Client Name / HMIS #: _____

Austin / Travis County Homeless Management Information System
Data Sharing Policy and Release of Information (ROI)

Agency Completing Form: _____

This agency collects information about people who ask about our homeless services. When we meet with you, we will ask you for information about you and your family. We will put the information you give us into a computer program called Mediware ServicePoint (or "HMIS").

Austin / Travis County HMIS data is all stored in one computer system. Your information will be shared with all agencies that use our system (all "HMIS Agencies") to help you get services more quickly and easily. A list of all current HMIS Agencies is on the next page of this form, and you can ask for a new copy at any time.

The Personal Information we share may include:

- Personal Identifying Information (such as name, social security number, and date of birth)
- Who is in your household
- Job history
- Military history
- Living situation and housing history
- Educational background
- Demographic information (such as race, gender, and ethnicity)
- Your income and income sources
- Services you request or receive
- If you are experiencing homelessness or not
- Reasons for seeking services
- Self-reported health needs

You can refuse to answer **any** question at **any** time, including questions about the things listed above. You will **never** be denied help because you did not answer a question, unless we need to know that answer to know if you are eligible for a service.

We will not store or share treatment records about Mental Health, HIV/AIDS, or Drug, Alcohol, or Substance Abuse Treatment unless you give us specific permission.

We may also share some of your information from HMIS with agencies that do not use our HMIS system ("Outside Agencies") for different summary reports about homelessness. Personal Information that could be used to tell who you are will only be put in those reports if we have your written permission, or if the law lets us or requires us to share that information without your permission.

_____ **Please initial here to show that you have read and understand the rules above.**

<u>Consent for Release of Personal Information</u>
In addition to the information sharing above, you can also choose:

- To let HMIS Agencies share and discuss your Personal Information outside of the computer system to help give you services;
- To let HMIS Agencies share your Personal Identifying Information with Outside Agencies for research, reporting, and coordinating services; and
- To let HMIS Agencies put any treatment records about Mental Health, HIV/AIDS, or Drug, Alcohol, or Substance Abuse Treatment into our computer system as part of your Personal Information.

Please think about the information below before making your decisions:

- Personal Information that can be used to tell who you are (Personal Identifying Information) will only be shared with Outside Agencies with your permission, or when the law lets us share that information without your permission.

- If you let us put any treatment records related to Mental Health, HIV/AIDS, or Drug, Alcohol, or Substance Abuse Treatment into our computer system, we will share that information just like the rest of your Personal Information.
- The current list of HMIS Agencies is below. Any agency not on that list is considered an Outside Agency. Other agencies may join this list in the future and share your information just like the current HMIS Agencies. You may ask for an updated list of the HMIS Agencies from **any** HMIS Agency at any time.
- Some of your Personal Information may be protected by additional state and federal privacy laws. Agencies that must follow these laws may need additional permission to collect or share some of your information.
- Once we share your information with an Outside Agency, that agency can sometimes share it with other Outside Agencies, if the law says they can.
- This consent is voluntary. You will **not** be denied services if you decline to sign this consent form.

Current Austin / Travis County HMIS Agencies:

- A New Entry
- AIDS Services of Austin
- Any Baby Can
- Austin Recovery
- Austin Voices for Education and Youth
- Caritas of Austin
- Casa Marianella
- Catholic Charities of Central Texas
- City of Austin – CDU, DACC, EMS
- CommUnity Care
- Ending Community Homelessness Coalition (ECHO)
- Family Eldercare
- Foundation Communities
- Foundation for the Homeless
- Front Steps
- Seton Good Health Solutions Center
- Goodwill Industries of Central Texas
- Green Doors
- Housing Authority – City (HACA)
- Housing Authority of Travis County (HATC)
- Integral Care
- LifeWorks
- LINC Austin
- Meals on Wheels and More
- Mobile Loaves and Fishes
- SAFE Alliance
- Saint Louise House
- Sunrise Homeless Navigation Center
- The Salvation Army
- Travis County – Health & Human Services & Veteran Services
- Travis County – Mental Health Public Defenders
- Trinity Center
- U.S. Department of Veteran Affairs

Client Name / HMIS #: _____

Optional Agencies Section

Please choose one:

_____ **Yes**, all Austin/Travis County HMIS Agencies may share and discuss Personal Information about me and my family outside of the computer system to help give us services. They may also share that information with Outside Agencies for research, reporting, and coordinating services.

