4.8.4 HOPWA-STRMU/TBRA/PHP ASSISTANCE – INTAKE ASSESSMENT FORM

(Regular & COVID)

PLEASE PRINT THE ANSWERS TO THE FOLLOWING QUESTIONS:

Date: ___/___/___ **Enrollment Date:** ___/___/___ Client Character Code _____

Last Name: _____ **First Name:**_____ **Middle:**_____ Suffix: ____

Social Security #:_____-____-_____ **DOB**: ____/____/_____

Demographic Information:

Race:

☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ White

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Marital Status:

☐ Single
☐ Never Married
☐ Divorced
☐ Married living with spouse
☐ Married not living with spouse
☐ Common Law
☐ Living together
☐ Widowed
☐ Other
☐ Civil Union

Gender:

☐ Male ☐ Female ☐ FtM ☐ MtF ☐ I Don't identify as M,F,FtM or MtF
☐ Other If other, please specify _____

Disabling Condition: ☐ Yes ☐ No
Veteran Status: ☐ Yes ☐ No

Primary Language: _____

Address:

Street Address**:**_____ City**:**_____ TX Zip code**:**_____

Phone#: _____ ☐ Home ☐ Mobile ☐ Work **Email:** _____

Emergency Contact:

Relationship_____ Name_____ Phone_____

Family Information:

Family Members: Use one of the following for each corresponding field:

Gender: M-Male, **F-**Female, **T-**Transgender (**MtF, FtM)**
Race: A-Asian, **AI/AN-**American Indian/Alaskan Native, **B/AA-**Black/African American, **NH/PI-**Native Hawaiian/Pacific Islander, **W-**White **Ethnicity: H-**Hispanic, **NH-**Non-Hispanic
Disabling Condition: ***AA*** – Alcohol Abuse, ***CHC*** – Chronic Health Condition, ***DD*** – Developmental Disability, ***DA*** – Drug Abuse, ***HIV/AIDS***, ***MH*** – Mental Health, ***PD*** – Physical Disability
Relationship to Head of Household (HoH): D – Daughter, **S** – Son, **W** – Wife, **H** – Husband, **DC** – Dependent child, **P** – Parent, **SC** – Stepchild, **GP** – Grandparent, **G** – Guardian, **OFM** – Other family member, **OC** – Other caretaker, **ONM** – Other non-family member

Name	Gender	DoB	Race	Ethn	SSN	Relationship to HoH	Disabling Condition	Vet Status:
		/ /						◯◯
		/ /						◯◯
		/ /						◯◯
		/ /						◯◯
		/ /						◯◯

Housing Assessment

Housing Status:

☐ Homeless ☐ At risk of homelessness
☐ At imminent risk of losing housing ☐ Fleeing domestic violence
☐ Homeless only under other federal statutes ☐ Stably Housed ☐ Don't know ☐ Refused
Were you recently effected by a natural disaster? ☐ Yes ☐ No
If yes, what natural disaster? _____
Was your home directly impacted? ☐ Yes ☐ No Were you indirectly impacted? ☐ Yes ☐ No
Did you utilize a HUD waiver for Fair Market Rent? ☐ Yes ☐ No

Prior Living Situation:

☐ Homeless situation ☐ Institutional situation ☐ Transitional & Permanent housing situation

If choosing "Homeless situation" as Prior Living Situation, check one of the following as prior residence:

☐ Place not meant for habitation ☐ Safe haven ☐ Interim housing ☐ Emergency Shelter (includes hotel/motel paid with emergency shelter voucher)

If you chose "Institutional Situation" as Prior Living Situation, check one of the following as prior residence:

☐ Foster care home or foster care group home ☐ Hospital or other residential non-psychiatric medical facility
☐ Jail, prison or juvenile detention facility ☐ Stay Long-term care facility or nursing home
☐ Psychiatric hospital or other psychiatric facility ☐ Substance abuse treatment facility or detox center

If you chose "Transitional & Permanent Housing Situation" as Prior Living Situation, check one of the following as prior residence:

☐ Hotel or motel paid for without emergency shelter voucher ☐ Owned by client, no ongoing housing subsidy
☐ Owned by client, with ongoing housing subsidy ☐ Permanent housing for formerly homeless persons
☐ Rental by client, no ongoing housing subsidy ☐ Rental by client, with VASH subsidy
☐ Rental by client, with GPD TIP subsidy ☐ Rental by client, with other ongoing housing subsidy
☐ Residential project or halfway house with no homeless criteria ☐ Don't know
☐ Staying or living in a family member's room, apartment or house ☐ Refused
☐ Staying or living in a friend's room, apartment or house ☐ Substance abuse treatment facility or detox center
☐ Transitional housing for homeless persons (including homeless youth)

Length of Stay in the Prior Living Situation:

☐ 1 night or less ☐ 2 to 6 nights ☐ 1 week or more, but less than 1 month
☐ 1 month or more, but less than 90 days ☐ 90 days or more, but less than 1 year
☐ 1 year or longer ☐ Don't know ☐ Refused

Homelessness Assessment:

What is the approximate date homelessness began? ___/___/_____
Regardless of where you stayed last night, please write the number of times you've been on the streets or in a shelter in the past 3 years? _____
Total number of months homeless on the street or in a shelter in the past 3 years: _____

Insurance Assessment:

Health insurance: ☐ Yes ☐ No ☐ Don't know ☐ Refused
If no, why don't you have insurance? ☐ I applied, decision is pending ☐ I applied, not eligible ☐ I did not apply

If yes, what type(s)? ☐ Medicaid ☐ Medicare ☐ S-CHIP
☐ VA Military Service ☐ Employer-based ☐ COBRA
☐ Private Pay Health Insurance ☐ Indian Health Services Program
☐ Other If other, please specify _____

If insured, please indicate if coverage is active or inactive: _____

Indicate whether primary insurance and status (active or not) if there are multiple: _____
_____

Barriers Assessment:

