HUD CoC and ESG Annual Assessment for Adults 18 and Over

This form is for HMIS users of all projects to record Annual Assessment of client-level data who have been in a project for 365 days. All information on this form should be collected and entered into HMIS-Erie within 5 days.

CONSENT TO SHARE CONFIDENTIAL INFORMATION

Client Name: _____ Start Date: _____

End Date: _____

I request and authorize: _____ at
Staff Person(s)

Agency Name: _____

Project Name: _____

to disclose confidential information to HMIS-ERIE, the homeless database that supports the Erie, PA Continuum of Care PA-605, administered by Erie County Department of Human Services at:

HMIS Administrator
Erie County Department of Human Services MH/ID
154 West 9th Street
Erie, PA 16501

This request and authorization applies to:

☐ Client demographics and program entry/exit information

☐ Program-specific information for services and referrals only, and/or: _____

☐ Yes ☐ No I expressly release the above-named staff person(s) and Agency from all liability arising from compliance with this request and disclosure of the requested information to HMIS-ERIE.

☐ Yes ☐ No I understand my rights regarding personally identifying information as explained by the above-named staff person(s) and outlined in the HMIS-ERIE Consumer Privacy Policy.

☐ Yes ☐ No I authorize the release of my information, such as personal demographics, income, health, and disabilities (including drug, alcohol, and/or mental health diagnosis) to be shared with other HMIS-ERIE providers to determine program eligibility, send referrals and coordinate services.

☐ Yes ☐ No I authorize my demographics information only to be shared with other HMIS-ERIE providers to determine program eligibility and maintain data integrity within HMIS-ERIE.

Client Signature: _____ Date Signed: _____

Staff Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES ONE (1) YEAR AFTER IT IS SIGNED.

Total Monthly Income: $_____

Income from Any Source: ○ Yes ○ No ○ Client doesn't know ○ Client refused ○ Data not collected

Source of Income:

$_____Alimony or other spousal support
$_____Child support
$_____Earned Income
$_____General Assistance
$_____Other: _____
$_____Pension or retirement from a former job
$_____Private disability insurance
$_____Retirement income from Social Security
$_____Social Security Disability Income (SSDI)
$_____Supplemental Security Income (SSI)
$_____Temporary Assistance for Needy Families (TANF)
$_____Unemployment Insurance
$_____VA non-service-connected disability pension
$_____VA service-connected disability compensation
$_____Worker's compensation

Non-Cash Benefit from Any Source: ○ Yes ○ No ○ Client doesn't know ○ Client refused ○ Data not collected

Source of Non-Cash Benefit:

$_____Supplemental Nutrition Assistance Program (SNAP)
$_____Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
$_____TANF Child Care services
$_____TANF transportation services
$_____Other TANF-funded services
$_____Other Source: _____ (Specify source)

Covered by Health Insurance: ○ Yes ○ No ○ Client doesn't know ○ Client refused ○ Data not collected ○ Da

Health Insurance Type:

○ MEDICAID
○ MEDICARE
○ State's Children Health Insurance Program
○ Veteran's Administration (VA) Medical Services
○ Employer-Provided Health Insurance
○ Health Insurance obtained through COBRA
○ State Health Insurance for Adults
○ Private Pay Health Insurance
○ Indian Health Services Program
○ Other: _____

NOTE: Any changes to a client's disability status should be entered on the Client's Entry record. To note changes, please refer to the Project Intake form.