Chittenden County Homeless Alliance
Working to End Homelessness

CCHA – HMIS CLIENT INFORMED CONSENT AND RELEASE OF INFORMATION

PERMISSION TO SHARE CONFIDENTIAL INFORMATION TO SECURE NECESSARY HOUSING SERVICES

Please read the following notice and authorization (or ask to have it read to you) before signing.

This agency, ____, participates in Vermont's Homeless Management Information System (VTHMIS), ServicePoint. Agencies that participate in VTHMIS belong to an internet-based network. This network is administered by the Institute for Community Alliances.

BENEFITS TO DATA SHARING FOR THE CONSUMER	
Eliminates duplicate intakes.	Faster access to the Coordinated Entry System, resulting in receiving services more quickly.
Reduces the amount of time spent answering basic questions regarding your situation.	Allows agencies to focus on meeting your unique service needs.
Reduces the amount of times you have to tell your story to service providers.	Multiple Services can be easily coordinated and streamlined.

* Vermont HMIS ensures the security of its system. Please see below for detailed information on security measures. *

This network is made up of many service providers in Vermont, however, the sharing of client data between agencies is limited. **Agencies in the Chittenden County Homeless Alliance** are in agreement to share client information intended to improve service delivery to clients. Because of this sharing agreement, you have the option to share your information with other service providers from whom you might be seeking services. Your identity and information collected in VTHMIS will be shared, with your written consent, with the agencies listed in the sharing agreement in the network. VTHMIS includes your demographic information and other essential personal information needed to best determine your housing and service needs. If your information was previously entered into the system and not shared, the historical data will now be shared between the agencies listed.

The computer program used for this purpose has industry standard security protocols, and is updated regularly to meet these security requirements. The information you provide will only be shared with this agency, the agencies listed in the sharing agreement, and limited staff of the Institute for Community Alliances. No personally identifying information will be shared by our network with any department in the State of Vermont or the Federal Government that is not engaged in the provision of direct client services. Information collected is housed in a secure server located at Mediware Information systems in Shreveport, Louisiana. Limited Mediware Information Systems staff have access to this server and the data for the purposes of network support and maintenance. Data collected for the network will be maintained for at least seven years from the last date of service.

A current list of Chittenden County Homeless Alliance agencies participating in VTHMIS is included below. The list can also be accessed at www.icalliances.org/vermont-documents. This list may change.

ANEW Place
Burlington Housing Authority
Champlain Housing Trust
Champlain Valley Office of Economic Opportunity – Chittenden County
Committee on Temporary Shelter
Community Health Centers of Burlington
Easter Seals Vermont
Howard Center
Pathways Vermont
Spectrum Youth & Family Services
Supportive Services for Veteran Families at The University of Vermont
Vermont Cares
Vermont Coalition for Runaway and Homeless Youth Programs
Veterans' Inc.

Please note that if you grant permission for your information to be shared, it will be in effect for 3 years from the date you sign this form. However, you can contact ___________________________________ (agency) at ____________________ (phone number) to revoke your permission to share data. You may end your agreement verbally, or in writing, and your personal and service information will no longer be shared from that date going forward. If you revoke this consent, you give permission to the agency to inform the parties indicated in your selection of Option 1 or Option 2 below to ensure there is no further re-disclosure of your information. If you do not give permission for this agency to release your information, no other agency in the network will have access to it.

Maintaining the privacy and the safety of those using our services is very important. Your record will only be shared if you give permission. You cannot be denied services that you would otherwise qualify for if you choose not to share information. Each adult in the household can give permission to share only their own personal information. Any guardian may give permission to share a child's information

Type of Information to be Shared:

- Personal Identifying Information: Name (First, Middle, and Last), Social Security Number, Date of Birth, Ethnicity, Gender, Last Residence Information, Military Status, Contact Information
- Housing/Program Specific: Entry/Exits, Housing-related Assessments, Service Transactions related to Housing, Coordinated Entry, Referrals, including if you have disclosed a substance use disorder. No information regarding a child's substance use disorder will be shared.
- Assessment Specific: Income, Non-cash Benefits, Disability, Domestic Violence, Health Insurance

Please indicate your choice regarding data sharing:

Option 1: _______ By initialing here, I agree to **share** my and my child/children's above specified information and coordination of services **with all participating agencies in the network**.

Option 2: _______ By initialing here, I agree to **limit sharing** of my and my child/children's above specified information and coordination of services **to this agency and the agencies listed below**.

_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________

Please indicate name and date of birth of each child, below.

Name	Date of Birth

Substance Abuse Treatment Records:

Substance use disorder treatment records are protected by Federal confidentiality rules (42 CFR Part 2) and cannot be disclosed or re-disclosed without a patient's express written consent or as allowed by the regulation.

If applicable, ☐ **I am** ☐ **I am not** authorizing ____
to share information about my substance use disorder, treatment, or referral for treatment, and HIV status.

By signing this form, ☐ **I am** ☐ **I am not** authorizing subsequent or re-disclosure of this information.

I understand that signing below relates only to sharing data within the VTHMIS and does not guarantee I will receive assistance. Alternatively, I understand that I will NOT be denied services if I refuse to consent to data sharing.

Client/Parent or Guardian Signature: ____

Date: ________________________

Print Name: ____

Client/Parent or Guardian Signature: ____

Date: ________________________

Print Name: ____

Interviewer Name: ____ ☐ Staff ☐ Volunteer

Organization: ____ Date: ___________________