ALBANY COUNTY COORDINATED ENTRY APPLICATION

APPLICATION SUBMISSION INSTRUCTIONS

Please scan and message the required documents (listed below) and any relevant supporting documents *through the AWARDS messaging module* to the **Housing Agencies** you indicated in the "REFERRAL FOR SERVICES" section below and **CC: mgrillo in AWARDS**

Faxed, hand-delivered, or applications sent via regular email will not be eligible for review.
If you do not have an AWARDS account email brobson@caresny.org to request an account to send messages

Required Coordinated Entry Documents: -

- ❑ Completed Coordinated Entry Application
- ❑ Proof of Homelessness
- ❑ Proof of HUD-defined Disabling Condition

ARE YOU SEEKING HOUSING SERVICES?	HAVE YOU PREVIOUSLY COMPLETED AN APPLICATION FOR ASSISTANCE THROUGH COORDINATED ENTRY?
❑ No ❑ Yes	❑ No ❑ Yes

IF CLIENT IS NOT SEEKING HOUSING SERVICES, A HOUSING ASSESSMENT DOES NOT NEED TO BE COMPLETED

NAME OF REFERRING AGENCY	REFERRING AGENCY STAFF CONTACT NAME	
REFERRING AGENCY STAFF CONTACT EMAIL	**REFERRING AGENCY STAFF CONTACT PHONE NUMBER**	**REFERRING AGENCY STAFF CONTACT FAX NUMBER**

HMIS HOUSEHOLD INFORMATION

*INTAKE DATE	*FIRST NAME	*LAST NAME (and Suffix)
/ /		

*NAME DATA QUALITY	ALIAS
❑ Full Name Reported ❑ Partial Name, Street Name or Code Name Reported ❑ *Data Not Collected* ❑ *Client Doesn't Know* ❑ *Client Refused*	

*SOCIAL SECURITY NUMBER	*SSN DATA QUALITY
(enter "9" for any missing numbers in an Approximate or Partial SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___	❑ Full SSN Reported ❑ Approximate or Partial SSN Reported ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

*GENDER
❑ Male ❑ Female ❑ Trans Male (FTM) ❑ Trans Female (MTF) ❑ Gender Non-Conforming ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

*BIRTHDATE	*BIRTHDATE DATA QUALITY
_____/_____/_____	❑ Full DOB Reported ❑ Approximate or Partial DOB Reported ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

*ETHNICITY
❑ Hispanic ❑ Non-Hispanic ❑ *Data Not Collected* ❑ *Client Doesn't Know* ❑ *Client Refused*

*RACE (choose all that apply)
❑ American Indian/Native Alaskan ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑White ❑ *Data Not Collected* ❑ *Client Doesn't Know* ❑ *Client Refused*

*DO YOU HAVE A **PHONE NUMBER** AT WHICH YOU CAN BE REACHED?	
❑ No ❑ Yes (SEE RIGHT)	**IF YES**: PLEASE PROVIDE YOUR PHONE NUMBER **WITH AREA CODE** (____) - _____ - _____

---NEXT PAGE---

*PRIOR LIVING SITUATION

Based on the client's living situation **the night before project entry**, record responses in one (1) section: Homeless Situation, Institutional Situation, Transitional/Permanent Situation, OR Unknown (**only** if necessary)

HOMELESS SITUATIONS:

TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)	*LENGTH OF STAY IN PREVIOUS PLACE
❑ **Place not meant for human habitation** (vehicle, abandoned building, bus/train/subway station etc) ❑ **Emergency shelter**, including **hotel or motel** paid for **with emergency shelter voucher** ❑ Safe Haven ❑ Interim Housing	❑ 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 ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

*APPROXIMATE DATE HOMELESSNESS STARTED:

_____/_____/_____

*REGARDLESS OF WHERE THEY STAYED LAST NIGHT NUMBER OF TIMES ON THE STREETS, IN ES, OR SH IN THE PAST THREE YEARS	*TOTAL NUMBER OF MONTHS HOMELESS ON THE STREETS, IN ES, OR IN SH IN THE PAST THREE YEARS
❑ 1 ❑ 2 ❑ 3 ❑ 4+ ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12 ❑ More than 12 ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

OR

INSTITUTIONAL SITUATIONS:

TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)	*LENGTH OF STAY IN PREVIOUS PLACE
❑ **Foster care** home or foster care group home ❑ **Hospital** or other residential non-psychiatric medical facility ❑ **Jail**, prison or juvenile detention facility ❑ **Long-term care facility** or n**ursing** home ❑ **Psychiatric hospital** or other psychiatric facility ❑ **Substance abuse treatment** facility or detox center	❑ 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 ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