Barriers	Present?	Receiving Treatment	Condition Indefinite?	Documentation on file?
Alcohol Abuse				
Chronic Health Condition				
Developmental Disability				
Drug Abuse				
HIV/AIDS				
Mental Health				
Physical Disability				

Domestic Violence Assessment:

Domestic violence experienced: ☐ Yes ☐ No ☐ Don't know ☐ Refused

If yes, when? ☐ Within the past 3 months ☐ 3 to 6 months ago
☐ 6 to 12 months ago ☐ One year ago or more ☐ Don't know ☐ Refused

Currently fleeing? ☐ Yes ☐ No ☐ Don't know ☐ Refused

T-cell/Viral Measurement

T-cell Count Available: ☐ Yes ☐ No ☐ Don't know ☐ Refused

If yes, T-cell count? _____

How was the data obtained? ☐ Medical Report ☐ Client report ☐ Other

Viral load available? ☐ Available ☐ Not Available ☐ Undetectable ☐ Refused

If yes, Viral load? _____

How was the data obtained? ☐ Medical Report ☐ Client report ☐ Other

Assistance Assessment:

Receiving public HIV/AIDS medical assistance: ☐ Yes ☐ No ☐ Don't know ☐ Refused

If not, why not: ☐ Applied, waiting decision ☐ Applied, not eligible
☐ Did not apply ☐ Not available for client

Receiving AIDS Drug Assistance Program (ADAP): ☐ Yes ☐ No ☐ Don't know ☐ Refused

If not, why not: ☐ Applied, waiting decision ☐ Applied, not eligible
☐ Did not apply ☐ Not available for client

Support with HOPWA-funded Housing Assistance:

☐ Client has a housing plan
☐ Contact with a primary health care provider
☐ Obtained job created by this project sponsor
☐ Accessed or maintained qualification for income
☐ Contact with a case manager/benefit counselor
☐ Medical insurance coverage or medical assistance
☐ Obtained job outside this agency

Financial Assessment:

Cash Income

Type	Monthly Amount	Type	Monthly Amount
Earned Income		General Assistance	
Unemployment Insurance		Retirement (Social Security)	
Supplemental Security Income		Veteran's Pension	
SS Disability Income		Other Pension	
Veteran's Disability Payment		Child Support	
Private Disability Insurance		Alimony	
Worker's Compensation		Other Income	
TANF			

Non-cash Benefits

Type	Monthly Amount	Type	Monthly Amount
Food Stamps		Section 8, Public Housing	
WIC		Temporary Rental Assistance	
TANF Child Care Services		Harris Health "Gold" Card	
TANF Transportation Service		Other Source	
Other TANF services			

Please detail income and benefits other household members may receive: _____

_____

_____

_____

Employment Assessment:

Employed: ☐ Yes ☐ No ☐ Don't know ☐ Refused

If yes, type of employment: ☐ Full-time ☐ Part-time ☐ Seasonal

How many hours worked in last week: _____

Employment Tenure: ☐ Permanent ☐ Temporary ☐ Seasonal ☐ Don't Know ☐ Refused

If no, why not employed: ☐ Looking for work ☐ Unable to work ☐ Not looking for work

Education Assessment:

Currently in school/Working on degree: ☐ Yes ☐ No ☐ Don't know ☐ Refused

Received vocational training/apprenticeship: ☐ Yes ☐ No ☐ Don't know ☐ Refused

Highest grade completed: ☐ No school completed ☐ Nursery school to 4th Grade ☐ 5th to 6th Grade
☐ 7th to 8th Grade ☐ 9th Grade ☐ 10th Grade ☐ 11th Grade
☐ 12th Grade, no diploma ☐ High school diploma ☐ GED ☐ Post-secondary school
☐ Don't know ☐ Refused

If post-secondary, what type of degree: _____

Health Assessment:

General Health Status: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Don't know ☐ Refused
Dental Health Status: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Don't know ☐ Refused
Mental Health Status: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Don't know ☐ Refused

If female, pregnancy status: ☐ Yes ☐ No

_____ ___/___/___
Client's Signature Date

Case Manager Use Only

Services received by Client:
___Housing Assistance
___Case Management/Care Coordination

11.2.9 CONSENT FOR EMERGENCY MEDICAL CARE

Client Name: _____
Medical Conditions: _____

_____

Drug Allergies: _____

_____

Physician's Name: _____
Physician's Address: _____
Physician's Phone Number(s): (_____)_____-_____ (_____)_____-_____

MEDICAL FACILITY DESIGNATED BY CLIENT TO PROVIDE EMERGENCY CARE:

Facility: _____
Phone Number(s): (_____)_____-_____ (_____)_____-_____

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

Name: _____

Address: _____

Relationship: _____
Phone Number(s): (_____)_____-_____ (_____)_____-_____

I, _____, authorize the Montrose Center staff to notify my physician and/or emergency contact listed above in case of a medical emergency. In the event of an emergency, I hereby authorize and direct the Center to take emergency action on my behalf.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Patient Records, § 42 CFR, Part 2, § 33 of Public Law 91-616 as amended by Public Law 93-282, HIPAA Privacy Act §45 CFR 160 – 164, and all applicable state and local laws, rules, and regulations; and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g.: probation, parole, etc.). A photographic copy of this authorization shall be considered as valid as the original.

This consent expires one (1) year after my last date of service (individual, family, or group session) at the Montrose Center, or ____ other _____unless I revoke it as provided for above.

_____ ____/____/____ _____
Client's Signature Date Parent, Guardian, or Authorized Representative's Signature

1.1 STATEMENT OF CLIENT RIGHTS & RESPONSIBILITIES

RIGHTS

All applicants/clients/participants/families (client or through their surrogate) admitted to services and applicants for services of the Montrose Center shall have all the rights and responsibilities of other residents of the State of Texas and the United States of America including the following rights and responsibilities:

1. **Confidentiality:** Clients have the right to confidentiality. No information from which the identity of clients or their treatment can be determined shall be given directly or by reference to the public or any other individual or agency without the written consent of the client as governed by local, State, and Federal regulations.

