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

4.8.4.2 HOPWA INTAKE SUPPLEMENT FORM - OTHER ADULTS IN HOUSEHOLD

PLEASE PRINT THE ANSWERS TO ALL OF THE FOLLOWING QUESTIONS:

HOPWA Client Name: _____ **DATE**: _____/____/_____

Other Adult Name: _____

Housing Assessment:

Current Housing Status:

☐ Homeless ☐ At risk of homelessness
☐ Homeless only under other federal statutes ☐ Fleeing domestic violence
☐ At imminent risk of losing housing ☐ 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:

☐ Literally Homeless ☐ Institutional Situation ☐ Transitional & Permanent Housing Situation

If you chose "Literally Homeless" 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/group home ☐ Hospital/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 Prior Living Situation:

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

Homelessness Assessment:

What was the date of the last time that you had a place to sleep that was not on the streets, emergency shelter, or safe haven? _____/____/_____
Number of times the client has been homeless in the past three years: _____
Total number of months homeless on the street, in emergency shelter, or safe haven in the past 3 years: _____
Homeless status documented: ☐ Yes ☐ No

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 Medical Services ☐ 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: _____

***Barriers Assessment:**

Barriers	Present?	Receiving Treatment	Condition Indefinite?	Impairs ability to live independently	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

If yes, are you currently fleeing? ☐ Yes ☐ No ☐ Don't know ☐ Refused

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 Services		Other Source	
Other TANF Services			

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 ☐ In school
☐ 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 ☐ Don't know ☐ Refused

4.8.21 APPLICATION FOR HOUSING ASSISTANCE PERMANENT HOUSING PLACEMENT

Month_____ Year_____

Last Name:	**First Name:**	**DOB:** / /
Street:	**City:**	**Zip:**
Home Phone: ( ) -	**Cell Phone:** ( ) -	**SS#:** - -

I am requesting Permanent Housing Placement assistance through The Montrose Center, Housing Services Program. I have applied and been approved for residence at the following address:

Property/Owner Name:		
Street:	**City:**	**Zip:**
Expected Move-In Date: / /		

I request assistance with the following bills that are either in my name or my legal spouse's name:

Application/credit check fee:	**Rent Deposit:**
Rent:	**Utilities Deposit:**

I agree to keep confidential the identity, name, or any other information about any other clients I may come in contact with while at the Montrose Center.

I certify that I am not on Section 8 housing. I also certify that I am not receiving, have not applied, nor will I apply for STRMU or TBRA assistance with any other housing agency for the same month in which I have applied for assistance through the Montrose Center, Housing Services Program. I understand that if I apply or have applied for assistance for the same month, then I will be terminated from receiving services at Montrose Center, Housing Services.

I understand that any housing assistance I receive through the Montrose Center can only be used for a residency with smoke detectors.

I confirm that all information I have provided on this form is true to the best of my knowledge.

Client signature:	**Date:** / /

Client Character Code:

	Mailing Address/Vendor	Account#	Amount	Date
Rent				/ /
Deposit				/ /
Other				/ /

2.5.4 CONSENT FOR RELEASE/EXCHANGE OF INFORMATION TO VERIFY ELIGIBILITY FOR SERVICES & FOR CARE COORDINATION

Client 11-Character Code												ARIES Code		

By signing the Consent for Services form, you allow the Center to enter the information you give us during client registration into a database. All identifying information will stay on the Center's computer. The information that is transmitted to the CPCDMS will be identified by the scrambled 11 character code above. If you agree to paragraph 2, your case manager or therapist at the Center will be able to access information through the database about dates when you attended those services. They will not receive details about the visit. This form allows your the Center caregiver to access data to coordinate your services. **It does not allow other agencies to see information about your services here, however authorized data system administrators may view such information stored at the Center site.**

I, _____, Date of Birth _____/_____/_____, hereby authorize the Montrose Center to access the ***Centralized Patient Care Data Management System (CPCDMS) or AIDS Regional Information and Evaluation System (ARIES)*** to verify my enrollment at any agency currently participating in the ***CPCDMS/ARIES*** maintained by Harris County Public Health Services and Department of State Health Services and to verify my receipt of Ryan White A services, Department of State Health Services (DSHS) – HIV/STD or Substance Abuse Services.

Furthermore, I authorize my Case Manager/Care Coordinator to access the encounters information for any Chemical Dependency Treatment, Psychiatric Treatment**,** and/or Professional Counseling services I have received to verify my receipt of these protected services at any of the agencies participating in the ***CPCDMS/ARIES*** maintained by Harris County Public Health Services/Department of State Health Services. I do understand that the content of these services will not be accessed without a separate release of information by me.

The purpose of this exchange is to verify my eligibility for Ryan White A or DSHS funded services provided by this agency and to coordinate my service delivery, monitor the service(s) and is limited to the following specific types of information:

- my registration date and client status (open or closed; active or inactive)
- name of the agency maintaining my client record
- my eligibility expiration date
- my HIV/AIDS status
- my zip code and county of residence
- my financial eligibility level

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 91-6161 as amended by Public Law 93-282; Texas Health & Safety Code, Chapter 81, Section 81.050 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 am authorizing this release/exchange of information of my own free will and with informed consent. I may revoke this consent in writing at any time, except to the extent that action may already have been taken in reliance on it.

Further, I understand that this consent shall expire one (1) year after my last contact with the Montrose Center or one (1) year after the last CPCDMS registration expires whichever is later, or ____ other _____ unless I revoke it as provided for above.

A photographic copy of this authorization shall be considered as effective and valid as the original.

_____ _____/_____/_____ _____

Client's Signature | Date | Parent, Guardian, or Authorized Representative's Signature

2.5.4.2 CONSENT FOR SERVICES – HOPWA & CONSENT FOR EXCHANGE OF INFORMATION & ARIES & HMIS PARTICIPATION

Client 11-Character Code												ARIES Code		

I, _____ wish to receive services provided by the Montrose Center, an agency participating in the ***HMIS*** for HOPWA funded services and ***AIRES*** system for rural HOPWA funded services**.**

Use of a Homeless Management Information System (HMIS) is required by the US Department of Housing and Urban Development (HUD) for agencies that receive certain types of HUD funding. Other funding sources may also require program participation in HMIS. This system is not electronically connected to HUD and is only used by authorized agencies. Center staff accessing the HMIS have received confidentiality training and have signed agreements to protect clients' person information and limits its use appropriately. The HMIS Privacy Policy is available upon request and is posted on the Coalition for the Homeless of Houston/Harris County website (http://www.homelesshouston.org/hmis). Any additional data sharing agreements providing details on how the Center handles client information beyond the baseline HMIS Privacy Policy are available through your case manager. Use of the AIDS Regional Information Exchange System (ARIES) system is maintained by Department of State Health Services – HIV/STD and required by the Texas Department of State Health Services for agencies managing rural HOPWA funds.

I give permission to the Montrose Center to collect and enter my personal, household and service information into the HMIS and/or ARIES. I understand that the HMIS is shared with and used by other authorized agencies in Houston/Harris County for the purposes of:

- Accessing clients' needs in order to provide better assistance and to improve their current or future situations.
- Improving the quality of care and services for people in need.
- Tracking the effectiveness of community efforts to meet the needs of people who have received assistance.
- Reporting data on an aggregate level that does not identify specific people or their personal information.

I understand that my identity and my participation in the ***HMIS*** and ***ARIES*** are confidential. I understand that no information or records associated with my case will be knowingly released to anyone or any agency that is not currently participating in the ***HMIS*** or ***ARIES*** without my informed written consent, or a subpoena, court order or legal statute. Furthermore, I understand that an additional consent for the release/exchange of information to verify my eligibility will be required ***before*** I can receive HOPWA, or Department of State Health Services – HIV/STD funded services. I understand that:

- The information I give about my physical and mental health will not be shared outside the Center.
- I have the right to review my HMIS or ARIES record with an authorized user.
- I am not guaranteed that I will receive requested services by signing this release form.
- All agencies that use HMIS or ARIES will treat my information with respect and in a professional and confidential manner.
- Unauthorized people or organizations cannot gain access to my information without my consent.

I fully release and hold the entity(ies) administering the funding for the service(s) listed above; Coalition for the Homeless of Houston/Harris County, who is the entity responsible for overseeing and maintaining the ***HMIS***; The Resource Group who locally administer rural HOPWA funds, Department of State Health Services who is responsible for overseeing and maintaining ***ARIES***, the 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.

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 §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 six (6) months after my last date of service at the Center, or ____ other _____unless I revoke it as provided for above.

I was given a copy of the Client Handbook which includes my Client Rights and Responsibilities, the Complaint/Grievance Policy, HIPAA Privacy Act notices and procedures provided by the Montrose Center and Houston Housing and Community Development Department. I was offered an opportunity to discuss them in a language and format I understand and I agree to abide by them.

_____ ____/____/____ _____

Client's Signature Date Parent, Guardian, or Authorized Representative's Signature

4.8.5 APPLICATION FOR HOUSING SERVICES-STRMU

MONTH: _____ YEAR: _____

Please Print

Last Name:	**First Name:**	**DOB:** / /
Street:	**City:**	**Zip:**
Home Phone: ( ) -	**Cell Phone:** ( ) -	**SS#:** - -

I am requesting STRMU assistance through the Montrose Center, Housing Services. The emergency or unexpected situation that happened this month is:

I request assistance with the following bills that are either in my name or my legal spouse's name:

Rent/Mortgage: $	**Electricity: $**	**Water: $**	**Gas: $**

I agree to keep confidential the identity, name, or any other information about any other clients I may come in contact with while at the Montrose Center. I certify that I am not on Section 8 housing. I also certify that I am not receiving, have not applied, nor will I apply for STRMU or TBRA assistance with any other housing agency for the same month in which I have applied for assistance through the Montrose Center-Housing Services. I understand that if I apply or have applied for assistance for the same month, then I will be terminated from receiving housing services at the Montrose Center. I understand that any housing assistance I receive through the Montrose Center can only be used for a residence with smoke detectors. I confirm that all information I have provided on this form is true to the best of my knowledge.