DID THE CLIENT STAY LESS THAN 90 DAYS	**IF YES:** THE NIGHT BEFORE THAT, DID THEY STAY ON THE STREETS, ES, or SH?
❑ No ❑ Yes	❑ No ❑ Yes

IF YES TO 'ON THE NIGHT BEFORE DID YOU STAY ON THE STREETS, ES OR SH?' PROVIDE DETAILS OF PREVIOUS HOMELESSNESS:

*APPROXIMATE DATE HOMELESSNESS STARTED:

_____/_____/_____

*REGARDLESS OF WHERE THEY STAYED LAST NIGHT NUMBER OF TIMES ON THE STREETS, IN ES, OR SH IN THE PAST THREE YEARS	*TOTAL NUMBER OF MONTHS HOMELESS ON THE STREETS, IN ES, OR IN SH IN THE PAST THREE YEARS
❑ 1 ❑ 2 ❑ 3 ❑ 4+ ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12 ❑ More than 12 ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

OR

TRANSITIONAL AND PERMANENT HOUSING SITUATIONS:

TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)		*LENGTH OF STAY IN PREVIOUS PLACE
❑ **Hotel or Motel** paid for **without** emergency shelter voucher ❑ Owned by client, **no** ongoing subsidy ❑ Owned by client **WITH** ongoing subsidy ❑ Permanent housing **(other than RRH)** for formerly homeless persons (PSH, HOPWA) ❑ Rental by client, **no** ongoing subsidy ❑ Rental by client with GPD TIP subsidy ❑ Rental by client with VASH subsidy	❑ Rental by client with other housing subsidy (**including RRH**) ❑ Residential project or halfway house with no homeless criteria ❑ **Staying or in a family** member's room, apartment or house ❑ **Staying or in a friend's** room, apartment or house ❑ **Transitional housing** for homeless persons (incl. homeless youth)	❑ 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 ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

DID YOU STAY LESS THAN 7 DAYS?	**IF YES: THE NIGHT BEFORE THAT, DID THEY STAY ON THE STREETS, ES, or SH?**
❑ No ❑ Yes	❑ No ❑ Yes

IF YES TO 'ON THE NIGHT BEFORE DID YOU STAY ON THE STREETS, ES OR SH?' PROVIDE DETAILS OF PREVIOUS HOMELESSNESS:

*APPROXIMATE DATE HOMELESSNESS STARTED:

_____/_____/_____

*REGARDLESS OF WHERE THEY STAYED LAST NIGHT NUMBER OF TIMES ON THE STREETS, IN ES, OR SH IN THE PAST THREE YEARS	*TOTAL NUMBER OF MONTHS HOMELESS ON THE STREETS, IN ES, OR IN SH IN THE PAST THREE YEARS
❑ 1 ❑ 2 ❑ 3 ❑ 4+ ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12 ❑ More than 12 ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

OR

UNKNOWN (ONLY IF NECESSARY)

TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)

❑ *Client doesn't know* ❑ *Client refused* ❑ *Data not collected*

---NEXT PAGE---

*CURRENT LIVING SITUATION

Based on the client's living situation **tonight**, record responses in one (1) section:
Homeless Situation, Institutional Situation, Transitional/Permanent Situation, OR Unknown (**only** if necessary)

HOMELESS SITUATIONS:

TYPE OF RESIDENCE (TONIGHT)

- ❑ **Place not meant for human habitation** (vehicle, abandoned building, bus/train/subway station etc)
- ❑ **Emergency shelter**, including **hotel or motel** paid for **with emergency shelter voucher**
- ❑ Safe Haven
- ❑ Interim Housing

OR

INSTITUTIONAL SITUATIONS:

TYPE OF RESIDENCE (TONIGHT)

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

IS CLIENT GOING TO LEAVE WITHIN 14 DAYS?	HAS A SUBSEQUENT RESIDENCE BEEN IDENTIFIED?
❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*

DOES INDIVIDUAL OR FAMILY HAVE RESOURCES OR SUPPORT NETWORKS TO OBTAIN OTHER PERMANENT HOUSING?

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*

HAS THE CLIENT HAD A LEASE OR OWNERSHIP INTEREST IN A PERMANENT HOUSING UNIT IN THE LAST 60 DAYS?

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*

HAS THE CLIENT MOVED 2 TIMES OR MORE IN THE LAST 60 DAYS?

