

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

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 Native Hawaiian or Pacific Islander
 Asian White
 Black or African American

Ethnicity: Hispanic Non-Hispanic

Marital Status:

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

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:
		/ /						Y N
		/ /						Y N
		/ /						Y N
		/ /						Y N
		/ /						Y N
		/ /						Y N

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

Financial Assessment:

Cash Income

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

Non-cash Benefits

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

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

Employment Assessment:

Employed: Yes No Don't know Refused

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

How many hours worked in last week: _____

Employment Tenure: Permanent Temporary Seasonal
 Don't Know Refused

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

Education Assessment:

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

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

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

If post-secondary, what type of degree: _____

Health Assessment:

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

If female, pregnancy status: Yes No

 Client's Signature _/_/_/_____
Date

Case Manager Use Only

Services received by Client:
 ___ Housing Assistance
 ___ Case Management/Care
 Coordination

11.2.9 CONSENT FOR EMERGENCY MEDICAL CARE

Client Name: _____

Medical

Conditions: _____

Drug

Allergies: _____

Physician's Name: _____

Physician's

Address: _____

Physician's Phone

Number(s): (____)____-____ (____)____-____

MEDICAL FACILITY DESIGNATED BY CLIENT TO PROVIDE EMERGENCY CARE:

Facility: _____

Phone

Number(s): (____)____-____ (____)____-____

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

Name: _____

Address: _____

Relationship: _____

Phone

Number(s): (____)____-____ (____)____-____

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

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

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

Client's Signature

____/____/____
Date

Parent, Guardian, or Authorized
Representative's Signature

1.1 STATEMENT OF CLIENT RIGHTS & RESPONSIBILITIES

RIGHTS

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

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

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

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

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

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

- 3. Research:** Clients have the right to refuse to participate in research without affecting access to services.
- 4. Informed Consent:** Clients have the right to give informed consent or to refuse treatment and to be advised of the consequences of such a decision. Informed consent includes information about the condition to be treated; the proposed treatment; risks, side effects, and benefits of all proposed treatments; alternative treatments and which ones might be appropriate; probable physical and mental health consequences if treatment is refused; and expected length of stay. If a client is disoriented or lacks the capacity to understand 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) | Harris Center for Mental Health and IDD | Pink Giraffe |
| Access Care | Harris Co. Community Dev. Agency (HCCDA) | PRIDE Charities |
| ADORE | Harris Co. Guardianship Payer | Recenter Houston |
| AIDS Foundation Houston (AFH) | Harris Co. Juvenile Probation | Reliant Energy |
| AIDS Housing Coalition Houston | Harris County Rides | St. Hope Foundation |
| Alliance for Multicultural Community Services | Harris Co. Sheriff's Department (Jail) | St. Vincent de Paul Society |
| American Red Cross | Harris Co. Psychiatric Center (HCPC) | Salvation Army |
| Area Agency on Aging | Harris Co. Social Services | Second Blessings |
| AssistHers | Health and Human Services Commission | Sheltering Arms Senior Services |
| Assoc. Advancement of Mexican Americans (AAMA) | Healthcare for the Homeless | SNAP – Spay & Neuter Assistance Program |
| ASPCA | Houston Galveston Trauma Institute | Social Security Administration |
| Assurance Wireless | Houston Area Assistance Ministries | Southeast Area Ministries |
| AT&T | Houston Area Parkinson's Society | SETX Transitional Center |
| Avenue 360 | Houston Area Women's Center | South Texas College of Law |
| Baker-Ripley Neighborhood Center | Housing Authority of the City of Houston | Southeast Texas Legal Clinic |
| Beacon | Houston Center for Independent Living | Southside Pharmacy |
| Bee Busy | Houston Compass | Southwest Area Ministries |
| Braes Interfaith Ministries | Houston Food Bank | Star of Hope |
| Bread of Life, Inc. | Houston Hospice | SER Jobs for Progress |
| Brentwood Foundation | Houston Humane Society | Texas Board of Pardon/Parole – TDCJ |
| Career & Recovery Resources, Inc. | Houston Volunteer Lawyers Program, Inc. | Texas Commission for the Blind |
| Career Gear | Interfaith Care Partners | Texas Dept. of Criminal Justice/Parole |
| Catholic Charities of the Archdiocese of Gal.- Houston | Interfaith Ministries for Greater Houston | Texas Dept of Health & Human Services |
| Center for AIDS Info. and Advocacy | Jewish Family Services | Texas Dept. of Protective Family Service |
| CenterPoint Energy | Kroger Pharmacy | Texas HIV Medication Prog. (ADAP) |
| City of Houston – Mayor's Assistance Program | Lambda | Texas Workforce Solutions |
| Community Family Center | Lazarus House | Triangle AIDS Network |
| Change Happens! | Legacy Community Health | United Way of Greater Houston |
| Children's Protective Services (CPS) | Lighthouse of Houston | University of Houston College of Optometry |
| City of Houston – Water Department | Loaves and Fishes | University of Houston Law Center |
| Community Endowment Fndtn. (Swehla House) | Lone Star Legal Aid | University of Houston Speech & Hearing |
| Cottage Thrift Store | Lord of the Streets | USCIS – Citizenship & Immigration |
| The Council on Recovery | Memorial Assistance Ministries | U.S. Vets Initiative |
| CVS Pharmacy | Metropolitan Transit Authority (METRO) | UTMB Galveston/Conroe |
| Cypress Assistance Ministries | North Channel Assistance Ministries | Veterans Administration Medical Cntr (VA) |
| Dress for Success | Northwest Assistance Ministries | Viiv Healthcare |
| Family Services of Greater Houston | Palmer Way Station | Visiting Nurse Association (VNA) |
| First Presbyterian Church: Operation ID | PAWS Houston | Volunteers of America |
| Gilead Sciences, Inc. | Pet Patrol | Walgreens Pharmacy |
| Goodwill Houston | PetSafe | West Houston Assistance Ministries |
| Gulf Coast Community Services Association | Planned Parenthood | 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.

_____/____/____ Date _____ Parent, Guardian, or Authorized Representative's Signature
 9/13, 2/15, 3/15, 2/16, 6/17, 7/17, 9/17, 9/18



4.8.11 HOPWA – HOUSING STABILITY SERVICE PLAN

Client Name: _____ Date: ____/____/____

11 Character Code:

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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 Plan

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 Addendum

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:** ____ / ____ / ____