Chicago Homeless Management Information System
Client Consent for Data Sharing (effective June 1, 2018)

Agency Name: Casa Central La Posada

This Agency is part of a group of stakeholders that coordinate their efforts to end homelessness in Chicago. This group is referred to in this document as the Chicago Homeless Management Information System (HMIS) Collaborative ("Collaborative", "we", or "us"). The Agency and members of the Collaborative collect your information and enter it into HMIS)*.

A representative of this Agency is going to ask you for information about you and your dependents. (The word "dependent" is used in this document to refer to any person under the age of 18 for whom you consider yourself to be responsible.) Once your information is entered into HMIS it will be shared as described below.

This form has three parts. The purpose of this form is to allow you to decide how much of the information that you provide to this Agency can be shared with third parties and how it might be shared within the Collaborative. You may decline to allow this Agency to share any of your information other than to the system administrator of HMIS, which may disclose such information in accordance with the Standard Agency Privacy Practices Notice. If you decline, the ability of this Agency and the Collaborative to provide housing to you may be reduced, but this Agency will still provide emergency services to you.

PART I – BRIEF ANSWERS TO QUESTIONS YOU MAY HAVE

What Are the Reasons for Sharing Information about Me?

- Help service providers offer suitable housing and care options to you.
- Assist the Collaborative in documenting the need and obtaining funding for its housing and services.
- As described in the Standard Agency Privacy Practices Notice, as may be amended from time to time.

How Is My Data Protected?

- Every Agency is required to comply with the Standard Agency Privacy Practices Notice.
- Members of the Collaborative must sign an agreement to protect your privacy and comply with state and federal laws and policies before seeing any information.
- HMIS incorporates industry standard security requirements and is updated to stay current with these security requirements.

What Are My Rights?

- You can obtain an electronic version or paper copy of your information that has been entered HMIS upon request and obtain a list of partner agencies within the Collaborative,
- You can ask to amend or revoke the sharing of your information entered in HMIS at any time, by signing a new Consent form.

Are There Circumstances in Which My Information Might Be Disclosed Without My Consent?

- Yes, there are multiple reasons for which your information will be used or disclosed without your consent, which include but are not limited to for administrative functions, payment or reimbursement of services, when required by law, system maintenance and reporting, and academic research purposes described in the Standard Agency Privacy Practices Notice, as may be amended from time to time.

For more detailed information, ask to see a copy of our Standard Agency Privacy Practice Notice.

PART II – YOUR CONSENT

Basic Information:

This information will be shared through HMIS and with members of the Collaborative.

- Personal Identifying Information (Name, Social Security Number, Date of Birth, Gender, Veteran Status, photo)
- Personal identifying information about your dependents (if applicable) (*Note*: Anyone 18 years of age or older must sign a separate consent form.)
- Enrollment information (may include your past enrollment information)
- Recipient Identification Number (if you do not know the number we will try to look it up)
- Contact information

(2) Coordination of Care and Housing Information:

This information, along with other information from the HMIS, will be used or disclosed for the purposes of matching you to the appropriate services and possible housing, to conduct referrals and assessments, to determine program eligibility, to otherwise collaborate to address specific needs and circumstances, and to share information in case conference meetings for the purposes of finding and/or coordinating services for you and your dependents.

Information about your military service (if applicable)

- Experience with homelessness and living situation (housing status)
- Household income and source(s)
- Presence of a current disabling condition
    - Illinois law requires us to obtain your explicit consent to share information with respect to mental health, substance use, and/or HIV/AIDS issues. ***A separate consent form will be offered to you before you are asked to share information about these conditions.***
- Services you receive, including your receipt of financial assistance
- Medical insurance/primary care provider information

For purposes of this consent, Basic Information and Coordination of Care and Housing Information shall be referred to herein collectively as the "information".

I,_____(Name) agree to share information as detailed below.

A. Share my information to provide housing and/or coordinate services to help me end my homelessness.

B. Share my information as a locked file to provide housing and/or coordinate services to help me end my homelessness.

Note: The locked file will be visible to the system administrators and be shared with the agencies overseeing/assigned to providing me with matching of housing and care, and agencies I am currently receiving or received services from. My information will not be used or disclosed at case conference meetings for finding and/or coordinating services for me. ***Information from Survivors of Domestic Violence and/or Human Trafficking will automatically be treated only as locked file.***

C. Do not agree to share any information: I do not want any of the information about me shared for the purposes of housing and /or coordination of care; I understand the system administrator will have access and my information may be shared in accordance with the Standard Agency Privacy Practices Notice. I acknowledge that if my information is shared as permitted or required, I may be contacted by agencies to which my information was disclosed.