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*

OR

TRANSITIONAL AND PERMANENT HOUSING SITUATIONS:

TYPE OF RESIDENCE (TONIGHT)

- ❑ **Hotel or Motel** paid for **without** emergency shelter voucher
- ❑ Owned by client, **no** ongoing subsidy
- ❑ Owned by client **WITH** ongoing subsidy
- ❑ Permanent housing **(other than RRH)** for formerly homeless persons (PSH, HOPWA)
- ❑ Rental by client, **no** ongoing subsidy
- ❑ Rental by client with VASH subsidy
- ❑ Rental by client with GPD TIP subsidy
- ❑ Rental by client with other housing subsidy (**including RRH**)
- ❑ Residential project or halfway house with no homeless criteria
- ❑ **Staying or in a family** member's room, apartment or house
- ❑ **Staying or in a friend's** room, apartment or house
- ❑ **Transitional housing** for homeless persons (incl. homeless youth)

IS CLIENT GOING TO LEAVE WITHIN 14 DAYS?	HAS A SUBSEQUENT RESIDENCE BEEN IDENTIFIED?
❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*

DOES INDIVIDUAL OR FAMILY HAVE RESOURCES OR SUPPORT NETWORKS TO OBTAIN OTHER PERMANENT HOUSING?

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*

HAS THE CLIENT HAD A LEASE OR OWNERSHIP INTEREST IN A PERMANENT HOUSING UNIT IN THE LAST 60 DAYS?

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*

HAS THE CLIENT MOVED 2 TIMES OR MORE IN THE LAST 60 DAYS?

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*

OR

UNKNOWN (ONLY IF NECESSARY)	LIVNG SITUATION VERIFIED BY (NAME OF AGENCY)
❑ *Client doesn't know* ❑ *Client refused* ❑ *Data not collected*	

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*INCOME & SOURCES / NON-CASH BENEFITS

***INCOME FROM ANY SOURCE**

❑ No ❑ Yes (SEE BELOW) ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*

IF YES: CHECK & FILL IN **MONTHLY AMOUNT** FOR ALL THAT APPLY

❑ Earned Income ..... $_____	❑ Unemployment Insurance ..... $_____
❑ SSI ..... $_____	❑ SSDI ..... $_____
❑ VA Service-Connected Disability Compensation ..... $_____	❑ VA Non-Service Connected Disability Pension ..... $_____
❑ Private Disability Insurance ..... $_____	❑ Worker's Compensation ..... $_____
❑ TANF ..... $_____	❑ General Public Assistance ..... $_____
❑ Retirement from SSA ..... $_____	❑ Pension or Retirement from former job ..... $_____
❑ Child Support ..... $_____	❑ Alimony or Other Spousal Support ..... $_____
❑ Other ..... $_____	

***NON-CASH BENEFITS FROM ANY SOURCE**

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

IF YES: CHECK ALL THAT APPLY

❑ SNAP (Food Stamps) ❑ Special Supplemental Nutrition Program for Women, Infants and Children ❑ Other TANF Funded Srvcs
❑ TANF Child Care Services ❑ TANF Transportation Service

*HEALTH INSURANCE / DISABLING CONDITIONS

***COVERED BY HEALTH INSURANCE**

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

IF YES: CHECK ALL THAT APPLY

MEDICAID	❑ No ❑ Yes	MEDICARE	❑ No ❑ Yes
State Children's Health Insurance Program	❑ No ❑ Yes	VA Medical Services	❑ No ❑ Yes
Employer provided Health insurance	❑ No ❑ Yes	Health ins. Via COBRA	❑ No ❑ Yes
Private Pay Health Insurance	❑ No ❑ Yes	State Health Ins. Adults	❑ No ❑ Yes
Indian Health Services	❑ No ❑ Yes		

***PHYSICAL DISABILITY**	**IF YES:** EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes (SEE RIGHT) ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

***DEVELOPMENTAL DISABILITY**

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

***CHRONIC HEALTH CONDITION**	**IF YES:** EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes (SEE RIGHT) ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

***HIV/AIDS**

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

***MENTAL HEALTH PROBLEM**	**IF YES**: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes (SEE RIGHT) ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

***SUBSTANCE ABUSE PROBLEM**			**IF YES**: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No	❑ Yes, Alcohol (SEE RIGHT) ❑ Yes, Drug (SEE RIGHT) ❑ Yes, Both (SEE RIGHT	❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

* DV STATUS

*DOMESTIC ABUSE VICTIM/SURVIVOR

❑ No ❑ Yes (SEE BELOW) ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

IF YES: WHEN EXPERIENCE OCCURRED			**IF YES:** ARE YOU CURRENTLY FLEEING?	
❑ Within the past 3 months ❑ 3 to 6 months ago	❑ From 6 to 12 months ago ❑ More than a year ago	❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes	❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

DO YOU NEED A CONFIDENTIAL LOCATION TO STAY?