   The law authorizes the Center to disclose information in the case of: (1) a court order, (2) imminent harm that might come to the client or others (child abuse, homicide, suicide, physical harm, abuse by a previous Therapist), (3) mandatory reporting for abuse or suspected abuse of children, the elderly or people with disabilities; and (4) coded intake, treatment and follow-up data (with client name removed) sent to the funding source as a requirement for sponsorship. In addition, coded data (client name removed) or aggregate data is used by the Center for the purpose of program evaluation and research. Clients have the right to be informed when information is released without permission due to the above listed exceptions.

   By appointment, clients may inspect their own clinical and financial records that are maintained by the Center, unless deemed harmful to the client. Copies can be obtained by signing a release. Copies shall be available within seven (7) calendar days of the request. There is a fee of 10¢ per page unless the copy is necessary to file or appeal a disability claim or designation.

2. **Discrimination:** Clients have the right not to be discriminated against and to receive appropriate care. No person shall be denied services in any the Center program based on their age, sex, race, ethnicity, creed, national origin, sexual/affectional orientation, gender identity or expression, physical or mental ability, religious practice or preference, HIV status, chemical dependency status, marital status, or pregnancy, although, some programs give priority to certain groups or target populations.

   No person who qualifies for grant subsidized services shall be denied services based on their ability to pay for the services.

3. **Research:** Clients have the right to refuse to participate in research without affecting access to services.

4. **Informed Consent:** Clients have the right to give informed consent or to refuse treatment and to be advised of the consequences of such a decision. Informed consent includes information about the condition to be treated; the proposed treatment; risks, side effects, and benefits of all proposed treatments; alternative treatments and which ones might be appropriate; probable physical and mental health consequences if treatment is refused; and expected length of stay. If a client is disoriented or lacks the capacity to under this at the time of admission, they are informed again when they are able to understand.

   Clients have the right to accept, refuse or withdraw from treatment after receiving the above information and to leave treatment at any time, unless otherwise prohibited by law. All services at the Center are outpatient and voluntary.

5. **Treatment/Service/Wellness Plans:** Clients have the right to actively participate in the development of an individualized treatment plan including periodic review at least once a month.

   Clients have the right not to be given medication not needed or too much medication. The Center does not prescribe or administer medications.

   Clients have the right not to be held or placed in a locked room alone unless the client is a danger to themselves or others. The Center does not use personal restraint in treatment.

   Clients have the right to participate in an client annual needs assessment and client satisfaction survey. Surveys are available in the lobby and at the reception desk throughout the year.

   Clients have the right to receive individualized services and to refuse or accept services after being informed of services and responsibilities, including: program goals and objectives, rules and regulations and client rights.

   Clients have the right to include members of the client's family of choice in treatment planning and discharge planning.

6. **Provider Information, Communication and Choice:** Clients have the right to know the identity and qualifications of the staff providing treatment and to have competent, qualified and experienced staff to supervise and carry out services. Clients have the right to know the reason for any proposed change in staff responsible for their care. Clients have the right to an explanation of any professional relationship between the Center and any other health care or educational institution involved in the client's care. Clients have a right to a second opinion.

   Clients have the right to be informed about program rules and regulations before admission.

   Clients have the right to have freedom of choice when choosing a provider of comprehensive outpatient health and psychosocial support services.

   Clients have the right to appropriate treatment in the least restrictive setting available that meets the client's needs. The Center only provides outpatient services. The right to designate a surrogate decision maker if the client is incapable of understanding a proposed course of care or is unable to communicate their wishes regarding that care.

   Clients have the right to free communication within the constraints of the individualized treatment plan with justification for any restrictions documented in the client's record. Since the Center is an outpatient facility, there are no restrictions.

   Answering Service: the Center answers the phones during normal business hours and utilizes an answering service after 7:00 pm weekdays and on weekends for emergencies.

   The Center phones and employees home phones show up as anonymous on Caller ID. If a client does not accept anonymous calls, the Center's number will appear on the Caller ID.

7. **Complaints and Grievances** (see section on complaints)**:** Clients have the right to receive a copy of the complaints procedures within 24 hours of admission. Clients have the right to a comment, complaint and grievance procedure without fear of denial of service or other punitive measures and receive a fair response from the Center within a reasonable amount of time. Complaints may be brought about any part of services including modifying, suspending or terminating service.

8. **Humane Environment, Abuse, Neglect and Exploitation:** Clients have the right to a humane environment that provides reasonable protection from harm and privacy for personal needs which is free from physical, mental or sexual abuse, neglect and exploitation.

9. **Dignity:** Clients have the right to be treated with respect, consideration and recognition of their dignity, individuality and personal privacy. Clients have the responsibility to render the same to the provider to receive personal care and treatment in safe, clean surroundings. Clients have the right to treatment, care and settings that is considerate and respectful of the client's beliefs and values.

10. **Peers serving as employees or volunteers:** Clients have the right to serve as peer support specialists as either an employee or volunteer. Clients have a right to integrate peer work into a care plan.

11. **Fees and Payments:** The right to know in advance about the cost and conditions of payment for treatment, including limitations on the duration of services.

12. **Explanation of Rights and Responsibilities:** The right to receive a complete explanation of these rights in clear, non-technical terms and in a language the client understands within 24 hours of admission.

    The right at the time of admission or at anytime upon request throughout the span of service, to have a staff member inform the client of their client rights, and to have any questions about these rights answered.

    The right to receive a written copy and explanation of these client rights and the grievance procedure at the time of admission or at anytime upon request throughout the span of service including the funding sources address and phone number.

13. **Detention:** The right not to be detained against the client/consenter's will.

14. **Conditions for Service:** The right to receive services free from conflict of interest or dual relationships. If now or at anytime while receiving services here a client is involved in a partner/spouse relationship with a staff member or member of the board of directors, services should be discontinued and three referrals will be given. Since dual relationships between clients and the Center staff and volunteers can interfere with the therapeutic process, the relationship needs to be over for at least one (1) year before services can resume.