When you sign this form, it shows that you:

- Acknowledge that certain information may be shared without your consent in accordance with the Standard Agency Privacy Practices Notice, as may be amended from time to time.
- Read this Client Consent or heard an explanation of its contents.
- Understand this consent does not expire unless you withdraw your consent to share at any time by signing a new copy of this Consent; however, any information already shared with another agency cannot be taken back or revoked.
- Understand that housing providers may record significant incidents in which you are involved in their programs, and that these incidents will be shared with the entities that provide emergency services, housing coordination and outreach services for matching individuals to appropriate programs.

Names of Dependents (please list ALL dependents):

Name 1: _____ **Name 2:** _____

Name 3: _____ **Name 4:** _____

Name 5: _____ **Name 6:** _____

Data Sharing Selection for Head of Household (check one):

A. Share my information

B. Share my information as a locked file

C. Do not agree to share any information.

Data sharing selection for all dependents, as listed (check one, if applicable):

A. Share my information

B. Share my information as a locked file.

C. Do not agree to share any information.

Client or Representative Signature: _____ **Date:** _____

Agency Witness Signature: _____ **Date:** _____

For Organization Use only: (Initial all that apply)

The Client above received a telephonic explanation of this form, as needed. On behalf of the Client, staff at this agency served as the representative. The Consent was read in its entirety. _____

An authorized representative completed this consent for the Client. A description of the representation as required by the agency is approved and included in the file.

Homeless Management Information System (HMIS)

Supplemental Client Consent for Sharing of Certain Disability Data and Health Information (effective June 1, 2018)

Agency Name: _____

This Supplemental Client Consent for Sharing of Certain Disability Data and Health Information should be completed at the time of initial assessment, in addition to the Client Consent for Data Sharing. This supplemental consent is consistent with the policies laid out in the All Chicago Making Homelessness History HMIS Standard Agency Privacy Practice Notice ("Privacy Notice"). The current version of the Privacy Notice and a list of partners in the Collaborative can be viewed at www.allchicago.org. Alternatively, the agency you are working with should also be able to provide you with these documents upon request.

We are required by law to obtain your explicit consent to share information with respect to your experience with mental health issues, HIV/AIDS, and substance abuse. Some agencies within the Collaborative have specific eligibility requirements. Sharing this information allows us to connect you with as many housing and care options as possible for which you might be eligible.

This information will be collected as part of your assessment and will be disclosed by the agency you are working with to the Collaborative to improve the ability of the Collaborative to make an appropriate housing match and coordinate care on your behalf. You may decline to share this information as noted below, but doing so may make it more difficult for the participating agencies in the Collaborative to qualify you for assistance suited to your needs.

Please check the appropriate box below:

_____ I consent to the use and disclosure of my mental health condition, HIV/AIDS status, alcohol and/or drug abuse history, as may be applicable, with the Collaborative. I authorize the agency providing me with services to enter my mental health condition, HIV/AIDS status, alcohol and/or drug abuse history, as may be applicable, into the HMIS and I authorize the Collaborative to use such information to make an appropriate housing match and coordinate care on my behalf. In addition, I authorize the use and disclosure of my mental health condition, HIV/AIDS status, alcohol and/or drug abuse history, as may be applicable, on an aggregate basis so long as my information is de-identified.

_____I decline to share any information relating to my mental health condition, HIV/AIDS, alcohol and/or drug abuse for the purposes of matching or other specific services; provided that I understand that the foregoing information will be; (i) shared among a certain cohort of assessors within the Collaborative, only if this information is being collected as part of the Standardized Housing Assessment and (ii) used and disclosed on an aggregate basis so long as my information is de-identified and I expressly authorize the foregoing.

_____I do not presently experience the above conditions or have any information to share.

This authorization shall be in force and effect for seven years from the date of signing, at which time this authorization to use or disclose this information expires.

I understand that I have the right to inspect and copy any mental health information included in or made part of the information disclosed in accordance with this consent.

I understand that the Collaborative will not disclose information about my experience with these conditions without my specific written authorization unless a disclosure is authorized by applicable law including Confidentiality of Alcohol & Drug Abuse Patient Records (42 CFR, Part 2). I also understand that I may revoke my authorization to disclose this information by signing a new copy of this Supplemental Client Consent in which I decline future sharing of the information. I understand that my revocation will not be effective to the extent that my information has been used or disclosed in reliance on this consent. I also understand that the Collaborative will not use or disclose personal health information beyond the scope of this authorization without my written authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act. However, except as provided herein, information regarding mental health, HIV/AIDS, substance abuse and alcoholism may not be disclosed by the person or entity authorized herein to receive said information without my express written consent.

If I am requesting disclosure of psychological test material, I understand that all records related to any psychological testing shall only be disclosed to a psychologist designated by me.

Client Name: _____

Client Signature: _____ Date: _____

Agency Witness: _____ Date: _____