the name given by HUD to certain HUD-funded apartment-based programs for chronically homeless disabled individuals; persons living in Safe Havens are considered homeless for purposes of determining chronic status. There are three Safe Havens in Missouri: Access House in Kansas City; The Haven in St. Joseph; and the Safe Haven in Dunklin County.

☐ I have read the above information and believe that the Applicant meets the definition of chronically homeless. The required documentation is attached to this Application.

➢______________________________ ➢______________________________

(Print Name of Case Manager) ***(Signature of Case Manager)***

➢______________________________ ➢________ / ________ / ________

(Name of Referring Agency) ***(Date)***

➢ATTACHMENT E. CONSENT FOR DISCLOSURE OF APPLICANT'S PROTECTED HEALTH INFORMATION

I, (full name): ____,

Social Security Number: _______ - _______ - _______ **Date of Birth: _______ / _______ / _______**

hereby authorize the **MISSOURI DEPARTMENT OF MENTAL HEALTH (DMH)** and the programs, agencies and persons listed below to communicate and disclose to one another written and verbal information regarding my protected health information:

DMH rent subsidy processing center
Homeless management information data system (HMIS)
U.S. Department of Housing and Urban Development (HUD)
local housing authority
rental property owner or manager

The purpose of the disclosure is to obtain information used to secure and/or maintain rental assistance and housing through DMH's rent subsidy programs Shelter Plus Care and/or Rental Assistance Program, or through a local housing authority.

DMH does not have my permission to disclose the following items: ____

____

I understand that my medical/health information records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and cannot be disclosed without written consent unless otherwise provided for in the regulations. I understand that by signing this authorization, I am allowing the release of my protected health information. The protected health information in my record may include mental/behavioral health information, information relating to acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), alcohol/drug abuse, and/or a developmental disability.

I understand that I may revoke this consent at any time, except to the extent that disclosures have already been made in reliance on this or any other consent. Revocation may be accomplished by written request and may be for specific items or the entire release. To revoke this consent, mail a signed written request to revoke consent to: Missouri Department of Mental Health, Housing Director, 1706 East Elm Street, Jefferson City, MO, 65101.

I understand that this consent remains effective until I am no longer a participant in the DMH rent subsidy program, unless I specify expiration on the following date, or based on the following event or special condition: ____________________________

____

I understand that while signing this consent form is not a precondition to being declared eligible for housing assistance, DMH cannot complete the process of delivering such assistance to me unless I sign this consent form. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Would you like a copy of this consent form? Please initial: (   ) **YES** (   ) **NO**

Signature of Consumer: ____ **Date: _________ / _________ / __________**

Signature of Witness: ____ **Date: _________ / _________ / __________**

Signature of Parent/Guardian/Representative:

____ **Date: _________ / _________ / __________**

Guardian/Representative: please include a description of authority to act on Consumer's behalf: _________________________

____

HOMELESS MISSOURIANS INFORMATION SYSTEM

Notice of Client Rights

The information that is collected in the HMIS database is protected by limiting access to the database and by limiting with whom the information may be shared, in compliance with applicable federal and state laws. Every person and agency that is authorized to read or enter information into the database has signed an agreement to maintain the security and confidentiality of the information. Any person or agency that is found to violate their agreement may have their access rights terminated and may be subject to further penalties.

FOR DATA BEING ENTERED INTO THE HMIS I UNDERSTAND THAT:

- Staff of other agencies who will see my information have promised to protect it.
- Others using HMIS will protect my information.
- Information I give about physical or mental health problems will not be shared with others.
- Partner Agencies may share information that does not identify me to others.
- I have the right to request who has looked at my file.
- I understand I have the right to ask, "Can I refuse to answer that question," and how my refusal might affect my receipt of services.
- I have the right to view confidentiality policies used by HMIS.
- If I receive assistance through the Supportive Services for Veteran Families (SSVF) Program that my personally identifying information will be exported from HMIS and uploaded to a Veterans Administration (VA) Repository to meet VA-required reporting.
- Another Partner Agency may enter my data into HMIS and therefore may retain the paper copy file.
- If I decide at a later date that I no longer want my information in HMIS, I can request that it be removed.

______________________________	______________________________	____________________
Client Name (*please print*)	Client Signature	Date
______________________________	______________________________	____________________
Agency Personnel Name (*please print*)	Agency Personnel Signature	Date