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

*NON-HMIS DATA ELEMENTS

EMPLOYMENT STATUS	IF YES: TYPE OF EMPLOYMENT	IF NO: WHY NOT EMPLOYED * unable to turn off in HMIS
❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ Full Time ❑ Part Time ❑ Seasonal	❑ Looking for Work ❑ Unable to Work ❑ Not Looking for Work

CURRENTLY PREGNANT?	IF YES: DUE DATE
❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	_____/_____/_____
*VETERAN STATUS	IF YES: SELECT BRANCH
❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ Army ❑ Air Force ❑ Navy ❑ Marines ❑Coast Guard ❑ Other ❑ *Data Not Collected* ❑ *Client Doesn't Know* ❑ *Client Refused*

DISCHARGE STATUS

❑ Honorable ❑ General Under Honorable Discharge ❑ Under Other than Honorable Conditions ❑ Bad Conduct ❑ Dishonorable ❑Uncharacterized ❑ *Data Not Collected* ❑ *Client Doesn't Know* ❑ *Client Refused*

HOMELESS CAUSE (check only one)

❑ Benefits loss/reduction	❑ Released behavioral health facility	❑ Drug/alcohol abuse
❑ Job income loss/reduction	❑ Illness	❑ Other:_____
❑ Eviction	❑ Injury/ Disability	❑ Don't know
❑ Relocation	❑ Domestic Violence	❑ Refused
❑ Released from prison/jail	❑ Asked to leave shared residence (e.g. living in a home of another due to hardship)	
❑ Released from hospital		

*ZIP CODE OF LAST PERMANENT ADDRESS	CAN YOU PROVIDE THE FOLLOWING? (Select all that apply)
_____ _____ _____ _____ _____	❑ Social Security Card ❑ Birth Certificate ❑ Driver's License Picture or Non-Driver ID ❑ Passport ❑ Alien Registration

HAVE YOU OR ANY MEMBER OF YOUR HOUSEHOLD EVER BEEN CONVICTED OF A CRIME (yes no box)

❑ No ❑ Yes ❑ *Client Refused* ❑ *Data Not Collected*	If so what was the conviction?: ❑ Arson ❑ Robbery ❑ Assault ❑ Murder ❑ Sexual Offense (If Yes, indicate level): ❑ Other Convictions:

Are there legal limitations on where you can live due to probation, parole, or SO/Arson status

❑ No ❑ Yes ❑ *Client Refused* ❑ *Data Not Collected*	Explanation:

HAVE YOU OR ANY MEMBER OF THE HOUSHOLD BEEN ON/CURRENTLY ON PROBATION OR PAROLE?	IF YES: WHO
❑ No ❑ Yes ❑ *Client Refused* ❑ *Data Not Collected*	❑ Self ❑ Household Member (Name)_____

IF YES: Provide Probation/Parole Officer's Name and Contact Number

Name:_____ Contact Number: ( ) ____ - _____

HAVE YOU OR ANY MEMBER OF YOUR HOUSEHOLD BEEN INVOLVED WITH ANY PROTECTION AGENCY	IF YES: WHO
❑ No ❑ Yes ❑ *Client Refused* ❑ *Data Not Collected*	❑ Self ❑ Household Member (Name)_____

IF YES: SELECT AGENCY	IF YES: IS THIS A CURRENT CASE
❑ CPS ❑ APS ❑ Juvenile Justice ❑ Family Court ❑ Foster Care ❑ Other:	❑ No ❑ Yes

IF CURRENT: Provide Protective Agency Worker's Name and Contact Number	IF NOT CURRENT: Provide the date the case was closed
Name: Contact Number: ( ) -	_____/_____/_____

I understand that the information on this form may be shared with the Albany County Department of Social Services, agencies funded through the Albany County Continuum of Care (CoC), and agency recipients of the Emergency Solutions Grant (ESG)

Signature of Head of Household: _____ Date: _____

---END---

PROCEED TO VULNERABILITY INDEX

VULNERABILITY INDEX SCORING FOR INDIVIDUALS

Chronic Homelessness (CH) Status (CoC Priority)
Client has been continuously homeless for at least one year **OR** experience 4 or more episodes of homelessness within the last 3 years (where combined length of time homeless equals at least 12 months) **AND** has a documented disabling condition.

❑ Yes (If yes, **add "C" to final score** below) ❑ No ❑ Unable to determine

Assisted Outpatient Treatment (AOT) Status (County Priority; below CH)
Client has active court-ordered AOT, **verified** via court paperwork or AOT Care Coordinator.