RESPONSIBILITIES

1. **Confidentiality:** As a client you have the responsibility to never repeat to anyone else the name or identifying information of any other clients you see at the Center. All clients deserve the same privacy from each other that the staff gives you.

2. **Information:** As a client you have the responsibility to inform your Therapist or Case Manager when you do not understand instructions or information that you receive. If you need someone to help you complete forms, explain an instruction or read or interpret for you, staff needs to know that from you. As a client you have the responsibility to keep your Case Manager or Therapist informed about the quality, appropriateness and timeliness of services that you are receiving. The Center tries to provide services that fit you and your situation. If you have had problems with the services here you have options. Tell your Therapist or Case Manager, talk to their supervisor or fill out an anonymous survey in the lobby. As a client you have the responsibility to provide accurate and complete information about your history and changes in your condition during services.

3. **Appointments:** As a client you have the responsibility to keep your scheduled appointments with your Therapist or Case Manager and other service providers and to notify them when you need to cancel or reschedule. All counseling services are scheduled by appointment only. If you cannot get to your appointment, please call at least 24 hours in advance. In emergencies, call as soon as you can so that we may give the time to another person who may be waiting for service.

The usual session charge will be applied for appointments not kept or appointments that are canceled less than 24 hours in advance. Clients who need to cancel a Monday appointment may leave a message with the answering service 24 hours in advance to avoid charges.

4. **Collaborative Effort and Follow Through:** As a client you have the responsibility to complete those activities that you agree to do and to notify your Therapist or Case Manager when you are unable to do so. The Center staff works hard with you. If you have agreed to make phone calls or check up on something, please complete your task. If you are unable to do so, please let your Therapist or Case Manager know as soon as possible so they may help you. As a client you have the responsibility to accept the consequences of the outcome or no outcome if you do not do your part.
5. **Obtaining Services on Your Own:** As a client you have the responsibility to notify your care manager or Therapist of services that you obtained by yourself. So we will not spend time working on a service you already have, please let your Therapist or Case Manager know as soon as possible.
6. **Needs:** As a client you have the responsibility to communicate your needs to and ask questions of your Case Manager or Therapist as quickly as possible, understanding that your Case Manager or Therapist may not be able to satisfy "last minute" requests. Many agencies close at 5:00 pm. While you can reach the Center by phone after that time, we may not be able to get in touch with another agency to help you. It is also important to keep your requests reasonable. It is not always possible to fulfill requests, particularly housing. For example, there are no sources of free apartments.
7. **Conduct:** As a client you have the responsibility to conduct yourself appropriately when interacting with staff and other clients. Inappropriate behavior includes intoxication, threats, harassment, sexual advances or comments, and physical and verbal abuse. Weapons are not allowed in any the Center buildings. If discovered, they may be turned over to law enforcement. Smoking is not permitted in the Center's buildings. As a client you have the responsibility to give truthful information to your Therapist or Case Manager. Anyone who knowingly gives false information to their Therapist or Case Manager may lose the right to receive grant funded services at the Center. As a client you have the responsibility to keep the Center free of political candidate campaigning. No campaign materials (T-shirts, literature, cards, buttons, etc.) or speeches advertising a candidate for an active election are allowed in any the Center facility.
8. **Documentation:** As a client you have the responsibility to provide documentation needed to qualify you for services before services can be provided, such as, proof of where you live, current proof of income, and proof of HIV status if applicable. In order to provide you with grant funded services, your Therapist or Case Manager must show proof that you qualify.
9. **Fees:** As a client you have the responsibility to pay the fees you have agreed to and to notify your therapist if your insurance plan, or insurance company or income has changed. You will be responsible for paying any increase, if applicable, of co-insurance or copays incurred due to a delay in informing us of the insurance change. The Center has a sliding scale and tries to work with you in setting a reasonable fee. Once you agree to a fee, we count on that.

_____ _____/_____/_____
Client's Signature Date

_____ _____/_____/_____
Parent, Guardian or Authorized Representative's Signature Date

18.1.3.11 CONSENT FOR THE RELEASE/EXCHANGE OF INFORMATION – GENERAL SERVICES

I, _____ (phone: ____/_____-_____, email: _____@ _____._____), authorize the Care Management staff of the Montrose Center and the respective staff of the agencies listed below to exchange verbal and/or written information about me, unless I have specifically removed them from the list by crossing them out and placing my initials next to them. The exchange/release of information is for the purpose of facilitating my access to community resources and/or services requested by me. Information regarding my identity, HIV status, psychosocial history, substance use disorder history, and need for and/or eligibility for services may be released as needed.