Permission to share your information will last for seven years from the date you sign this form. You can cancel this permission at any time by sending a written letter to the agency where you filled out this form. It may take up to three business days to process the cancellation letter.

_____ **No**, I do not want HMIS Agencies to share and discuss my Personal Information outside of the computer system. I also do not want information that can be used to tell who I am to be part of any outside reports or research. HMIS Agencies may only share information in the computer system for questions I choose to answer.

If you chose **NO** above, you can still choose to let HMIS Agencies share and discuss your Personal Information **with specific Outside Agencies or individuals** outside of the computer system to coordinate services. If you want to do that, please initial your choices below.

_____ Contact Person: _____

_____Austin Police Department
_____Capital of Texas Workforce
_____Community Care Collaborative
_____Dell Medical Center
_____Dept. of Assistive & Rehab Services
_____Integrated Care Collaborative
_____Managed Care Organizations
_____Seton/Brackenridge Hospitals
_____Social Security Administration
_____St. David's Hospital
_____TX RioGrande Legal Aid
_____Other
_____Other

Optional Treatment Records Section

Please initial below if you would like to put treatment records about Mental Health, HIV/AIDS, or Drug, Alcohol, or Substance Abuse Treatment in our computer system as part of your Personal Information. We will share this sensitive health information for the record types you initial below:

_____Mental Health Treatment Records

_____HIV/AIDS Test Results and/or Treatment Records

_____Drug, Alcohol, or Substance Abuse Treatment Records

Client Name: _____

Dependents Name(s): _____

Client or Representative Signature: _____ Date: _____

Witness Signature: _____ Date: _____

FOR ORGANIZATIONAL USE ONLY (Initial all that apply):

( ) The client received a telephonic explanation of this form. Staff obtained telephonic acknowledgement of HMIS Data Sharing Policy and documented that consent with the staff signature on this form.
( ) The client wishes to remain anonymous in HMIS.
( ) An authorized representative completed this consent for the client. A description of their right to do so is attached.
( ) Other: _____

Front Steps, Inc. & Austin Resource Center for the Homeless (ARCH)

Consent to Release Information – ARCH Shelter

Updated: 09-29-15

Client Printed Name: _____ _____ **ID#:** _____
First Name *Last Name* *ServicePoint ID*

Front Steps adheres to a strict policy of confidentiality. The identity of all clients and all relevant records and/or information will be kept strictly confidential, with the following exceptions:

1) In cases where we are required by law to report information concerning child, adult or elder abuse.
2) In cases where you report information that you are in danger of harming yourself or others.
3) When you have authorized us in writing to release information about you.

Please be aware that Front Steps staff works as a team and may periodically discuss clients' cases.

In order to best assist you as you continue to work for your goals, it may be helpful for Front Steps staff to release information about you to other social service agencies that you are involved with or seeking assistance from.

Emergencies
In order for Front Steps to best facilitate services during an emergency situation, staff may share the following medical information with medical personnel.

Allergies *(medical, food, etc.)*: _____

_____

_____

Other Medical Issues: _____

_____

_____

In case of emergencies, I ____ DO ____ DO NOT allow Front Steps to share medical information with one or both of the emergency contacts listed below. An emergency may include, but is not limited to hospitalization, incarceration, deportation, death, or other situation that may otherwise leave me incapable.

Emergency Contact #1

Full Name: _____
Relationship to Client: _____
Primary Phone: (_____) _____
Alternate Phone: (_____) _____
Address: _____
City, State, Zip: _____

Emergency Contact #2

Full Name: _____
Relationship to Client: _____
Primary Phone: (_____) _____
Alternate Phone: (_____) _____
Address: _____
City, State, Zip: _____

X _____ Date: _____
(Client Signature)

R6

HMIS Client Intake & Annual Assessment Form PY 2019

Staff Printed Name: _____ Date: _____ ☐ New Client ☐ Annual Assessment

Enter Data As: ☐ Day Resource ☐ Night Shelter ☐ Front Steps-Admin ☐ Case Mgmt. ☐ Other: _____

ID to verify identity (check all that apply): ☐ US Driver's License ☐ US State ID ☐ SS Card ☐ None ☐ Other: _____

ServicePoint ID#: _____ Client's Printed Name: _____
(Last, First, M.I.)

SSN: ___ - ___ - ___ ☐ CL DK ☐ Approx./Partial ☐ CL Ref.

Client Location: ☒ TX-503

DOB: ___ / ___ / ___ *MM/DD/YY* ☐ CL DK ☐ Approx./Partial ☐ CL Refused

U.S. Military Veteran:* ***see key***
- ☐ Yes
- ☐ No
- ☐ Client Doesn't Know
- ☐ Client Refused

Primary / Secondary Race:
- ☐ ☐ Asian
- ☐ ☐ Black or African American
- ☐ ☐ White
- ☐ ☐ Am. Indian/Alaskan Native
- ☐ ☐ N. Hawaiian/Pacific Islander
- ☐ ☐ Client Doesn't Know
- ☐ ☐ Client Refused

Ethnicity:
- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Non-Latino
- ☐ Client Doesn't Know
- ☐ Client Refused

Gender:
- ☐ Female
- ☐ Male
- ☐ Trans Female (Male to Female)
- ☐ Trans Male (Female to Male)
- ☐ Gender Non-Conforming (i.e. Not Exclusively Male or Female)
- ☐ Client Doesn't Know
- ☐ Client Refused

Disabling Condition of a <u>Long</u> Duration: *Answer below;* ***enter specific info on p.2***
- ☐ Yes
- ☐ No
- ☐ CL DK
- ☐ CL Ref

Is Client entering from Streets, Emergency Shelter, or Safe Haven?
- ☐ Yes
- ☐ No

If "Yes", Approximate Start Date:

___ / ___ / ___

Residence Prior to Project Entry:
- ☐ Place not meant for habitation
- ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher
- ☐ Safe Haven
- ☐ Interim housing
- ☐ 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 nursing home
- ☐ Psychiatric hospital or other psychiatric facility
- ☐ Substance abuse treatment facility or detox center
- ☐ 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 (other than RRH) 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 RRH or equivalent subsidy
- ☐ Rental by client, other ongoing housing subsidy
- ☐ Residential project or halfway house with no homeless criteria
- ☐ Staying or living in a family member's room, apartment or house
- ☐ Staying or living in a friend's room, apartment or house
- ☐ Transitional housing for homeless persons
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected
  FEMA subsidized housing

Length of Stay at Prior Residence:
- ☐ 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

Housing Status:
- ☐ Cat. 1 – Literally Homeless
- ☐ Cat. 2 – Imminent Risk
- ☐ Cat. 4 – Fleeing DV
- ☐ At-Risk of Homelessness
- ☐ Stably Housed
- ☐ Client Doesn't Know
- ☐ Client Refused

Regardless of where they stayed Last night, Number of Times the Client has been Homeless in Past 3 Years (including Today)
- ☐ Never
- ☐ 1 Time
- ☐ 2 Times
- ☐ 3 Times
- ☐ 4 or More Times
- ☐ Client Doesn't Know

Status Documented:
Length of Time Homeless
☐ Yes ☐ NO

Total Number of Months Homeless On the Street, in Emergency Shelter, Or Safe Haven in the Past 3 Years? _____

Relationship to Head of Household
- ☐ Self (Head of Household)
- ☐ Child
- ☐ Spouse or Partner
- ☐ Other Relation Member
- ☐ Other: Non-Relation Member

In Perm. Housing?
(RRH/BSS+ Only)
- ☐ Yes
- ☐ **No**

If "Yes," Date of Move-In?

___ / ___ / ___

HMIS Client Intake & Annual Assessment Form PY 2019

(Add amounts listed below for total) $ _____

Receiving Income From Any Source:
(If "Yes," list amounts below)
☐ Yes
☐ No
☐ CL DK
☐ CL Ref

Amount, Source of Income & Start Date ***(MM/DD/YY)***

$	Earned Income	
$	Alimony/Spousal Support	
$	Child Support	
$	General Asst.	
$	Other	
$	Pension/Ret. Former Job	
$	Private Disability Ins.	
$	SS-Retirement Income	
$	SSDI	
$	SSI	
$	TANF	
$	Unemployment Insurance	
$	VA Service-Connected Disability Compensation	
$	VA Non-Service-Connected Disability Compensation	
$	Worker's Compensation	

Health Insurance & Start Date: ***(MM/DD/YY)***

☐ Y	☐ N	MEDICAID	
☐ Y	☐ N	MEDICARE	
☐ Y	☐ N	State Children's Ins.	
☐ Y	☐ N	VA Medical Services	
☐ Y	☐ N	Employer Health Ins.	
☐ Y	☐ N	Cobra Ins.	
☐ Y	☐ N	Indian Health Services	
☐ Y	☐ N	Other	

Source of Non-Cash Benefit(s) & Start Date:
(List amount to right) ***(MM/DD/YY)***

☐ Y	☐ N	SNAP (Food Stamps)		$
☐ Y	☐ N	WIC		$
☐ Y	☐ N	TANF Child Care		$
☐ Y	☐ N	TANF Transportation		$
☐ Y	☐ N	Other TANF Services		$
☐ Y	☐ N	Other		$

Disability Type
see key (Answer each)

ST	LT	NO		Start Date *(MM/DD/YY)*	Impairs Client's Ability to Live Independently ? (Y/N)
☐	☐	☐	Alcohol Abuse		
☐	☐	☐	Drug Abuse		
☐	☐	☐	Both Alcohol/Drug Abuse		
☐	☐	☐	Chronic Health Condition		
☐	☐	☐	Developmental		
☐	☐	☐	HIV/AIDS		
☐	☐	☐	Mental Health Condition		
☐	☐	☐	Physical		

Domestic Violence Victim/Survivor?
☐ Yes
☐ No
☐ CL DK
☐ CL Ref

If "Yes," When Did the Experience Occur?
☐ Not a victim of DV
☐ In the past 3 months
☐ 3 – 6 months ago
☐ 6 – 12 months ago
☐ More than 1 year ago
☐ CL DK
☐ CL Ref

If "Yes," are you currently fleeing DV?
☐ Yes
☐ No
☐ CL DK
☐ CL Ref

If "Yes" to Non-Cash Benefit, List Amount
$ _____
$ _____
$ _____
$ _____
$ _____
$ _____

Is Client Chronically Homeless?
☐ Yes
☐ No
☐ CL DK
☐ CL Ref

Formerly a Ward of Child Welfare/ Foster Care Agency?
☐ Yes
☐ No
☐ CL DK
☐ CL Ref

Enrolled in MAP?
☐ Y ☐ N

As the client named above, I verify that the information recorded on this form is true and correct to the best of my knowledge. I understand that my answers to these questions are for data collection purposes only, and I will not be discriminated against for providing honest answers. I understand that Front Steps, Inc. will release and share this information with other programs and services within the organization.

X _____

Date: _____

STAFF USE ONLY (Initial to confirm completion)

Client Signed:

	HMIS Intake Form, HE Form & Self-Cert?
	FS ROI, Rules Agreement, HMIS Card Agreement?

Staff:

	Enter CL Intake Data & FS (146) ROI into HMIS.
	Create CL Entry into appropriate program.
	Take CL photo/upload/issue Card.
	Create "Note" for Card Issued in HMIS.
	Scan in and Rename HMIS files. Upload files into profile. Move original scans from Record Scans to appropriate drive.

CITY OF AUSTIN

HMIS #_____

EMERGENCY SOLUTIONS GRANT (ESG)

HOMELESS ELIGIBILITY FORM

ESG HOMELESS ELIGIBLITY CATEGORY: *(check only one)*

NOTE: Form is not complete unless the client and staff have signed the second side of document.

☐ *Category 1- Homeless*

(1) Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

i. An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; or

ii. An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, and local government programs for low income individuals); or

iii. An individual who is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

DOCUMENTATION REQUIRED IN HUD'S PREFERRED ORDER:

_____ Third Party/Written:
- If unsheltered: Written referral by of street outreach, law enforcement, EMS, or other shelter record, or homeless certification; or
- If sheltered/exiting an institution: HMIS shelter stay record, or homeless certification, or referral from shelter services or other housing provider; or

_____ Written observation by the intake staff worker; or

_____ Self-Certification by the individual or head of household seeking assistance stating that s(he) was living on the streets or in shelter;

_____ For individuals exiting an institution- one of the forms of evidence above and:
- Discharge paperwork or written/oral referral, or
- Written record of intake worker's due diligence to obtain evidence and certification by individual that they exited institution.

☐ *Category 2- At Imminent Risk of Losing Housing*

(2) An individual or family who will imminently lose their primary nighttime residence, provided that:

i. The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance; and

ii. No subsequent residence has been identified; and

iii. The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks needed to obtain other permanent housing.

DOCUMENTATION REQUIRED:

_____ A court order resulting from an eviction action notifying the individual or family that they must leave; or

_____ For individuals and families leaving a hotel or motel- evidence that they lack the financial resources to stay; or

_____ A documented and verified oral statement; and
- Certification that no subsequent residence has been identified; and
- Self-certification or other written documentation that the individual lacks the resources and support necessary to obtain permanent housing.