❑ Yes (If yes, **add "A" to final score** below) ❑ No ❑ Unable to determine

	SCORE	SUBTOTAL
If client indicates they are currently homeless	1	
If client is currently staying in a place not meant for human habitation or is street homeless (remove comma)	**1**	
If client is 18-24 years of age	**2**	
If client is 60 years of age or older	**2**	
If client has served one day (other than training) in active military, naval, or air service	**1**	
If Veteran is female	**1**	
If client acknowledges experiencing domestic violence (DV) in the last 60 days	**2**	
If client indicates having limitations on where they can live due to DV	**2**	
If client is pregnant	**1**	
If client has a documented disability, as defined by HUD	**1**	
If client has two (2) or more documented disabilities, as defined by HUD	**1**	
If client has a terminal illness or end-stage disease that cannot be cured or adequately treated and is reasonably expected to result in death	**1**	
If client has a serious underlying medical condition and may be at higher risk for severe illness from COVID-19 due to the following: chronic lung disease, moderate to severe asthma, severe obesity, diabetes, immunocompromised, chronic kidney disease, and/or liver disease	**2**	
If client has a disabling condition or illness that substantially impairs their ability to access a housing unit, and accommodations are required for unit accessibility ***Please briefly explain:**	**1**	
If client indicates they have no income OR only receive DSS assistance	**1**	
If client indicates criminal history, and/or current probation or parole status	**1**	
If client indicates having limitations on where they can live due to probation, parole, or SO/Arson status	**1**	
If client has had any recent involvement with a Child Protective, Adult Protective, Juvenile Justice, Family Court, or Foster Care Agency; including Youth/Young adults who left foster care within the prior five years and who were in Foster Care at or over age 16	**1**	
If client has had multiple points of contact (3 or more) with Emergency Responders such as ambulance, ER visits, crisis, detox, fire, or police/LEAD Program within the last 90 days	**1**	
If client indicates that they have been homeless due to eviction, utility shut off, or Code Enforcement three (3) or more times in the last 2 years	**1**	
Additional Points Section (2-point maximum) – User the space below to explain your reasoning for adding additional points. • *Points many not be given for conditions already captured within Coordinated Entry intake* • *Additional points may be subject to change based upon review of explanation* ***Include explanation here or attached to referral – No points will be given if explanation is blank**	**2**	
TOTAL POINTS – If documented CH or AOT status, add "C" or "A" to score, respectively (i.e., "4C")		

---OR---

VULNERABILITY INDEX SCORING FOR FAMILIES

Chronic Homelessness (CH) Status (CoC Priority)
Head of Household has been continuously homeless for at least one year **OR** experience 4 or more episodes of homelessness within the last 3 years (where combined length of time homeless equals at least 12 months) **AND** has a documented disabling condition.

❑ Yes (If yes, **add "C" to final score** below) ❑ No ❑ Unable to determine

	SCORE	SUBTOTAL
If household indicates they are currently homeless	1	
If household is currently staying in a place not meant for human habitation or is street homeless	**1**	
If household is 18-24 years of age	**2**	
If household is 60 years of age or older	**2**	
If household has served one day (other than training) in active military, naval, or air service	**1**	
If Veteran is female	**1**	
If any household member acknowledges experiencing domestic violence (DV) in the last 60 days	**2**	
If household indicates having limitations on where they can live due to DV	**2**	
If any household member is pregnant	**1**	
If head of household has a documented disability, as defined by HUD	**1**	
If head of household has two (2) or more documented disabilities, as defined by HUD	**1**	
If any other member(s) of the household (not head) have a documented disability, as defined by HUD	**1**	
If any household member has a terminal illness or end-stage disease that cannot be cured or adequately treated and is reasonably expected to result in death	**1**	
If any household member has a serious underlying medical condition and may be at higher risk for severe illness from COVID-19 due to the following: chronic lung disease, moderate to severe asthma, severe obesity, diabetes, immunocompromised, chronic kidney disease, and/or liver disease	**2**	
If any household member has a disabling condition or illness that substantially impairs their ability to access a housing unit, and accommodations are required for unit accessibility: ***Please briefly explain:**	**1**	
If household indicates they have no income OR only receive DSS assistance	**1**	
If any household member indicates criminal history, and/or current probation or parole status	**1**	
If household indicates having limitations on where they can live due to probation, parole, or SO/Arson status	**1**	
If household has had any recent involvement with a Child Protective, Adult Protective, Juvenile Justice, Family Court, or Foster Care Agency; including Youth/Young adults who left foster care within the prior five years and who were in Foster Care at or over age 16	**1**	
If any household member has had multiple points of contact (3 or more) with Emergency Responders such as ambulance, ER visits, crisis, detox, fire, or police/LEAD Program within the last 90 days	**1**	
If household indicates that they have been homeless due to eviction, utility shut off, or Code Enforcement three (3) or more times in the last 2 years	**1**	
Additional Points Section (2-point maximum) – User the space below to explain your reasoning for adding additional points. • *Points many not be given for conditions already captured within Coordinated Entry intake* • *Additional points may be subject to change based upon review of explanation* ***Include explanation here or attached to referral – No points will be given if explanation is blank**	**2**	
TOTAL POINTS – If documented CH or AOT status, add "C" or "A" to score, respectively (i.e., "4C")		