Adult Protective Services (APS)
Access Care
ADORE
AIDS Foundation Houston (AFH)
AIDS Housing Coalition Houston
Alliance for Multicultural Community Services
American Red Cross
Area Agency on Aging
AssistHers
Assoc. Advancement of Mexican Americans (AAMA)
ASPCA
Assurance Wireless
AT&T
Avenue 360
Baker-Ripley Neighborhood Center
Beacon
Bee Busy
Braes Interfaith Ministries
Bread of Life, Inc.
Brentwood Foundation
Career & Recovery Resources, Inc.
Career Gear
Catholic Charities of the Archdiocese of Gal.- Houston
Center for AIDS Info. and Advocacy
CenterPoint Energy
City of Houston – Mayor's Assistance Program
Community Family Center
Change Happens!
Children's Protective Services (CPS)
City of Houston – Water Department
Community Endowment Fndtn. (Swehla House)
Cottage Thrift Store
The Council on Recovery
CVS Pharmacy
Cypress Assistance Ministries
Dress for Success
Family Services of Greater Houston
First Presbyterian Church: Operation ID
Gilead Sciences, Inc.
Goodwill Houston
Gulf Coast Community Services Association
Harris Center for Mental Health and IDD
Harris Co. Community Dev. Agency (HCCDA)
Harris Co. Guardianship Payer
Harris Co. Juvenile Probation
Harris County Rides
Harris Co. Sheriff's Department (Jail)
Harris Co. Psychiatric Center (HCPC)
Harris Co. Social Services
Health and Human Services Commission
Healthcare for the Homeless
Houston Galveston Trauma Institute
Houston Area Assistance Ministries
Houston Area Parkinson's Society
Houston Area Women's Center
Housing Authority of the City of Houston
Houston Center for Independent Living
Houston Compass
Houston Food Bank
Houston Hospice
Houston Humane Society
Houston Volunteer Lawyers Program, Inc.
Interfaith Care Partners
Interfaith Ministries for Greater Houston
Jewish Family Services
Kroger Pharmacy
Lambda
Lazarus House
Legacy Community Health
Lighthouse of Houston
Loaves and Fishes
Lone Star Legal Aid
Lord of the Streets
Memorial Assistance Ministries
Metropolitan Transit Authority (METRO)
North Channel Assistance Ministries
Northwest Assistance Ministries
Palmer Way Station
PAWS Houston
Pet Patrol
PetSafe
Planned Parenthood
Pink Giraffe
PRIDE Charities
Recenter Houston
Reliant Energy
St. Hope Foundation
St. Vincent de Paul Society
Salvation Army
Second Blessings
Sheltering Arms Senior Services
SNAP – Spay & Neuter Assistance Program
Social Security Administration
Southeast Area Ministries
SETX Transitional Center
South Texas College of Law
Southeast Texas Legal Clinic
Southside Pharmacy
Southwest Area Ministries
Star of Hope
SER Jobs for Progress
Texas Board of Pardon/Parole – TDCJ
Texas Commission for the Blind
Texas Dept. of Criminal Justice/Parole
Texas Dept of Health & Human Services
Texas Dept. of Protective Family Service
Texas HIV Medication Prog. (ADAP)
Texas Workforce Solutions
Triangle AIDS Network
United Way of Greater Houston
University of Houston College of Optometry
University of Houston Law Center
University of Houston Speech & Hearing
USCIS – Citizenship & Immigration
U.S. Vets Initiative
UTMB Galveston/Conroe
Veterans Administration Medical Cntr (VA)
Viiv Healthcare
Visiting Nurse Association (VNA)
Volunteers of America
Walgreens Pharmacy
West Houston Assistance Ministries
YMCA, YMCA International

By my signature below, I hereby agree that I shall not hold the Center or Houston Regional HIV Care Management System liable for the quality or degree of performance of services provided by the agencies/individuals named above. This authorization for exchange of information is made with informed consent.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Patient Records, §42 CFR, Part 2; HIPAA Privacy Act §45 CFR 160-164, §33 of Public Law 91-616 as amended by Public Law 93-282; Texas Health and Safety Code §81.103 HIV records and Chapter 611 mental health records, and Texas Administrative Code §379.2011 family violence records and all applicable state and local laws, rules, and regulations; and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g.: probation, parole, etc.). A photographic copy of this authorization shall be considered as effective and valid as the original.

This consent expires one (1) year after my last contact with the Montrose Center unless I revoke it as provided for above.

_____	____/____/____	_____
Client's Signature	Date	Parent, Guardian, or Authorized Representative's Signature

9/13, 2/15, 3/15, 2/16, 6/17, 7/17, 9/17 , 9/18

18.1.3.13 CONSENT FOR THE RELEASE/EXCHANGE OF INFORMATION – HOSPITALS & CLINICS

I, _____ (phone: ____/_____-_____, email: _____@ _____._____), authorize the Care Management staff of the Montrose Center and the agencies listed below to exchange verbal and/or written information about me, unless I have specifically removed them from the list by crossing them out and placing my initials next to them. The exchange/release of information is for the purpose of facilitating my access to community resources and/or services requested by me. Information regarding my identity, HIV status, psychosocial history, substance use disorder history, assessment, and need for and/or eligibility for services may be released as needed.

Outpatient:
AAMA
Access Health
AIDS Healthcare Foundation
Bay Area Council on Drugs and Alcohol, Inc.
Brazoria Co Alcohol & Recovery
Career and Recovery Resource Center
DAPA
El Centro DeCorazon
Fort Bend Regional Council on Alcoholism & Drug Abuse
Good Neighbor Health Clinic
Gulf Coast Center - Galveston
HHS – Northwest Community Health Center - ADL
HHS – Thomas Street Clinic
HHS- Smith Clinic
Joseph Hines Clinic
Legacy Community Health
Montgomery/Walker County Council
New Hope Center
Odyssey House
Palmer Drug Abuse Program-
Spring/Bellaire/Pinemont/Memorial SB/Katy/Ft. Bend
Saint Hope Foundation
Turning Point
Unlimited Visions
UT Physicians
University of Texas

Residential:
A Caring Safe Place
Cenikor
Center for Success & Independence
Cheyenne Center
Covenant House
Cypress Creek Center-Cali Dr (West Oaks branch)
Extended Aftercare
Harmony House/Bakery Lofts
Houston Aftercare
Last Chance Recovery Center
Oxford House
Open Door Mission Foundation
Path to Success
Recovery Center, The - Montrose/Galveston
Right Step, The
H.E.L.P. House
Rogers Street Recovery Center
Salvation Army
Santa Maria Hostel
Star of Hope Transitional Living Center
The Serenity Center
Volunteers of America
West Oaks Counseling Center

Inpatient:
All About Recovery
Bayou City Medical Center South
Behavioral Hospital of Bellaire
Bayshore Hospital
Clear Lake Regional Medical Center
Cypress Creek Hospital
Harris County Psychiatric Center (HCPC)
Harris Health System (HHS)
Ben Taub/LBJ/Quentin Mease Hospitals
Homeward Bound
Intracare Hospital
Memorial Hermann Hospitals
Menninger Clinic
Methodist Hospital
Neuro-Psych Center (NPC)
Omega House
PARC, The
Park Plaza Hospital
St. Joseph's Hospital
St. Luke's Hospital
Texas Children's Hospital
Veterans Administration Medical Center
West Oaks Hospital