Client Signature:	**Date:**

For Office Use Only _____ Approved _____ Denied

Reason for decision: _____

_____

_____

Case Manager's signature: _____ Date: _____/_____/_____

Utility Pledge: **YES/NO** ☐ **Power** ☐ **Water** ☐ **Gas**

Client ID _____

	Mailing Address/Vendor	**Account #**	**Amount**	**Date**
Rent/Mortgage				
Electricity				
Water				
Gas				

4.8.6 DETERMINING HOUSEHOLD INCOME & SUMMARY OF HOUSEHOLD INCOME DATA

INCOME INFORMATION

What is the total annual income of all members in the household? (Include wages, salaries and tips; other income such as alimony, child support, regular contribution/gifts, Unemployment/Disability, Social Security, AFDC and or other benefits) Income Verification Forms must be completed for each source of income listed.

Household Members Full Name Last, First, Middle	Source of Income (employment, SSI/D, Child Support, etc)	Monthly Amount Net	Annual Amount Net	Monthly Amount Gross	Annual Amount Gross
A.					
B.`					
C.					
D.					
		Monthly Total:$	Annual Total:$	Monthly Total:$	Annual Total:$
Case Manager's Signature:_____		Date: _____/_____/_____			

INCOME UPDATE

Household Members Full Name Last, First, Middle	Source of Income (employment, SSI/D, Child Support, etc.)	Monthly Amount Net	Annual Amount Net	Monthly Amount Gross	Annual Amount Gross
A.					
B.`					
C.					
D.					
		Monthly Total:$	Annual Total:$	Monthly Total:$	Annual Total:$
Case Manager's Signature:_____		Date: _____/_____/_____			

INCOME UPDATE

Household Members Full Name Last, First, Middle	Source of Income (employment, SSI/D, Child Support, etc.)	Monthly Amount Net	Annual Amount Net	Monthly Amount Gross	Annual Amount Gross
A.					
B.`					
C.					
D.					
		Monthly Total:$	Annual Total:$	Monthly Total:$	Annual Total:$
Case Manager's Signature:_____		Date: _____/_____/_____			

APPLICATION CERTIFICATION: I/we understand that the above information is being collected to determine if I/we are eligible to receive rental assistance. I/we authorize the STRMU - Program – Housing Assistance to verify all information provided on this application form.

_____ _____ _____/_____/_____
Applicant/Head of Household – Print Name Signature Date

_____ _____ _____/_____/_____
Spouse – Print Name Signature Date

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

4.8.9 HOPWA SHORT-TERM RENT / MORTGAGE / UTILITY ASSISTANCE (STRMU) POLICIES & PROCEDURES

Overview:
The City of Houston – Housing and Community Development – HOPWA Office, in partnership with funded Community-Based Agencies, recognizes the value of a safe, affordable, clean-living environment for individuals and families living with HIV disease. Through the use of HOPWA funds we seeks to empower clients to obtain the ability to live independently of rental and utility subsidies by providing a financial assistance program with a grant from the City of Houston called the Short-Term Rent, Mortgage & Utility assistance program (STRMU).

Purpose:
The U.S. Department of Housing and Urban Development Notice: CPD 06-07 defines STRMU with the following: "The goal of STRMU assistance under the HOPWA program is to provide short-term interventions that help maintain stable living environments for households who are experiencing a financial crisis as a result of issues arising from their HIV/AIDS condition. It seeks to foster long-term solutions to housing problems for participants receiving this time-limited housing assistance. This is done by the creation and use of individual housing service plans. The goals should involve efforts of the participant to restore them to self-sufficiency and future independence from the need for housing support." (p.2)

"As a short-term intervention tool, STRMU assistance is not intended to provide continuous or perpetual assistance. STRMU assistance is 'needs-based' and intended to benefit clients who are temporarily unable to meet their monthly housing and utility expenses due to unexpected situations. STRMU assistance should be connected to the establishment of a related individual housing service plan to address those needs." (p.5)

"STRMU is a 'needs-based' program; therefore, clients must demonstrate the level of benefits needed through verifiable documentation. Program staff (the Case Manager) are responsible for verifying and documenting the participant's inability to make required payments. The assessed needs must be: 1) for actual costs, 2) that household income is not reasonably available to address the needs, 3) that the STRMU payments will prevent eviction or utility cut-off and, 4) that the on-going housing needs were assessed in connection with the development of the housing service plan. STRMU payments must not be used to relieve the household responsibility for their rent, mortgage or utility payments in the absence of an *inability* to pay." (p.6)

A participant is defined as anyone living in the household who receives Short Term-Rental Assistance. All participants seeking Short-Term Rent / Mortgage / Utility (STRMU) Assistance are required to comply with the following program rules and regulations as a condition of receiving STRMU.

GUIDELINES:

1.0 Eligibility for Assistance

1.1 To qualify a participant must become a client (or be a current client) of a HOPWA funded agency (Current status requires proof of HIV/AIDS diagnosis (Western Blot lab report with client's preprinted name on it or a statement on letterhead signed by a physician, physician's assistant or a nurse practitioner), picture ID (drivers' license, business employee ID, passport), proof of income or lack thereof (check stubs, SSI, VA or other disability award letter, tax returns, employment verification letter on company letterhead, copy of current bank statement), and verification of residency (lease, mortgage coupon, letter on letterhead from apartment complex office) within the Houston EMSA, and active or updated in the agency's data base systems.

1.2 Receipt of assistance is subject to approval by the HOPWA Homeless Management Information System (HMIS) clearinghouse. A participant and their household cannot receive STRMU

assistance from more than one provider within the same month. Any participant found "double-dipping" (getting STRMU assistance from another provider within the same month) is subject to dismissal and suspension from the program.

1.3 Participants must submit the required documentation prior to receiving assistance. Participants who falsify any documents or provide inaccurate information of any kind including, but not limited to, medical information, household size or composition, or income are subject to termination from the program. The required documents, which must be in the client's (or legal guardian) name are:

A. Proof of gross income of all adult members of the household (for past 2 to 4 months to current) or zero income. If claiming zero income the participant(s) must provide the following:

1. Proof of when last employed, or when you last had income and what was the source.

2. Or proof of how household expenses (rent, etc.) have been paid up until time of application.

B. Current complete, signed lease / lease renewal or mortgage payment slip that indicates monthly payment and, if applicable, late charge, penalty and *Non-Sufficient Fund* fees clearly outlined by the lease. (If there are additional names on the lease proof must be provided that they are under 18 years of age (birth certificates & social security cards) or that they are family members who are part of the household (in which case they must provide picture ID, social security cards and income information). If no proof is available then the rent will be divided by the number of non-family adults. *If primary participant is listed as an "occupant" then proof of past and current financial responsibility toward payment of rent must be provided*.

C. If claiming eviction then current eviction notice or mortgage default letter is required.

D. Current utility bill in the participant's or eligible household member's name (electric, water, or natural/propane gas only when seeking utility assistance in addition to rent/mortgage, or by itself). If claiming cut-off of utility then cut-off notice is required.

E. Completion by the manager/landlord/mortgage company of the W-9 form.

F. Full completion of Acceptance of Pledge Form by the manager/landlord/mortgage company.

G. Receipts of claimed expenses (such as, prescriptions, doctor/clinic/medical bills, house repairs, car repair, etc.) that are no more than 30 days old and that show they are paid.

H. Receipt of documents must be complete by the deadline date that is determined during the appointment with the HOPWA staff person. If the deadline date passes and no contact from the participant is received, it will be assumed that the assistance is no longer needed.

1.4 Rent / Mortgage assistances amounts are subject to the following rules:

A. The amount of assistance is determined by the Assistance Calculation Worksheet.

B. Participants with income are subject to the limit of the Fair Market Rate (FMR) as defined by HUD FMR for Houston and participating metropolitan areas and surrounding counties.

1. Individuals or married couples without children qualify for the FMR of an efficiency or a one bedroom dwelling.

2. Families (individuals with children or couples with children) qualify for a 2 or more bedroom dwelling (depending on the number and age of the children).

C. Participants without income are subject to the actual amount of rent allowed by Assistance Calculation Form Worksheet.

1.5 Participants who live in a HOPWA, HUD assisted/rent reduced facility, or receive Housing Choice Vouchers (formerly called Section 8) rental subsidy, or any other subsidy from a federal, state or local source, may not receive STRMU assistance.

1.6 Participants cannot receive STRMU assistance if the owner of the property from whom they are renting is the parent, child, grandparent, grandchild, sister, brother or any other member of the family, including by marriage. *The exception to renting from a relative can only be allowed when the participant is renting a unit/room from the adult family member and a "reasonable accommodation" is determined necessary by a physician for the client's health and wellbeing.*

2.0 Participant Responsibilities During the Term of Assistance

2.1 Participants must provide all requested documentation by the deadline given by the Housing Assistance Specialist throughout their term on the program. Failure to provide documentation may constitute grounds for dismissal for that month's assistance.

2.2 Participants must abide by all provisions in their lease/loan, and must pay their portion of the rent/mortgage to the landlord/mortgage company in accordance with their lease/loan.

2.3 Participants must notify the Housing Assistance Specialist immediately of any changes in household size, composition, or income. Failure to report changes may constitute grounds for disqualification of current and/or future assistance.

2.4 Participants must complete a **Housing Stability Service Plan** with the Housing Assistance Specialist. The Housing Plan will guide the participant to additional resources, opportunities and services (such as employment, more affordable housing, Food Stamps {Lone Star Card}, TANF, Link Up America, Housing Choice Vouchers, etc.), and with budget counseling it will increase household income and guide the participant to decrease unnecessary household expenses. The Housing Stability Service Plan will provide the client with realistic goals so that in the long-term the client will live within their means. Failure to follow through with the Housing Stability Service Plan agreement may result in a delay or disqualification in assistance from the program.

2.5 Participants who have a regular case manager through another agency must have their case manager participate in the assistance process and service planning. It is the responsibility of the client, with their regular case manager, to work with the Housing Assistance Specialist to develop a plan for long-term stability (such as, seeking better income, more affordable housing, applying for Housing Choice Vouchers aka Section 8, etc.). Clients must supply the Housing Assistance Specialist with a copy of their plan that they and their regular case manager have developed.

3.0 Limits of Liability

3.1 The lease is a contract between the tenant and landlord only. The providing agency, **the Montrose Center,** assumes no responsibility or liability whatsoever arising from the lease agreement between any STRMU program participant and the landlord/owner.