CONSENT TO RELEASE PERSONAL INFORMATION

Signing this consent allows Coordinated Entry-participating programs in The Albany County Continuum of Care to review some personal information related to your application, and to determine eligibility for housing and/or prevention services. Regardless of which housing/prevention program you may prefer, all applications may be reviewed by the Coordinated Entry Committee which is comprised of representatives from participating provider agencies in the County. The purpose for this *Coordinated Entry Review* process is to ensure each applicant has information and fair access to the range of housing options and services in the county:

I acknowledge signing this consent allows my release of personal information related to my housing assistance eligibility to representatives of the ACCH Coordinated Entry Committee

I further understand that the information on this form may be shared with Partner Members of Albany County Continuum of Care (CoC), and agency recipients of the Emergency Solutions Grant (ESG).

The content of information to be released includes: My identifying information, household composition, housing & homelessness history, income & benefit status, veteran status, health information, disabilities (if any), certain criminal justice information (if any), and accommodations required (if any).

COORDINATED ENTRY-PARTICIPATING PROGRAMS THAT WILL HAVE ACCESS TO THIS INFORMATION INCLUDE:

Capital Area Council of Churches (CCSES)	Capital City Rescue Mission (CCRM)
Community Maternity Services (CMS)	Catholic Charities
Equinox Inc.	Hope House
St. Catherine's Center for Children	IPH (formerly Interfaith Partnership for the Homeless)
Schuyler Inn	St. Peter's Addiction Recovery Center (SPARC)
Albany Damien Center	Albany County Department of Social Services (DSS)
Albany Housing Coalition	Capital Area Peer Services (CAPS)
CARES, Inc	Homeless and Travelers Aid Society (HATAS)
Joseph's House	Rehabilitation Support Services (RSS)
Support Ministries, Inc	Legal Aid Society (LAS)
Albany County Department of Mental Health	Family Promise of the Capital Region
Alliance for Positive Health	United Tenants of Albany (UTA)
Additional	
Agencies:_____	

The following items **must be initialed** to be included in the use and/or disclosure of other protected health information:

_____ HIV/AIDS related information and/or records
_____ Genetic testing information and/or records
_____ Drug/alcohol diagnosis, treatment, or referral information

I hereby authorize the periodic release of the above information to the organizations identified above as often as necessary to determine eligibility for services and, if eligible, coordinate placement in housing through Albany County Coordinated Entry. I understand that the information to be released is confidential and protected from further disclosure. The duration of this consent is one year from the date of my signature, unless I specify a date, event or condition upon which it will expire sooner. I understand that I may revoke this consent at any time by notifying my case manager, in writing, except to the extent that action has been taken in reliance on my consent.

Client signature:_____ **Date:**

PROCEED CCHMIS INCLUSION DISCLOSURE AND RELEASE OF INFORMATION

A. CCHMIS HMIS Consent

PURPOSE: To inform clients of HMIS data entry and for clients to authorize or modify data sharing preferences within the HMIS for the project listed below:

PROJECT:
CONTACT NUMBER:

INSTRUCTIONS: This form must be completed for every independent adult (18 years of age and over) and every unaccompanied minor PRIOR to data collection and entry into the HMIS at all CCHMIS-participating providers. This form also covers any household members under the client's guardianship, which includes all minors (persons under 18 years of age) and any incapacitated/disabled adults. The client is to be given pages 1 and 2 after completion.

HMIS PRIVACY NOTICE

This Notice applies to all CCHMIS-Participating Providers and addresses how information about clients may be used and disclosed at Providers as well as client rights over their information. This Notice may be amended at any time, and amendments may affect information obtained before the date of the amendment.

HMIS DATA COLLECTION & PURPOSE

A Homeless Management Information System (HMIS) is a local information technology system used to collect data on the housing and services provided to homeless individuals and families and persons at risk of homelessness. Providers participating in an HMIS are required to collect universal data elements from all clients, including Personally Identifying Information, demographic characteristics, and residential history. This information is critical for providers and communities to better understand the extent and nature of homelessness at a local level, evaluate program effectiveness, and improve future housing and service provision. Some providers are also required by their funders to obtain certain additional information to assess services, to determine eligibility, and to monitor outcomes. Most federally-funded homeless service providers are required to participate and record the clients they serve in an HMIS.