N/A *Category 3- Homeless Under Other Federal Statutes – Ineligible Category*

☐ *Category 4- Fleeing/Attempting to Flee Domestic Violence*

(4) Category 4 should only be used when the individual/household does NOT meet any other category but is homeless solely because they are fleeing domestic violence. Category 4 includes any individual or family who:

i. Is fleeing, or is attempting to flee domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence; and

ii. Has no other residence; and

iii. Lacks the resources or support networks, e.g. family, friends, faith-based or other social networks, to obtain other permanent housing.

DOCUMENTATION REQUIRED:

For non-victim service providers:

_____ Oral statement by the individual or head of household seeking assistance that they are fleeing. This statement is documented by a self-certification or by the caseworker. Where the safety of the individual or family is not jeopardized, the oral statement must be verified; and

_____ Certification by the individual or head of household that no subsequent residence has been identified; and

_____ Self-certification or other written documentation that the individual lacks the resources and support necessary to obtain permanent housing.

Does this client also meet the following definition of a Chronically Homeless Person?

The U.S. Department of Housing and Urban Development (HUD) defines a chronically homeless person as:

(1) A "homeless individual with a disability," as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

(i) Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter;

and

(ii) Has been homeless and living as described in paragraph (1)(i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1)(i).

[Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility]; **or**

(2) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; **or**

(3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

☐ **YES** ☐ **NO** ☐ **DON'T KNOW**

If **YES**, then provide the client information requested below:

HOUSING HISTORY FOR CHRONICALLY HOMELESS PERSONS

Most Recent Year

Month/Year	**Description of Homelessness**

Second Year

Month/Year	**Description of Homelessness**

Third Year

Month/Year	**Description of Homelessness**

The above statement of my chronic homeless status is true and complete.

Client Name (Printed) _____ *Client Signature* _____ *Date* _____

FOR INTAKE STAFF ONLY:

Verification Methods: Describe methods to obtain third party documentation (shelter records; outreach programs; medical services; law enforcement; etc.). Describe the outcome of the efforts to obtain documents: _____

The above statements regarding this client's ESG homeless eligibility is true and complete to the best of my knowledge. I have attempted to obtain third party documentation to the best of my ability.

Intake Staff Name (Printed) _____ *Intake Staff Signature* _____ *Date* _____

Self-Certify *for Homeless Eligibility Form* PY 2019

Print Client Name: _____ ServicePoint #: _____

Self-Certification of Homeless by HUD:

Please have client initial box for most appropriate category

☐ CL living in Places Not Meant for Human Habitation OR in a Shelter. (**Cat. 1 Par. 3**)
(please attach current shelter records if CL is staying in our shelter, shelter records must be either day sleep or emergency night shelter)

☐ Written Statement that CL is Fleeing ***OR*** Attempting to Flee Domestic Violence ***AND*** No Subsequent Residence has Been Identified ***AND*** CL Lacks Financial Resources & to Support to Obtain Permanent Housing. (**Cat. 4**)
Also document oral statement below

☐ Residence will be Lost Within 14 days ***AND*** No Subsequent Residence has Been Identified ***AND*** CL Lacks Financial Resources & Support to Obtain Permanent Housing. (**Cat. 2)**

☐ CL exited a Public Institution
***Also needs Proof of Due Diligence form ***

I self-certify that I _____

_____

Self-Certification of Chronically Homeless:

The U.S. Department of Housing and Urban Development (HUD) defines a chronically homeless person as:

(1) A "homeless individual with a disability," as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

(i) Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; **and**

(ii) Has been homeless and living as described in paragraph (1)(i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1)(i).

[Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility]; **or**

(2) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; **or**

(3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

.

☐ YES ☐ NO ☐ DON'T KNOW

** Each episode(s) of homelessness have been documented on the Eligibility Form*

By signing below I certify that the information presented in this certification is true and correct to the best of my knowledge.

_____ _____

Client Signature *Date*

_____ _____

Staff / Witness Printed Name *Staff / Witness Signature*

Front Steps, Inc. & Austin Resource Center for the Homeless (ARCH)

Shelter Rules & Behavior Agreement

Updated: 09-29-15

Client Printed Name: _____ _____ **ID#:** _____
First Name *Last Name* *ServicePoint ID*

All clients, staff, volunteers and guests at the ARCH are expected to adhere to the rules and behavior guidelines set forth within the Shelter. Each is also expected to follow all staff directives.

CLIENT GRIEVANCE PROCESS

The Client Report Form should be used for any shelter issue that a client feels needs correction, improvement, notification, or attention. This process can also be used to appeal a decision made in staffing or in the termination of services. The issue may involve a shelter employee, shelter space or materials, shelter policies, or other shelter clients.

An overview of the process:

1. Client should first talk to the appropriate department's on-duty manager to see if issue can be resolved.
2. If the issue cannot be resolved by the on-duty manager, or if the on-duty manager recommends that the client complete a Client Report Form, the client should do so and place it in the submission box.
3. Forms will be collected on a weekly basis, and distributed to the proper manager for follow-up
4. If client is not satisfied with the outcome, they may request the report be reviewed by the Executive Director.
5. If the client is still not satisfied with the outcome, they may request the report be reviewed by the Appeals Committee of the Front Steps Board of Directors.
6. The decision of the Appeals Committee will be the agency's final decision.

**For full details on the Client Grievance Process Policy, please see the Shelter Operations Standard Operating Procedures.*

Front Steps does not tolerate retaliation to reports submitted by any of its employees, volunteers or clients.

CLIENT STAFFING PROCEDURES

Clients who choose to break the rules and/or choose to not follow staff directive may be asked to leave and return for staffing. Staffing is a meeting between the client and a shelter manager. The incident is discussed, and any disciplinary action is determined.

Suspension lengths vary based on the infraction. In the event a client is asked to leave the shelter, they may be asked to return for staffing. The client must wait a minimum of 24 hours before returning to sign-up for a staffing meeting. Staffing meetings are available on a daily basis.

TERMINATION OF SERVICES

In instances of extreme client misbehavior, Front Steps may choose to terminate services by issuing a Criminal Trespass Warning (CTW). By issuing a CTW, Front Steps is terminating the client's access to all services offered on property at the ARCH. It will be a criminal offense for the client to be on property while CTW is in effect.

The client must participate in a Staffing session to be able to return to property and regain access to services after the end date of the applicable CTW.

CLIENT AGREEMENT

I understand that as a client of Front Steps, and by participating in programs at the Austin Resource Center for the Homeless, I am expected to abide by the rules and behavior guidelines set forth by the agency. I understand that these rules and guidelines may be updated by Front Steps Shelter Operations as needed, and that it is my responsibility to be aware of postings within the facility that notify me of these changes.

X _____ Date: _____

R5

Front Steps, Inc. & Austin Resource Center for the Homeless (ARCH)

New HMIS Card Agreement

Updated: 09-29-15

Client Full Printed Name: _____ **ServicePoint ID#:** _____

I understand that:

Initial each statement

_____ The card is the property of the Agency.

_____ The card is issued to assist in the identification of the valid cardholder and is to be presented to Agency staff for utilizing services *(services include entrance into the building)* offered to me.

_____ The card is non-transferable. Altering or intentionally damaging my card, using another person's card, or allowing my card to be used by another person will result in disciplinary action.

_____ The card is only valid while I am a registered client *(7 years from the last day of services used)*

_____ The photograph taken for the HMIS card must be perceptible *(i.e. no hats, no sunglasses, and no items obscuring the face, etc.)*

_____ I am responsible for following the Replacement Procedures outlined below in order to replace my card if lost, stolen or intentionally damaged.
As a courtesy, the Agency will replace your card for purposes of natural wear and/or deactivation.

Replacement Card Procedures:

1st Replacement:
FREE

2nd Replacement:
2 Service Hours

3 or more Replacements:
4 Service Hours per Replacement

Community Service hours must be completed through Front Steps' Community Service Restitution program in order to replace a lost, stolen or intentionally damaged HMIS identification card.

STAFF VERIFICATION
Please initial next to each step upon completion

PREPARER CHECK-LIST:

Form(s) of ID used to verify identity (check all that apply)

☐ US Driver's License ☐ US State ID

☐ SS Card ☐ None

☐ Other: _____

_____ Take and Upload Photo to HMIS

_____ Add note into HMIS that client signed form and received card

Place form in Completed HMIS File Folder

NIGHT STAFF ONLY

_____ Scan and upload agreement into HMIS

As the client named above, I agree to abide by the policies stated above in this document. Furthermore, I understand that the policies in the Card Agreement may be updated by the staff as needed, and that it is my responsibility to be aware of postings within the facility that notify me of these changes.

X _____ Date: _____

L7