3.2 All STRMU Assistance Program Awards are contingent upon receipt of funds from the grantor. The City of Houston and associated community-based agencies that receive HOPWA funding for distribution, bear no responsibility to continue assistance to clients if the contract with the grantee is discontinued or reduced for any reason.

3.3 The participant understands that the ***STRMU Policies and Procedures*** are a supplement to any obligations set forth in the lease. By signing this document, the participant is in no way released from compliance with any additional responsibilities as stated in the lease or as may be applicable through federal, state, or local law.

4.0 Supplemental Policies & Procedures Particular to Agency Providing Services

STRMU providers that are community-based may have some additional policies and procedures that are particular to their agency. Such additional information may be attached to this document and is valid and binding upon approval by the City of Houston – Housing and Community Development – HOPWA Office and by consenting signature of applicant.

EVERY RESIDENCE/DWELLING MUST HAVE WORKING SMOKE ALARMS IN ACCORDANCE WITH FEDERAL, STATE, AND LOCAL LAWS.

4.1 Client sessions are scheduled and coordinated between the Case Manager and client. The case management session has a duration of sixty (60) minutes for intake and assessment, fifteen (15) or thirty (30) minutes for brief simple follow-up or fifty (50) minutes for complex followup. Requests to extend the duration of the session, must be established, at the time, appointment is scheduled.

PARTICIPANT DECLARATION:

I understand the Policies and Procedures of the HOPWA Short-term Rent, Mortgage and Utility Assistance Program, and agree to abide by them. I understand that any violation can lead to cancellation of service.

I understand any falsification of records or statements may lead to criminal and/or civil charges and prosecution and restitution payments of any resulting from fraudulent records or statements.

By my signature below I verify that my residence has working Smoke Alarms in accordance with federal, state, and local laws.

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

_____ _____/_____/_____
Staff Member's Signature Date

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		

18.1.3.36 CONSENT FOR THE RELEASE/EXCHANGE OF INFORMATION – HOPWA

I, _____ (phone: ____/_____-_____,
Print Client's Name

email: _____@_____._____), _____/_____/____, authorize Montrose Center,
Date of Birth

to exchange information with the agencies and/or individuals identified below. This is to access community resources and/or services regarding any or all of the following:

_____ Proof of Identity
_____ HIV status
_____ Eligibility documents: _____
_____ Medical records: _____
_____ Other: _____

This consent may be revoked in writing by the undersigned at any time except to the extent that action may already have been taken on it.

A photocopy of this form shall be considered as effective and valid as the original.

NAME	RELATIONSHIP	PHONE NUMBER
City of Houston, HCD	Powersource	
Housing & Urban Development (HUD)	HOPWA Programs	
Bering Omega Community Service	Financial Assistance	
AIDS Foundation Houston	Financial Assistance	
Houston Area Community Services	Financial Assistance	
Catholic Charities	Financial Assistance	
Brentwood Community Foundation	Financial Assistance	
New Hope Counseling Center	Financial Assistance	
St. Hope Foundation	Financial Assistance	
	Emergency Contact	
	Utility	
	Utility	

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.

I UNDERSTAND THAT THIS CONSENT SHALL EXPIRE ONE YEAR FROM DATE SIGNED. THIS FORM WAS:_____ EXPLAINED TO ME or _____ READ BY ME, AND I UNDERSTAND IT'S MEANING. ALL THE BLANKS WERE FILLED IN BEFORE THE FORM WAS SIGNED BY ME.

_____ _____/_____/_____
Client's Signature or mark (if of legal age and legally competent) Date

_____ _____/_____/_____
Parent/Guardian/Power of Attorney's Signature Date

_____ _____/_____/_____
Printed Name of Witness Date

_____ _____/_____/_____
Witness's Signature Date

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

THIS PAGE MUST BE USED FOR EACH MONTH OF STRMU ASSISTANCE AS NEEDED

City of Houston – HOPWA – STRMU

4.8.10 APPLICANT'S DECLARATION & CERTIFICATION OF ZERO ($ Ø.00) INCOME

I, _____, _____/_____/_____, _____-_____-_____
NAME (PRINT) DATE OF BIRTH SOCIAL SECURITY NUMBER
have applied for services with the Montrose Center

I have stated that during this verification process I have no income at this time. I have not received any income since _____/_____/_____.
DATE

I do not expect to receive any income until: _____/_____/_____.
DATE

Reason for no Income: _____

_____

_____

_____

I CERTIFY that my statements regarding my income are true.

_____ _____/_____/_____
Participant/Co-Participant, Guardian or Authorized Representative's Signature Date
(With Copy of Proper Legal Authority Attached)

_____ _____/_____/_____
Staff Member's Signature Date

THIS PAGE MUST BE USED FOR EACH MONTH OF STRMU ASSISTANCE AS NEEDED

City of Houston – HOPWA - STRMU

4.8.10.1 APPLICANT'S DECLARATION & CERTIFICATION OF NO CHILD SUPPORT

($ Ø.00) Income

I, _____, _____/_____/_____, _____-_____-_____
NAME (PRINT) DATE OF BIRTH SOCIAL SECURITY NUMBER
have applied for services with the Montrose Center

I have stated that during this verification process I have no child support income at this time. I have not received any child support income since _____/_____/_____.
DATE

I do not expect to receive any child support income until: _____/_____/_____.
DATE

Reason for no Income: _____

_____

_____

_____

I CERTIFY that my statements regarding my child support income are true.

_____ _____/_____/_____
Participant/Co-Participant, Guardian or Authorized Representative's Signature Date
(With Copy of Proper Legal Authority Attached)

_____ _____/_____/_____
Staff Member's Signature Date

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:** _____/_____/_____

4.8.11.1 NOTICE OF OCCUPANCY RIGHTS UNDER THE VIOLENCE AGAINST WOMEN ACT

the Montrose Center
Notice of Occupancy Rights under the Violence Against Women Act

To all Tenants and Applicants

The Violence Against Women Act (VAWA) provides protections for survivors of domestic violence, dating violence, sexual assault, or stalking. VAWA protections are not only available to women, but are available equally to all individuals regardless of race, color, national origin, religion, sex, familial status, disability, or age, actual or perceived sexual orientation, gender identity, or marital status. The U.S. Department of Housing and Urban Development (HUD) is the Federal agency that oversees that the Montrose Center is in compliance with VAWA. This notice explains your rights under VAWA. A HUD-approved certification form is attached to this notice. You can fill out this form to show that you are or have been a survivor of domestic violence, dating violence, sexual assault, or stalking, and that you wish to use your rights under VAWA.

Protections for Applicants

If you otherwise qualify for assistance under the Montrose Center**,** you cannot be denied admission or denied assistance because you are or have been a survivor of domestic violence, dating violence, sexual assault, or stalking.

Protections for Tenants

If you are receiving assistance under the Montrose Center, you may not be denied assistance, terminated from participation, or be evicted from your rental housing because you are or have been a survivor of domestic violence, dating violence, sexual assault, or stalking.

Also, if you or an affiliated individual of yours is or has been the survivor of domestic violence, dating violence, sexual assault, or stalking by a member of your household or any guest, you may not be denied rental assistance or occupancy rights under the Montrose Center solely on the basis of criminal activity directly relating to that domestic violence, dating violence, sexual assault, or stalking.

Affiliated individual means your spouse, parent, brother, sister, or child, or a person to whom you stand in the place of a parent or guardian (for example, the affiliated individual is in your care, custody, or control); or any individual, tenant, or lawful occupant living in your household.

Removing the Abuser or Perpetrator from the Household

HP may divide (bifurcate) your lease in order to evict the individual or terminate the assistance of the individual who has engaged in criminal activity (the abuser or perpetrator) directly relating to domestic violence, dating violence, sexual assault, or stalking.

If the Center chooses to remove the abuser or perpetrator, the Center may not take away the rights of eligible tenants to the unit or otherwise punish the remaining tenants. If the evicted abuser or perpetrator was the sole tenant to have established eligibility for assistance under the program, the Center must allow the tenant who is or has been a survivor and other household members to remain in the unit for a period of time, in order to establish eligibility under the program or under another HUD housing program covered by VAWA, or, find alternative housing.

In removing the abuser or perpetrator from the household, the Center must follow Federal, State, and local eviction procedures. In order to divide a lease, the Center may, but is not required to, ask you for documentation or certification of the incidences of domestic violence, dating violence, sexual assault, or stalking.

Moving to Another Unit

Upon your request, HP may permit you to move to another unit, subject to the availability of other units, and still keep your assistance. In order to approve a request, the Center may ask you to provide documentation that you are requesting to move because of an incidence of domestic violence, dating violence, sexual assault, or stalking.

If the request is a request for emergency transfer, the housing provider may ask you to submit a written request or fill out a form where you certify that you meet the criteria for an emergency transfer under VAWA. The criteria are:

1. You are a survivor of domestic violence, dating violence, sexual assault, or stalking. If your housing provider does not already have documentation that you are a survivor of domestic violence, dating violence, sexual assault, or stalking, your housing provider may ask you for such documentation, as described in the documentation section below.
2. You expressly request the emergency transfer. Your housing provider may choose to require that you submit a form, or may accept another written or oral request.
3. You reasonably believe you are threatened with imminent harm from further violence if you remain in your current unit. This means you have a reason to fear that if you do not receive a transfer you would suffer violence in the very near future.

OR

You are a survivor of sexual assault and the assault occurred on the premises during the 90-calendar-day period before you request a transfer. If you are a survivor of sexual assault, then in addition to qualifying for an emergency transfer because you reasonably believe you are threatened with imminent harm from further violence if you remain in your unit, you may qualify for an emergency transfer if the sexual assault occurred on the premises of the property from which you are seeking your transfer, and that assault happened within the 90-calendar-day period before you expressly request the transfer.

HP will keep confidential requests for emergency transfers by survivors of domestic violence, dating violence, sexual assault, or stalking, and the location of any move by such survivors and their families.

HP's emergency transfer plan provides further information on emergency transfers, and HP must make a copy of its emergency transfer plan available to you if you ask to see it.

Documenting You Are or Have Been a Survivor of Domestic Violence, Dating Violence, Sexual Assault or Stalking

The Center can, but is not required to, ask you to provide documentation to "certify" that you are or have been a survivor of domestic violence, dating violence, sexual assault, or stalking. Such request from the Center must be in writing, and the Center must give you at least 14 business days (Saturdays, Sundays, and Federal holidays do not count) from the day you receive the request to provide the documentation. The Center may, but does not have to, extend the deadline for the submission of documentation upon your request.

You can provide one of the following to the Center as documentation. It is your choice which of the following to submit if the Center asks you to provide documentation that you are or have been a survivor of domestic violence, dating violence, sexual assault, or stalking.

- A complete HUD-approved certification form given to you by the Center with this notice, that documents an incident of domestic violence, dating violence, sexual assault, or stalking. The form will ask for your name, the date, time, and location of the incident of domestic violence, dating violence, sexual assault, or stalking, and a description of the incident. The certification form provides for including the name of the abuser or perpetrator if the name of the abuser or perpetrator is known and is safe to provide.
- A record of a Federal, State, tribal, territorial, or local law enforcement agency, court, or administrative agency that documents the incident of domestic violence, dating violence, sexual assault, or stalking. Examples of such records include police reports, protective orders, and restraining orders, among others.
- A statement, which you must sign, along with the signature of an employee, agent, or volunteer of a survivor service provider, an attorney, a medical professional or a mental health professional (collectively, "professional") from whom you sought assistance in addressing domestic violence, dating violence, sexual assault, or stalking, or the effects of abuse, and with the professional selected by you attesting under penalty of perjury that they believes that the incident or incidents of domestic violence, dating violence, sexual assault, or stalking are grounds for protection.

- Any other statement or evidence that HP has agreed to accept.

If you fail or refuse to provide one of these documents within the 14 business days, the Center does not have to provide you with the protections contained in this notice.

If the Center receives conflicting evidence that an incident of domestic violence, dating violence, sexual assault, or stalking has been committed (such as certification forms from two or more members of a household each claiming to be a survivor and naming one or more of the other petitioning household members as the abuser or perpetrator), the Center has the right to request that you provide third-party documentation within thirty 30 calendar days in order to resolve the conflict. If you fail or refuse to provide third-party documentation where there is conflicting evidence, the Center does not have to provide you with the protections contained in this notice.

Confidentiality

The Center must keep confidential any information you provide related to the exercise of your rights under VAWA, including the fact that you are exercising your rights under VAWA.

The Center must not allow any individual administering assistance or other services on behalf of the Center (for example, employees and contractors) to have access to confidential information unless for reasons that specifically call for these individuals to have access to this information under applicable Federal, State, or local law.

The Center must not enter your information into any shared database or disclose your information to any other entity or individual. The Center, however, may disclose the information provided if:

- You give written permission to the Center to release the information on a time limited basis.
- The Center needs to use the information in an eviction or termination proceeding, such as to evict your abuser or perpetrator or terminate your abuser or perpetrator from assistance under this program.
- A law requires the Center or your landlord to release the information.

VAWA does not limit the Center's duty to honor court orders about access to or control of the property. This includes orders issued to protect a survivor and orders dividing property among household members in cases where a family breaks up.

Reasons a Tenant Eligible for Occupancy Rights under VAWA May Be Evicted or Assistance May Be Terminated

You can be evicted and your assistance can be terminated for serious or repeated lease violations that are not related to domestic violence, dating violence, sexual assault, or stalking committed against you. However, the Center cannot hold tenants who have been victims of domestic violence, dating violence, sexual assault, or stalking to a more demanding set of rules than it applies to tenants who have not been survivors of domestic violence, dating violence, sexual assault, or stalking.

The protections described in this notice might not apply, and you could be evicted and your assistance terminated, if the Center can demonstrate that not evicting you or terminating your assistance would present a real physical danger that:

1. Would occur within an immediate time frame, and
2. Could result in death or serious bodily harm to other tenants or those who work on the property.
3. If the Center can demonstrate the above, the Center should only terminate your assistance or evict you if there are no other actions that could be taken to reduce or eliminate the threat.

Other Laws

VAWA does not replace any Federal, State, or local law that provides greater protection for survivors of domestic violence, dating violence, sexual assault, or stalking. You may be entitled to additional housing protections for survivors of domestic violence, dating violence, sexual assault, or stalking under other Federal laws, as well as under State and local laws.

Non-Compliance with the Requirements of This Notice

You may report a covered housing provider's violations of these rights and seek additional assistance, if needed, by contacting or filing a complaint with **Houston Housing and Community Development, 2100 Travis Street, 9th Floor, Houston, TX 77002 832.394.6200 hcdd@houstontx.gov** or **US Housing and Urban Development, Houston field Office 1301 Fannin Street, Suite 2200, Houston, TX 77002 713.718.3199**

For Additional Information

You may view a copy of HUD's final VAWA rule at https://www.federalregister.gov/documents/2016/11/16/2016-25888/violence-against-women-reauthorization-act-of-2013-implementation-in-hud-housing-programs

Additionally, HP must make a copy of HUD's VAWA regulations available to you if you ask to see them.

For questions regarding VAWA, please contact **your case manager at the Montrose Center.**

For help regarding an abusive relationship, you may call the National Domestic Violence Hotline at 1-800-799-7233 or, for persons with hearing impairments, 1-800-787-3224 (TTY). You may also contact **the Anti-Violence Program at the Montrose Center**.

For tenants who are or have been victims of stalking seeking help may visit the National Center for Victims of Crime's Stalking Resource Center at https://www.victimsofcrime.org/our-programs/stalking-resource-center

For help regarding sexual assault, you may contact **the Anti-Violence Program at the Montrose Center 713.529.0037**

Survivors of stalking seeking help may contact **the Anti-Violence Program at the Montrose Center 713.529.0037**

Attachment: Certification form HUD-5382 §4.8.11.3

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Expires 06/30/2017

4.8.11.2 CERTIFICATION OF DOMESTIC VIOLENCE, DATING VIOLENCE, SEXUAL ASSAULT OR STALKING AND ALTERNATIVE DOCUMENTATION

Purpose of Form: The Violence Against Women Act ("VAWA") protects applicants, tenants, and program participants in certain HUD programs from being evicted, denied housing assistance, or terminated from housing assistance based on acts of domestic violence, dating violence, sexual assault, or stalking against them. Despite the name of this law, VAWA protection is available to victims of domestic violence, dating violence, sexual assault, and stalking, regardless of sex, gender identity, or sexual orientation.

Use of This Optional Form: If you are seeking VAWA protections from the Montrose Center, the Center may give you a written request that asks you to submit documentation about the incident or incidents of domestic violence, dating violence, sexual assault, or stalking.

In response to this request, you or someone on your behalf may complete this optional form and submit it the Center, or you may submit one of the following types of third-party documentation:

1. A document signed by you and an employee, agent, or volunteer of a survivor service provider, an attorney, or medical professional, or a mental health professional (collectively, "professional") from whom you have sought assistance relating to domestic violence, dating violence, sexual assault, or stalking, or the effects of abuse. The document must specify, under penalty of perjury, that the professional believes the incident or incidents of domestic violence, dating violence, sexual assault, or stalking occurred and meet the definition of "domestic violence," "dating violence," "sexual assault," or "stalking" in HUD's regulations at 24 CFR 5.2003.
2. A record of a Federal, State, tribal, territorial or local law enforcement agency, court, or administrative agency; or
3. At the discretion of the housing provider, a statement or other evidence provided by the applicant or tenant.

Submission of Documentation: The time period to submit documentation is 14 business days from the date that you receive a written request from the Center asking that you provide documentation of the occurrence of domestic violence, dating violence, sexual assault, or stalking. The Center may, but is not required to, extend the time period to submit the documentation, if you request an extension of the time period. If the requested information is not received within 14 business days of when you received the request for the documentation, or any extension of the date provided by the Center, the Center does not need to grant you any of the VAWA protections. Distribution or issuance of this form does not serve as a written request for certification.

Confidentiality: All information provided to the Center concerning the incident(s) of domestic violence, dating violence, sexual assault, or stalking shall be kept confidential and such details shall not be entered into any shared database. Employees of your housing provider are not to have access to these details unless to grant or deny VAWA protections to you, and such employees may not disclose this information to any other entity or individual, except to the extent that disclosure is: (i) consented to by you in writing in a time-limited release; (ii) required for use in an eviction proceeding or hearing regarding termination of assistance; or (iii) otherwise required by applicable law.

U.S. Department of Housing and Urban Development
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Exp. 06/30/2017

TO BE COMPLETED BY OR ON BEHALF OF THE SURVIVOR OF DOMESTIC VIOLENCE, DATING VIOLENCE, SEXUAL ASSAULT, OR STALKING

Date the written request is received by client: _____/_____/_____

Name of client: _____

Your name (if different from client's): _____

Name(s) of other family member(s) listed on the lease: _____

_____

Residence of client: _____

Name of the accused perpetrator (if known and can be safely disclosed): _____

Relationship of the accused perpetrator to the client: _____

Date(s) and time(s) of incident(s) (if known): _____

Location of incident(s): _____

In your own words, briefly describe the incident(s): _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

This is to certify that the information provided on this form is true and correct to the best of my knowledge and recollection, and that the individual named above in Item 2 is or has been a victim of domestic violence, dating violence, sexual assault, or stalking. I acknowledge that submission of false information could jeopardize program eligibility and could be the basis for denial of admission, termination of assistance, or eviction.

Client's Signature: _____

Public Reporting Burden: The public reporting burden for this collection of information is estimated to average 1 hour per response. This includes the time for collecting, reviewing, and reporting the data. The information provided is to be used by the housing provider to request certification that the applicant or tenant is a victim of domestic violence, dating violence, sexual assault, or stalking. The information is subject to the confidentiality requirements of VAWA. This agency may not collect this information, and you are not required to complete this form, unless it displays a currently valid Office of Management and Budget control number.

4.8.12 ON-GOING FOLLOW-UP PLAN

☐ On-Going Follow-Up Housing Stability Service Plan

Referrals/ Plan:

_____

_____

_____

_____

_____

_____

_____

_____ _____/_____/_____
Client, Guardian or Authorized Representative's Signature Date
(Copy of authorizing documentation present in file)

_____ _____/_____/_____
Staff Member's Signature Date

☐ On-Going Follow-Up Housing Stability Service Plan

Referrals/ Plan:

_____

_____

_____

_____

_____

_____

_____

_____ _____/_____/_____
Client, Guardian or Authorized Representative's Signature Date
(Copy of authorizing documentation present in file)

_____ _____/_____/_____
Staff Member's Signature Date