This agency is an HMIS-participating homeless service provider ("CCHMIS Provider"), meaning we collect and enter information about the persons we serve in the private and secure CARES Collaborative HMIS (CCHMIS) database, the local HMIS for this community. There are firm policies and procedures in place to protect against unauthorized disclosure of any personal information collected, and this information is critical to obtain an accurate picture of the homeless population we serve and for this agency to continue to offer you the service(s) you are accessing today. We only collect information deemed appropriate and necessary for program operation or information that is required by law or by the organizations that fund this program. We do not need your consent to enter a record of your visit into the CCHMIS, but you may refuse to have your personal identifying information within this record and still be eligible to receive services.

If you have any concerns or questions about the information provided above, please speak to an intake worker.

PERMITTED DATA USES AND DISCLOSURES

The CCHMIS is designed to protect the confidentiality of personal information while allowing for reasonable, responsible, and limited uses and disclosures of data, including Personally Identifying Information (PII is any information that can be used to identify a particular individual, including a client's name, Social Security Number, and Date of Birth). Once collected, we (as a CCHMIS Provider) have obligations about how these data may be used and disclosed (**uses** are internal activities for which providers interact with client PII; **disclosures** occur when providers share PII with an external entity). CCHMIS **Providers are limited to the following circumstances for the use and disclosure of HMIS PII:**

HUD required:

(1) Client access to their information; and
(2) Disclosures for oversight of compliance with HMIS privacy and security standards.

HUD permitted:

(3) To provide or coordinate services to an individual;
(4) For functions related to payment or reimbursement for services;
(5) To carry out administrative functions, including but not limited to legal, audit, personnel, oversight and management functions;
(6) For creating de-identified reporting from PII;
(7) Uses and disclosures required by law;
(8) Uses and disclosures to avert a serious threat to health or safety;
(9) Uses and disclosures about victims of abuse, neglect or domestic violence;
(10) Uses and disclosures for research purposes; and
(11) Uses and disclosures for law enforcement purposes.

A client must provide prior written consent for any other use or disclosure of HMIS PII.

CCHMIS Providers must also ensure that **any use or disclosure does not violate other applicable local, state, or federal laws**. Therefore, some CCHMIS Providers **may have more restrictive privacy policies**, often dependent upon funding source or the nature of a projects. Specific, per-project information regarding data use and disclosure can be obtained upon request.

CLIENT CONTROL OVER DATA

The CCHMIS recognizes every independent legal adult (person over 17 years of age) as the owner of all information about themselves, and any parent, legal guardian, or legal power of attorney as the designated owner of all information about any household members under their guardianship (all minors and any incapacitated/disabled adults).

By seeking assistance from this CCHMIS Provider and consenting to your personal information being entered into a record within the CCHMIS, you transfer governance responsibility over your CCHMIS record to us, and we are responsible for handling your record in accordance with CCHMIS privacy policies and any applicable federal, state, or local requirements. You retain ownership of your information within your CCHMIS record, and as owner **you have the following rights, in general:**

- Refusal: to refuse to answer a question you do not feel comfortable with and not have it recorded within the CCHMIS;
- Access/Correction: to request and view a copy of your project information record within the CCHMIS from your provider, including those who have accessed and/or edited your record, and to request corrections to that record;
- Grievance: to ask questions of or submit grievances to your provider regarding privacy and security policies and practices;
- Anonymized Record: to request that your provider anonymize your personal data record within the CCHMIS; and
- Optional Data Sharing: to choose if your information is shared outside of the CCHMIS with researchers and other providers, and to make this decision at each project you receive services from. (Please note that if you decide NOT to data share, it does not prohibit the project from entering your data into the CCHMIS – it prohibits the sharing of your data as outlined on the consent form).

CCHMIS Providers reserve the following exceptions to the above: (1) Provider Right to Deny Review: if information is compiled in reasonable anticipation of litigation or comparable proceedings; if information about another individual other than the participating provider staff would be disclosed; if information was obtained under a promise of confidentiality other than a promise from this provider and disclosure would reveal the sources of the information; or if the disclosure of information would be reasonably likely to endanger the physical safety of any individual; and (2) Provider Right to Deny Access/Correction: in response to repeated or harassing requests.

RESPONSIBILITY TO PROTECT DATA

CARES of NY, Inc. (CARES) is the System Administrator of the CCHMIS. The CCHMIS uses Foothold Technology's AWARDS software application and database, which is maintained in compliance with all federal standards set forth in the Health Insurance Portability and Accountability Act (HIPAA) and its subsequent legislation – the standards required to protect medical records – as well as U.S. Department of Housing and Urban Development HMIS standards.