Criminal Justice Centers:
Brazoria County Jail
Carol S. Vance
Fort Bend County Jail
Gateway Foundation
Harris County Jail
Henley State Jail
Jefferson County Jail
Joe Keagans State Jail
Montgomery County Jail
Pam Lychner State Jail
Plane State Jail
Southeast Texas Transitional Center
TDCJ – Mark Stiles Unit
TDCJ – Carol S Young Medical Complex
UTMB

By my signature below, I hereby agree that I shall not hold the Center or Houston Regional HIV Care Management System liable for the quality or degree of performance of services provided by the agencies/individuals named above. This authorization for exchange of information is made with informed consent.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Patient Records, §42 CFR, Part 2; HIPAA Privacy Act §45 CFR 160-164, §33 of Public Law 91-616 as amended by Public Law 93-282; Texas Health and Safety Code §81.103 HIV records and Chapter 611 mental health records, and Texas Administrative Code §379.2011 family violence records and all applicable state and local laws, rules, and regulations; and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g.: probation, parole, etc.). A photographic copy of this authorization shall be considered as effective and valid as the original.

This consent expires one (1) year after my last contact with the Montrose Center unless I revoke it as provided for above.

_____ ____/____/____ _____
Client's Signature Date Parent, Guardian, or Authorized
Representative's Signature

9/13, 2/15, 3/15, 7/17, 9/18, 6/19

18.1.3.15 CONSENT FOR THE RELEASE/EXCHANGE OF INFORMATION–HOUSING RESOURCES

I, _____ (phone: ____/_____-_____, email: _____@ _____._____), authorize the Care Management staff of the Montrose Center and the agencies listed below to exchange verbal and/or written information about me, unless I have specifically removed them from the list by crossing them out and placing my initials next to them. The exchange/release of information is for the purpose of facilitating my access to community resources and/or services requested by me. Information regarding my identity, HIV status, psychosocial history, substance use disorder history, and need for and/or eligibility for services may be released as needed.

A Caring Safe Place, Inc., 1804 Carr Street
AFH - A Friendly Haven
AFH - Burress Street Apartments
AIDS Housing Coalition
Angela's House
Avenue 360
Bray's Crossing
Brentwood Cottages
The Bridge Over Troubled Water
Brigid's Hope
Bristow (MHMRA)
Canal Street
Catholic Charities
Chupik House
City of Houston Housing and Community Development
Coalition for the Homeless
Community Endowment Fndtn. (Swehla House)
Corder Place Apartments – 1414 Congress
Covenant House Texas, 1111 Lovett
DeGeorge (veterans)
Fort Bend County Women's Center
Hamilton Street – New Hope
Harmony House
Harris County Social Services
Help House - AFH
Houston Area Women's Center Shelter
Houston Heights House
Houston Heights Tower (over 62)
Houston Housing Authority, Sec 8
Houston Housing Corporation
Jackson Hines
Jonah's Place
Lavender Street (VOA)
Liberty Island, PCH
Live Oak Place
Lydia's Place
Madge Bush Transitional Center
Magnificat House
McGovern House
Miriam's Hostel
Mission of Yahweh
Montgomery Co Housing Authority
New Hope Housing
Odyssey House Texas, Inc., 5629 Grapevine
Oxford House
Perry Street – New Hope
Ritten House – New Hope
Rogers Street (VOA)
Saint Hope Foundation
Sakowitz Apartments
Sally's House
Salvation Army Shelters
San Jacinto Apartments
Santa Maria Bonita House
SEARCH, 2505 Fannin
SE Tx Transitional Facility
Shay's House
Star of Hope Shelter
Truxillo House
Ultimate Changes, Inc.
Veteran's Administration
VOA Scattered-Site Housing
Well Spring Village
The Women's Home

By my signature below, I hereby agree that I shall not hold the Center or Houston Regional HIV Care Management System liable for the quality or degree of performance of services provided by the agencies/individuals named above. This authorization for exchange of information is made with informed consent.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Patient Records, §42 CFR, Part 2; HIPAA Privacy Act §45 CFR 160-164, §33 of Public Law 91-616 as amended by Public Law 93-282; Texas Health and Safety Code §81.103 HIV records and Chapter 611 mental health records, and Texas Administrative Code §379.2011 family violence records and all applicable state and local laws, rules, and regulations; and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g.: probation, parole, etc.). A photographic copy of this authorization shall be considered as effective and valid as the original.

This consent expires one (1) year after my last contact with the Montrose Center unless I revoke it as provided for above.

_____	____/____/____	_____
Client's Signature	Date	Parent, Guardian, or Authorized Representative's Signature
9/10, 9/13, 4/14, 2/15, 3/15, 7/17, 9/18		

18.1.3.37 CONSENT FOR RELEASE/EXCHANGE OF INFORMATION – LANDLORD/MORTGAGE

I, _____ (phone: ____/_____-_____,
Printed Name of Client
email: _____@ _____._____), do hereby request and authorize _____ to release/exchange information regarding
Name of Apartment Complex / Landlord / Manager or Mortgage Company [Name must match HCAD – and any management company for the property must be included. A contact person for that property must be provided.]

my rental or mortgage [_____] status to the agency with whom I am
Mortgage Loan Number

applying for assistance, the Montrose Center

I understand that the name used by the Montrose Center when communicating with the landlord/mortgage company will be: the Center Housing Services.

This release/exchange also includes the terms of my lease/mortgage, late charges, and any/all legal liens or actions taken against me concerning my dwelling. The purpose of this exchange/release of information is to help qualify me for possible financial assistance for my rent/mortgage requested by me.

By my signature below I fully release and hold the entity(ies) administering the funding for these services, the Montrose Center, their Officers, Directors, Board Members, employees and agents (i.e.: volunteers, students) harmless from any and all damages, losses, liabilities (joint or several), payments, obligations, penalties, claims, litigation, demands, defenses, judgments, suits, proceedings, costs, disbursements or expenses (including without limitation, fees, disbursements and expenses of attorneys, and other professional advisors and of expert witnesses and costs of investigation and preparation) of any kind or nature whatsoever resulting from, relating to or arising out of my receipt of services. In addition, I fully release and hold harmless the same above listed persons and entities should the landlord of my dwelling call or come to the physical address of the Montrose Center of his or her own accord.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Patient Records, 42 CFR, Pt 2, Section 33 of Public Law 91-616 as amended by Public Law 93-282, and all applicable state and local laws, rules, and regulations, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g., probation, parole, etc.). A photographic copy of this authorization shall be considered as effective and valid as the original.

This consent expires 2 (two) years from the date below____/____/___ unless I revoke it in writing.
(expiration date)

_____ _____/_____/_____
Client, Guardian or Authorized Representative's Signature Date
(With Copy of Authority Attached)

_____ _____/_____/_____
Witness/Staff Member's Signature Date
Revised 5/15, 9/18

4.8.11 HOPWA – HOUSING STABILITY SERVICE PLAN

Client Name: _____ Date: ____/____/____

11 Character Code: | | | | | | | | | | | |

DEFINITION: The objectives of HOPWA programs are to ensure that clients:

1. Maintain housing stability.
2. Avoid homelessness.
3. Experience increased access to health care and HIV-related treatment.
4. Establish or maintain ongoing permanent housing.

The Housing Stability Service Plan is intended to assist the client/household to accomplish the above objectives by identifying problems and barriers and eventual solutions to them. The initial Housing Stability Service Plan establishes with the client goals and objectives that guide the client to the 4 objectives above. It is a "living document" and may be updated, amended, or replaced when the client, the Housing Specialist or Housing Case Manager agree that it is necessary or beneficial to meet the objectives.

In order to maintain their housing assistance clients must comply with the Housing Stability Service Plan. The client is responsible for completing those portions upon which they have agreed to, as is the Housing Specialist or Case Manager on services upon which they have agreed to assist.

STRMU/TBRA/PHP Assessment and Housing Stability Service Plain

Income Assessment

- ☐ No Income
- ☐ Inadequate income and/or spontaneous or inappropriate spending
- ☐ Can meet basic needs with subsidy; appropriate assistance
- ☐ Can meet basic needs and manage debt without assistance
- ☐ Income is sufficient, well managed; has discretionary income and is able to save
- ☐ Not applicable

The following plan and referrals were agreed upon and given: _____

_____

Anticipated Date of Completion: _____/_____/_____

Employment Assessment

- ☐ No job
- ☐ Employed full-time; inadequate; few or no benefits
- ☐ Employed full-time with adequate pay and benefits
- ☐ Temporary, part-time or seasonal; inadequate pay; no benefits
- ☐ Maintains permanent employment with adequate income and benefits
- ☐ Not applicable

The following plan and referrals were agreed upon and given: _____

_____

Anticipated Date of Completion: _____/_____/_____

Housing Assessment

- ☐ Homeless or threatened with eviction
- ☐ In transitional, temporary or substandard housing; and/or current rent/mortgage is unaffordable
- ☐ In stable housing that is safe but only marginally adequate
- ☐ Household is safe, adequate, subsidized housing
- ☐ Household is safe, adequate, unsubsidized housing
- ☐ Not applicable

The following plan and referrals were agreed upon and given: _____

_____

Anticipated Date of Completion: _____/_____/_____

Food Assessment

- ☐ No food or means to prepare it.
- ☐ Household is on food stamps
- ☐ Can meet basic food needs but requires occasional assistance
- ☐ Can meet basic food needs without assistance
- ☐ Can choose to purchase any food household desires
- ☐ Not applicable

The following plan and referrals were agreed upon and given: _____

_____

Anticipated Date of Completion: _____/_____/_____

Childcare Assessment

- ☐ Needs childcare, but none is available/accessible and/or child is not eligible
- ☐ Childcare is unreliable or unaffordable; inadequate supervision is a problem for childcare that is available
- ☐ Affordable subsidized childcare is available but limited
- ☐ Reliable, affordable childcare is available; no need for subsidies
- ☐ Able to select quality childcare of choice
- ☐ Not applicable

The following plan and referrals were agreed upon and given: _____

_____

Anticipated Date of Completion: _____/_____/_____

Children's Education Assessment

- ☐ One or more eligible children not enrolled in school.
- ☐ One or more eligible children enrolled in school, but not attending classes.
- ☐ Enrolled in school, but one or more children only occasionally attending classes
- ☐ Enrolled in school and attending classes most of the time
- ☐ All eligible children enrolled and attending on a regular basis and making progress
- ☐ Not Applicable

The following plan and referrals were agreed upon and given: _____

_____

Anticipated Date of Completion: _____/_____/_____

Adult Education Assessment

- ☐ Literacy problems and/or no high school diploma/GED are serious barriers to employment
- ☐ Enrolled in literacy and/or GED program and/or knows sufficient English (language not a barrier to employment)
- ☐ Has high school diploma/GED
- ☐ Needs additional education/training to improve employment situation and/or to resolve literacy problems
- ☐ Has completed education/training needed to become employable. No literacy problems
- ☐ Not Applicable

The following plan and referrals were agreed upon and given: _____

_____

Anticipated Date of Completion: _____/_____/_____

Legal Assessment

- ☐ Current outstanding tickets or warrants or other serious unresolved legal issues
- ☐ Current charges/trial pending; noncompliance with probation/parole/legal issues impacting housing qualifications
- ☐ Fully compliant with probation/parole terms/past non-violent felony convictions/resolving other legal issues
- ☐ Successfully completed probation/parole in past 12 months; no new charges filed; recently resolved other legal issues.
- ☐ No felony criminal history and/or no active criminal justice involvement in more than 12 months
- ☐ Not Applicable

The following plan and referrals were agreed upon and given: _____

_____

Anticipated Date of Completion: _____/_____/_____

Health Care Assessment

- ☐ No medical coverage with immediate need
- ☐ No medical coverage, great difficulty accessing medical care when needed. Some household members in poor health
- ☐ Some members (e.g. children) on Medicaid
- ☐ All members can get medical care when needed but may strain budget
- ☐ All members are covered by affordable, adequate health insurance
- ☐ Not Applicable

The following plan and referrals were agreed upon and given: _____

_____

Anticipated Date of Completion: _____/_____/_____

Life Skills Assessment

- ☐ Unable to meet basic needs such as hygiene, food, activities of daily living
- ☐ Can meet a few but not all needs of daily living without assistance
- ☐ Can meet most but not all daily living needs without assistance
- ☐ Able to meet all basic needs of daily living without assistance
- ☐ Able to provide beyond basic needs of daily living for self and family
- ☐ Not Applicable

The following plan and referrals were agreed upon and given: _____

_____

Anticipated Date of Completion: _____/_____/_____

Mental Health Assessment

- ☐ Danger to self/others; recurring suicidal ideation; experiencing difficulty in daily life due to psychological problems
- ☐ Recurrent mental health symptoms that may affect behavior but not a danger to self/others
- ☐ Mild symptoms may be present but are transient; moderate difficulty in functioning due to mental health problems
- ☐ Minimal symptoms that are expectable responses to life stressors; only slight impairment in functioning
- ☐ Symptoms are absent or rare; good or superior functioning in wide range of activities
- ☐ Not Applicable

The following plan and referrals were agreed upon and given: _____

_____

Anticipated Date of Completion: _____/_____/_____

Substance Abuse Assessment

- ☐ Meets criteria for severe abuse/dependence
- ☐ Meets criteria for dependence; preoccupation with use and/or obtaining drugs/alcohol
- ☐ Client has used during last 6 months
- ☐ No drug use/alcohol abuse in last 6 months
- ☐ Not applicable

The following plan and referrals were agreed upon and given:_____

_____

Anticipated Date of Completion_____

Family Relations Assessment

- ☐ Lack of necessary support from family or friends; abuse is present or there is child neglect
- ☐ Family/friends may be supportive but lack ability or resources to help; potential for abuse or neglect
- ☐ Some support from family/friends; family members acknowledge and seek to change negative behaviors
- ☐ Strong support from family or friends; household members support each other's efforts
- ☐ Has healthy/expanding support network; household is stable and communication is consistently open
- ☐ Not Applicable

The following plan and referrals were agreed upon and given:_____

_____

Anticipated Date of Completion_____

Mobility Assessment

- ☐ No access to transportation, public or private; may have car that is inoperable
- ☐ Transportation is available but unreliable, unpredictable, unaffordable; may have car but no insurance, license, etc.
- ☐ Transportation is available and reliable but limited and/or inconvenient; drivers are licensed and minimally insured
- ☐ Transportation is generally accessible to meet basic travel needs
- ☐ Transportation is readily available and affordable; car is adequately insured
- ☐ Not Applicable

The following plan and referrals were agreed upon and given: _____

_____

Anticipated Date of Completion: _____/_____/_____

Community Involvement Assessment

- ☐ Not applicable due to crisis situation
- ☐ Socially isolated and/or no social skills and/or lacks motivation to become involved
- ☐ Lacks knowledge of ways to become involved
- ☐ Some community involvement, but has barriers such as transportation, childcare issues
- ☐ Actively involved in community
- ☐ Not Applicable

The following plan and referrals were agreed upon and given: _____

_____

Anticipated Date of Completion: _____/_____/_____

Safety Assessment

- ☐ Home or residence is not safe
- ☐ Safety is threatened/temporary protection is available
- ☐ Current level of safety is minimally adequate
- ☐ Environment is safe, however, future of such is uncertain
- ☐ Environment is apparently safe and stable
- ☐ Not Applicable

The following plan and referrals were agreed upon and given: _____

_____

Anticipated Date of Completion: _____/_____/_____

Parenting Skills Assessment

- ☐ There are safety concerns regarding parenting skills
- ☐ Parenting skills are minimal
- ☐ Parenting skills are apparent but not adequate
- ☐ Parenting skills are adequate
- ☐ Parenting skills are well developed
- ☐ Not Applicable

The following plan and referrals were agreed upon and given: _____

_____

Anticipated Date of Completion: _____/_____/_____

Credit History Assessment

☐ No credit history
☐ Outstanding judgments or bankruptcy/foreclosure
☐ Has a credit repair plan
☐ Moderate credit rating
☐ Good credit / manageable debt ratio
☐ Not Applicable

The following plan and referrals were agreed upon and given: _____

_____

Anticipated Date of Completion: _____/_____/_____

Domestic Violence Assessment

☐ Yes* ☐ No ☐ Don't know ☐ Refused

The following plan and referrals were agreed upon and given: _____

_____

Anticipated Date of Completion: _____/_____/_____

* See §4.8.11.1 Notice of Rights Under VAWA; §4.8.11.2 VAWA Certification; §4.8.20.1 VAWA Lease Adendum

Veteran Assessment

Military Branch: ☐ Army ☐ Air Force ☐ Navy ☐ Marines
☐ Other ☐ Don't know ☐ Refused

Military Service Era: _____ **Duration Active Duty (Months):** _____

Discharge Status: ☐ Honorable ☐ General ☐ Medical ☐ Bad contact
☐ Dishonorable ☐ Other ☐ Other than Honorable ☐ Don't know ☐ Refused

Served in a War Zone: ☐ Yes ☐ No ☐ Don't know ☐ Refused

The following plan and referrals were agreed upon and given: _____

_____

Anticipated Date of Completion: _____/_____/_____

By my signature below I attest that I have participated in the development of this Housing Stability Service Plan. I also understand that I am responsible for completing those plans and goals of which I have agreed so as to quality for on-going and future services. If I am unable to fulfill a plan or goal, it is my responsibility to notify my Housing Assistance Specialist or Housing Case Manager, and participate in the revising or creation of a new plan and goal so as to remedy the problem.

Client's Signature: _____ **Date:** _____/_____/_____

Case Manager's Signature: _____ **Date:** _____/_____/_____