The CARES CCHMIS staff take the protection of client confidentiality and privacy seriously. **The following security measures, among others, are in place to ensure that your information is protected:**

- System Security: HMIS data is encrypted and securely transmitted from Providers to the HMIS database, extensive procedures are in place to prevent unauthorized access, and the entire HMIS system and database is protected at the highest level of security for health data;
- Access: Only CARES CCHMIS staff and staff at providers may receive authorization to access the CCHMIS, and authorization requires comprehensive initial training and annual privacy and security training thereafter;
- Confidentiality Agreements: Every CCHMIS Provider and every person authorized to read or enter information into the CCHMIS signs an agreement every year that includes: (1) commitments to maintain the confidentiality of all CCHMIS information; (2) commitments to comply with all security measures in compliance with federal HMIS requirements and any applicable federal, state, or local laws; and (3) penalties for violation of the agreement;
- Monitoring: Annual monitoring is conducted for CCHMIS providers to ensure compliance with privacy and security policies; and
- Reporting: Published CCHMIS reports are comprised of aggregate data only, and never contain any client-level or identifying (PII) data.

IMPORTANT INFORMATION FOR ALL CLIENTS – PLEASE READ

If you do not understand any of the information within this form, you may ask your intake worker for further explanation or an alternate format.

You may **keep the first 2 pages** of this form (containing the HMIS Privacy Notice) for your records.

You may request a copy of any participating provider or CCHMIS policies from your intake worker. Further information regarding CCHMIS privacy and security is also available in the CCHMIS Policies and Procedures (accessible online at www.caresny.org/).

You may contact your participating provider regarding any of your rights as listed above, including if you feel that any of these rights have been violated. If your provider's response does not satisfy you, you may then contact the CCHMIS directly at hmis@caresny.org or (518) 489-4130.

CCHMIS Inclusion Disclosure

The CCHMIS has moved from *inferred consent* (a posted sign) to an *inclusion disclosure* for the HMIS. **No consumer consent is required by the CCHMIS to enter consumer data**. This disclosure replaces the posted sign but fulfills the same purpose. Consumers are asked to initial that they received the information. This is in addition to any agency specific or CoC specific forms that may be presented upon intake.

While individual agencies and projects may have their own, overriding policies, refusing to initial the inclusion disclosure does **NOT** indicate a refusal to be included in the HMIS and does not automatically disqualify consumers from receiving services from the agency or project; agency and CoC policy regarding how to handle that situation should still be followed as it has been in past years.

ACKNOWLEDGEMENT OF INCLUSION

No client consent is required to enter client data from provider forms into the CCHMIS, including personally identifying information. All Protected Identifying Information (PII) entered into the HMIS for the purpose of Coordinated Entry may be shared with other participating providers through the HMIS to better serve your needs and streamline the intake process. Additional sharing of your PII will not happen without agreeing through the consent below.

To show you are aware of this, we ask you to initial below.

**_____ Please initial to indicate that you have read (or been read) and understand the above information.

Please indicate method by which acknowledgement was received.

□ Phone

□ In Person

IMPORTANT - CLIENT IS TO BE GIVEN PAGES 1 AND 2

Please indicate on the chart below which Housing Agencies that you are referring this application to.

The **Albany County CE Contact Index** can assist in completing this section; to request a copy, please email ce@hatas.org

REFERRAL FOR SERVICES
Please indicate the agencies/programs this referral will be sent to:

PERMANENT SUPPORTIVE HOUSING (PSH)

❑ Albany Damien Center PSH Program	❑ CARES TBRA for Homeless Persons YR 2	❑ IPH Sheridan Ave Housing Project II
❑ Albany Housing Coalition Shelter Plus Care for CH Vets	❑ CARES Housing	❑ IPH Bonus Project
❑ Albany Housing Coalition Shelter Plus Care for Homeless Vets with Disabilities	❑ HATAS Shelter Plus Care	❑SPARC
❑ Albany Housing Coalition Walter St Residence	❑ HATAS Pathways I	❑ RSS SAIL
❑ Capital Area Peer Services (CAPS) 100 Clinton Ave Apts	❑ HATAS Pathways II	❑ St. Catherine's Supportive Family Housing Program
❑ CARES TBRA for Homeless Persons YR 3	❑ HATAS TBRA	❑ St. Catherine's Bonus Project
	❑ HATAS Bonus Project	❑ Support Ministries Arvilla House
	❑ HAC SRO (Kendal House)	❑ Support Ministries Project Help
	❑ Hope House	
	❑ IPH Hope Through Housing	
	❑ IPH Sheridan Ave Housing Project	

Notes:

RAPID RE-HOUSING (RRH)

❑ HATAS STEHP Rapid Re-Housing	❑ Legal Aid Society Rapid Re-Housing Families
❑ HATAS The Next Step RRH Program	

Notes: