



COMMUNITY ACTION TEAM (CAT) HOUSING SOLUTIONS ASSESSMENT/INTAKE PACKET

www.cat-team.org ~ Ph:(503)397-3511 ~ Fax:(503)397-3290 ~ 125 N 17th St., Saint Helens OR 97051

Coordinated Entry:

Funding is limited and financial assistance is not guaranteed. To ensure a fair and equitable process all requests for assistance will be entered through Coordinated Entry. Coordinated Entry is a process developed to ensure that all people experiencing a housing crisis have fair and equal access and are assessed for, referred, and connected to housing and assistance based on their strengths and needs. Contact and demographic information for individuals/households applying for assistance may be maintained on the Coordinated Entry by-name list until which time it is removed.

Client Eligibility:

- Must prove that the household has ability to financially sustain housing without assistance.
- Must meet income eligibility.
- Must be homeless or at risk of homelessness (documentation required).
- Due to funding restrictions we will not assist with: Unmanaged single room occupancy, halfway house, drug rehabilitation, rent to own, or subsidized rent portions.
- Must be a Columbia County resident. Some private funding sources may require the applicant to be an established Columbia County Resident for 6 months or longer.

Intake Procedure:

- After the request for assistance is received, an assessment, review, and a request for any further information/documentation will be made within seven (7) business days of receipt.
- Eligibility will be determined within three (3) business days of receipt of all required information/documentation.
- If monetary assistance request is denied, a verbal notification will be attempted as well as a written notice stating the reasons for denial. Said notice will contain a copy of the Grievance Policy and Procedure.

Services for Deaf and/or hearing impaired customers:

Oregon Telecommunication Relay Service is a service that links Deaf and/or Hearing impaired persons via telephone.

TTY/Voice 711 or 1-800-735-2900

Hours: 9 a.m. to noon, 1 p.m. to 5 p.m.

To use this service, dial the number listed above. Give the agent the number you would like to call and he or she will stay on the line to relay the conversation. You can communicate directly with the person you contacted. All calls and information are confidential.

NOTE:

- Any rental assistance payments from CAT will be directly mailed to landlord, only if the landlord is willing to work with the tenant and CAT. The payable process takes 7 to 14 business days.
- CAT staff will not steer clients into any particular housing. We may make suggestions and inform you of options based on household needs/barriers but it is the applicant/client(s) responsibility to find/select housing that best fits their needs.

****Please turn in the following documentation when you turn in your packet, additional documentation may be required/requested.**

- 1) Photo ID for all adults listed
- 2) Social Security cards for everyone in the household
- 3) Proof of income for the last 30 days for the household (e.g. pay stubs, current year Social Security letter)
- 4) Any notices given by landlords, family members, etc. pertaining to your housing situation.

****Absence of the requested forms may delay evaluation and eligibility determination.**

Office Use Only

CAT Staff:

- Heather Johnson 503-366-6559
- Melissa Kyles 503-366-6561
- Kayla Davis 503-366-6591
- Kristen Erickson 503-366-6558
- Lacy Chamberlain 503-366-6557
- _____

Initial Assessment type and date:

- CAT Office Phone/Email
- Outreach Other: _____

Date contacted ____/____/____

Pending Assistance:

Task List:

Unable to Assist:

- Zero income
- No contact/disappeared
- Missing documents/information
- Other: _____

Ineligible due to:

- Lack of sustainable housing plan
- Housing status
- Income exceeds eligibility
- Zero funding available
- Other: _____

Referrals:

Apartment List

- ___ Private Landlords
- ___ Subsidized Housing (Woodland Trails 503-397-4988, Sol Havn 503-728-3169)
- ___ Senior Subsidized Housing (Columbia Hills 503-397-6131, Victorian 503-987-1842)
- ___ City/Team Overnight Shelter Voucher (526 Grand Ave, Portland)
- ___ Columbia Health Services (503-397-4651)
- ___ Community Meals (Lutheran Church) Tuesday & Thursday

DHS

- ___ Self Sufficiency (Food Stamps/TANF/Jobs Program 503-397-1784)
- ___ Adults and People with Disabilities (503-397-5863)
- ___ Eisenschmidt Pool Shower Pass
- ___ Energy Assistance (503-397-3511)
- ___ Food Bank (St. Helens 503-397-9708, Scappoose 503-543-7495, Rainier 503-556-0701, Clatskanie 503-728-3126, Vernonia 503-429-1414)
- ___ Healthy Families (Sunday Kamppi 503-366-0800)
- ___ Mental Health (CCMH 503-397-5211, Medicine Wheel 503-396-5322)
- ___ Mortgage/Foreclosure Assistance (503-325-8098)
- ___ OHP (Columbia Health Services 503-397-4651, Medicine Wheel 503-396-5322)

Oregon Law Center (503-397-1628)

OTAP (1-800-848-4442), Assurance Phone (1-888-321-5880)

Parole and Probation (503-397-6253)

Pregnancy Center (503-397-6047)

SAFE (503-397-6161)

Section 8 (NOHA 1-800-927-9275)

Self Help Housing (503-366-6550)

Senior Services (503-366-6542)

Shelter-Community House on Broadway (360-425-8679)

Tenant Landlord Hotline (1-877-296-4076)

Transitional Housing (Sheriff Department 503-397-6253)

Unemployment Office (503-397-4995)

Veteran Service Officer (503-366-6580) / VASH (971-200-0351)

Vocational Rehab (503-366-8383)

Warming Center (503-410-5800)

Weatherization (503-366-6552)

WIC (503-397-4651)

Work Source (503-397-6495)

Other _____

- X – Connected**
- R – Referred**
- N – Not eligible**



| Name (First, Middle, Last) | Relation to head of household | AGE | D/O/B <small>MM/DD/YY</small> | SOCIAL SECURITY NUMBER | Gender | Military Service Era: | | | | | | | | | | | Race | | | | | | | | Non-Cash Benefits | | | | | | | | | | | | | | | |
|----------------------------|-------------------------------|-----|----------------------------------|------------------------|--------|---------------------------|--------------------|----------------------|-----------------|-----------------|---------------------------|------------------------|-------------------------------|-------------|--------------------------------|-------------|--------------------------|------------------------|------------------------|--------------------|----------------|------------------|------------------------|-----------------------|-------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| | | | | | | Military Experience (Y/N) | Language (E,S,C,F) | Education (K-12/12+) | Disabled? (Y/N) | Pregnant? (Y/N) | Hispanic or Latino? (Y/N) | African American (Y/N) | Am.Indian/Alaska Native (Y/N) | Asian (Y/N) | Nat. Hawaiian/P.Islander (Y/N) | White (Y/N) | Don't Know/Refused (Y/N) | Food Stamps/SNAP (Y/N) | State Health Insurance | Medicaid/OHP (Y/N) | Medicare (Y/N) | VA Medical (Y/N) | Other Health Insurance | TANF Child Care (Y/N) | WIC (Y/N) | | | | | | | | | | | | | | | |
| | Self | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Household Contact Info:

Phone number: _____ Message Cell Home

E-Mail Address: _____@_____.com

Physical Address: _____ City: _____ State: _____ Zip: _____

Same as Mailing Address

Mailing Address: _____ City: _____ State: _____ Zip: _____

Are you a victim of Domestic Violence?
 Yes No

If yes, how long ago did it occur? _____

If yes, are you currently fleeing?
 Yes No

**Risk of homelessness:
(check only one)**

- Literally Homeless
- 72 hour notice
- 7 days or less
- 7-14 days
- 15-30 days
- More than 30 days

Where did you stay last night? (Check only one):

- Rent with no subsidy
- Rent with subsidy
- Section 8/ NOHA
- Own Home with subsidy
- Own home
- Hotel/Motel
- Foster Care/Group Home
- Nursing Home
- Staying/Living with Friends
- Staying/Living with Family
- Substance Abuse Treatment Facility
- Hospital (Non-Psychiatric)
- Psychiatric Hospital/Facility
- Jail, Prison or Juvenile Detention
- Other _____
- Car
- Street
- Camping
- Iron Tribe
- Transitional Housing
- Emergency Shelter

Length of Stay:

- One day or less
- Two days to 1 week
- More than 1 week/Less than 1 month
- 1 to 3 months
- 4 to 12 months
- 1 year or longer

1. Please give us a short summary of your housing situation:

2. Total Assistance Requested

a. How much are you requesting from Community Action Team? \$ _____

b. How much do you have to put towards your rent or deposit? * \$ _____

* Our funding is very limited and we are required to utilize every avenue possible when it comes to assistance. Your household may be required to pay a portion towards your rent/deposit.

3. How long have you been a resident of Columbia County? _____

4. Complete A or B below:

a. If Homeless:

• What caused you to be homeless? _____

• Last Night did you stay in/on the streets, emergency shelter, or safe haven? Yes/No

• Approximate date homelessness started: ____/____/____

• Can someone document the length of time you have been homeless? Yes/No

• Number of **times** you have been homeless in the past 3 years: _____

• If 4 or more times, total number of **months** homeless in the last 3 years: _____

• Total number of months **continuously homeless** on the street, emergency shelter, or safe haven in the past 3 years: _____

b. If housed:

• Approximate date you moved into your current place: ____/____/____

• Landlord information

1. Name of Landlord: _____

2. Landlord Phone number: _____

3. Address of landlord: _____

• Have you received a notice to vacate your current residence? Yes/No

• How will you pay your rent next month? _____

5. Have you been working with anyone to receive assistance with your housing within the last 12 months?

| Who: | Amount received this month: |
|--------------------|-----------------------------|
| Family: | |
| Friends: | |
| Church Name: _____ | |
| Agency: _____ | |
| Other: _____ | |

No resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent household from becoming literally homeless.

Budget and Barriers

RESOURCES:

| <u>SOURCE</u> | <u>MONTHLY AMOUNT:</u> | <u>PERSON RECEIVING:</u> |
|------------------------|------------------------|--------------------------|
| ___ No Income | | _____ |
| ___ Unemployment | \$ _____ | _____ |
| ___ Employment | \$ _____ | _____ |
| ___ Food Stamps | \$ _____ | _____ |
| ___ TANF | \$ _____ | _____ |
| ___ SSI | \$ _____ | _____ |
| ___ SSDI | \$ _____ | _____ |
| ___ Social Security | \$ _____ | _____ |
| ___ Child Support | \$ _____ | _____ |
| ___ Pension | \$ _____ | _____ |
| ___ VA Pension | \$ _____ | _____ |
| (non-svs connected) | | |
| ___ VA Pension | \$ _____ | _____ |
| (Svs Connected) | | |
| ___ Widows Benefits | \$ _____ | _____ |
| ___ Trust Fund | \$ _____ | _____ |
| ___ Alimony | \$ _____ | _____ |
| ___ Tribal Benefits | \$ _____ | _____ |
| ___ Family | \$ _____ | _____ |
| ___ Other: _____ | \$ _____ | _____ |
| Total Resources | \$ _____ | _____ |

EXPENSES:

| <u>ITEM</u> | <u>CURRENT</u> | <u>BACK OWING</u> |
|-----------------------|-----------------|-------------------|
| ___ Rent | \$ _____ | \$ _____ |
| ___ Security Deposit | \$ _____ | \$ _____ |
| ___ Mortgage | \$ _____ | \$ _____ |
| ___ Electric | \$ _____ | \$ _____ |
| ___ Natural Gas | \$ _____ | \$ _____ |
| ___ Water/Sewer | \$ _____ | \$ _____ |
| ___ Garbage | \$ _____ | \$ _____ |
| ___ Phone | \$ _____ | \$ _____ |
| ___ Internet | \$ _____ | \$ _____ |
| ___ TV | \$ _____ | \$ _____ |
| ___ Food | \$ _____ | \$ _____ |
| ___ Child Support | \$ _____ | \$ _____ |
| ___ Child Care | \$ _____ | \$ _____ |
| ___ Car Payment | \$ _____ | \$ _____ |
| ___ Car Insurance | \$ _____ | \$ _____ |
| ___ Gasoline | \$ _____ | \$ _____ |
| ___ Car Repair | \$ _____ | \$ _____ |
| ___ Household Items | \$ _____ | \$ _____ |
| ___ Laundry | \$ _____ | \$ _____ |
| ___ Health Insurance | \$ _____ | \$ _____ |
| ___ Cigs/Alcohol | \$ _____ | \$ _____ |
| ___ Medical Bills | \$ _____ | \$ _____ |
| ___ Medication | \$ _____ | \$ _____ |
| ___ Court Fees | \$ _____ | \$ _____ |
| ___ Credit Cards | \$ _____ | \$ _____ |
| ___ Storage Unit | \$ _____ | \$ _____ |
| ___ Other: _____ | \$ _____ | \$ _____ |
| Total Expenses | \$ _____ | \$ _____ |

BARRIERS:

| | √ (if applies) | Name: | | √ (if applies) | Name: |
|---------------------------|----------------|-------------|---------------------------------|----------------|-------|
| Physical Disability | _____ | _____ | Owe money to Past Landlord | _____ | _____ |
| Mental Health Disability | _____ | _____ | Damages to past rentals | _____ | _____ |
| Developmental Disability | _____ | _____ | Evictions/Last 10 yrs | _____ | _____ |
| Alcohol Abuse | _____ | _____ | Mortgage Foreclosure | _____ | _____ |
| Drug Abuse | _____ | _____ | Bankruptcy/Last 10 yrs | _____ | _____ |
| Chronic Health Condition | _____ | _____ | Illegal Chemical Conviction | _____ | _____ |
| Companion/Service Animals | _____ | Type: _____ | Misdemeanor Convictions | _____ | _____ |
| HIV Positive | _____ | _____ | Sex Offender | _____ | _____ |
| Lack of rent/mortgage | _____ | _____ | Felony Convictions/last 10 yrs. | _____ | _____ |
| Lack of Screening Fees | _____ | _____ | Theft Convictions | _____ | _____ |
| Lack of Security deposit | _____ | _____ | Assault Convictions | _____ | _____ |
| Lack of Day Care | _____ | _____ | | | |



Housing Options/Resource Eligibility/ Asset Worksheet

Applicant:

Name: _____ Date: _____

➤ Are there any financial or support networks available to your household that can be used to help you remain in your current housing or to obtain other appropriate housing? YES NO

If yes, please explain: _____

➤ Does anyone in the household have a checking or savings account? YES NO

If yes, please note account balances and attach bank statement for last 30 days.

Checking \$ _____ Savings \$ _____

➤ Non Cash Assets:

| TYPE OF ASSET | TOTAL VALUE | FEES OR PENALTIES | CASH VALUE (TOTAL VALUE MINUS PENALTIES) | INTEREST RATE | ACTUAL ASSET INCOME (MULTIPLY CASH VALUE BY INTEREST RATE) |
|----------------|-------------|-------------------|--|---------------|--|
| | | | | | |
| | | | | | |
| TOTALS: | | | | | |

To the best of my knowledge, I have no assets to report.

By signing these forms, I declare that all of the information provided to Community Action Team, Inc. Housing Solutions is true and correct to the best of my knowledge. I understand that if it is discovered that I have provided false information I could be denied services.

Applicant Signature

Date

OFFICE USE ONLY

CAT Staff:

Subsequent Housing Options: *Please assess with the applicant what appropriate subsequent housing options might be available to the household.*

➤ Are there any appropriate subsequent housing options for this household? YES NO

If yes, please explain: _____

➤ Have you verified that no other appropriate subsequent housing options are available? (I.e. Friends/family/ hotel/motel/other agencies) YES NO

Financial Resources and Support Networks: *Please assess with the participant all financial resources and support networks that might be available to the household.*

➤ Have you verified that the household lacks the financial resources and support networks to maintain housing? YES NO

Staff Signature _____ Date: _____



COMMUNITY ACTION TEAM, INC. INCOME VERIFICATION
(Only for new income prior to receiving the first paycheck)

Applicant's Name: Last 4 digits of SSN:

Applicant's Signature Date

Employer Agency: Phone: Fax:

Employer Address: City: Zip:

Dear Employer:

The person listed above is applying for assistance through CAT. Part of the criteria for this process includes income verification to determine this household's financial eligibility. We are required by Federal regulations to verify the income of all program participants. Please complete all the information below. Thank you for your assistance.

Place of employment:

Employee's title, position or type of work:

Date employment began: Date employment ended:

Number of hours worked per week (use average if inconsistent):

Hourly wages: \$ or Annual gross salary: \$

Gross year-to-date earnings: \$ as of what date: / /

Number of weeks employed each year:

Tips, commission, other: Year \$ Week \$ Month \$

Expected change in pay: \$ hourly/monthly/annually Effective date: (circle one)

Employer Signature Date Company

Employer Name (Printed) Phone Number

Record of Oral Verification: CAT Staff:

Person Contacted: Representing:

Information supplied: Date and time:

Blank lines for additional information.

Please return to: CAT, Inc. Housing Solutions Programs, 125 N. 17th St. Helens, OR. 97051 (Phone) 503-397-3511 (FAX) 503-397-3290

OFFICE USE ONLY



COMMUNITY ACTION TEAM, INC.
HOUSING SOLUTIONS

GENERAL RELEASE OF INFORMATION

Consent: I give permission for Community Action Team, Inc. to share and exchange information with other staff at the agencies listed below for the purpose of providing assistance to me.

Information Covered: I understand that depending on the program policies previous or current, information regarding my household or myself may be needed. Verification and inquiries that may be requested include but are not limited to:

- Identity Verification Social Security/Disability Status Employment/Income/Asset Verification
Marital Status Criminal/Credit/Rental History Medical/Mental Health Information

Groups or Individuals that may be asked: The groups or individuals that may be asked to release the about information (depending on program requirements) include but are not limited to:

- Potential Landlords Previous Landlords Medical and Mental Health Providers
Current Landlords Past and Present Employers Department of Human Services & their contractors
Utility Companies Social Security Administration Oregon Housing and Community Services (OHCS)
Foods Banks Courts and Probation & Parole Northwest Oregon Housing Authority (NOHA)
Homeless/DV shelters Law Enforcement Agencies Federal, State and/or local Tribal Benefits Agencies
Continuum of Care Support and Alimony Providers Credit Report Providers and Credit Bureaus
Public Health Agencies Child Care Providers Veteran's Administration
Retirement Systems Vocational Rehabilitation (DHS) Housing and Service Providers
Financial Institutions Community Action Agencies Drug and Alcohol Treatment Facilities
Schools and Colleges Other Other

Computer Matching HMIS Notice and Consent: I understand and agree that CAT, Inc. may conduct computer-matching programs (OPUS & ServicePoint) to verify the information supplied for my application rectification. If a computer match is done, I understand that I have a right to notification of any adverse information found and a chance to dispose of incorrect information. CAT, Inc. may in the course of its duties, exchange automated information with other Federal, State, County or Local agencies, including but not limited to: State Employment Security Agencies, Department of Defense; Office of Personnel Management; the US Postal Service; The Social Security Administration and State Welfare and Food Stamp agencies; OHCS-OPUS partner Agencies.

Conditions: I understand that this authorization cannot be used to obtain any information about me that is not pertinent to my eligibility for, and/or continued participation in a CAT, Inc. housing assistance program. I understand this release is valid for the duration of my program/assistance or one year unless otherwise noted. I understand that I can revoke this consent at any time, by notifying Community Action Team, Inc. (Note: If this occurs, client could write revoked on bottom of this form with date).

All adults over the age of 18 must sign this release of information.

Printed Name Signature Date
Printed Name Signature Date
Printed Name Signature Date

Columbia County Homeless Management Information System (HMIS) CLIENT CONSENT FOR DATA COLLECTION AND RELEASE OF INFORMATION

What is the HMIS? HMIS is a computer data system that collects and stores information on individuals and families using services. The data will be used to describe the number and characteristics of program clients. It tracks the type of service given and how often services are used. HMIS is used to assess local service needs and to assist our community to make informed decisions about the most effective service delivery models.

What is the purpose of this form?

With this form, you can give permission to have information about you collected and shared with partner agencies that help Community Action Team provide housing and services. Partner agencies are listed below.

| | |
|--|---|
| Oregon Housing and Community Services (OHCS) | Rural Oregon Continuum of Care (ROCC) |
| Northwest Oregon Housing Authority (NOHA) | Department of Human Services (DHS) |
| Medicine Wheel Recovery Services (MWRS) | Clatsop Community Action Team (CCA) |
| Community Action Resource Enterprise (CARE) | Department of Veteran’s Affairs (VA) |
| Housing and Urban Development (HUD) | Columbia Community Mental Health (CCMH) |

BY SIGNING THIS FORM, I AUTHORIZE Community Action Team to share HMIS information with partner agencies. The HMIS information shared will be used to help me get housing and services. It will also be used to better understand and improve housing and homeless service programs. I understand that the partner agencies may change over time. The information to be collected and shared includes:

| | |
|--|---|
| Name, birthday, gender, race, ethnicity, social security number, phone number, address | |
| Basic medical, mental health, substance use, and daily living information | |
| Housing Information | Use of crisis services, hospitals, and jail |
| Employment, income, insurance, and benefits | Results from assessments |

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- Community Action Team and partner agencies will keep my HMIS information private using strict privacy policies. I have the right to review their privacy policies.
- I can receive a copy of this Consent and the Client Information Sheet
- I may refuse to sign this Consent. If I refuse, I will not lose any benefits or services.
- This Consent will expire 7 years from my last HMIS recorded activity.
- I may revoke this Consent at any time in writing. The revocation will take effect upon receipt, except to the extent others have already acted under this Consent, and after partner, agencies and Community Action Team have been notified so that revocation does not interfere with care or service coordination.
- My HMIS information may be further shared by the partner agencies to other agencies for care coordination, counseling, food, utility assistance, and other services.
- My HMIS information may be viewed by auditors or funders who review work of the partner agencies, including HUD, the Dept. of Veteran Affairs, the Dept. of Health and Human Services, and Oregon Housing and Community Services (OHCS). I understand that the list of auditors and funders may change over time.
- My HMIS information may be used to help evaluate the quality of services provided. It may also be used for research purposes that align with Community Action Team’s goals and mission.

SIGNATURE:

_____ Printed Name

_____ Signature of Client or Representative

_____ Date

_____ Printed Name

_____ Signature of Client or Representative

_____ Date



Member Counties: Baker, Benton, Clatsop, Columbia, Coos, Curry, Douglas, Gilliam, Grant, Harney, Hood River, Josephine, Klamath, Lake, Lincoln, Linn, Malheur, Marion, Morrow, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Wheeler, Yamhill

Rural Oregon Continuum of Care (ROCC) HMIS Client Consent to Release of Information for Data Sharing in Rural Oregon Balance of State

Rural Oregon Continuum of Care Homeless Management Information System (HMIS) is a computer system that is used to collect and share information on homelessness and social services throughout Rural Oregon Balance of State. The information gathered by Community Action Team and HMIS allows agencies to plan and deliver services that help people in need. By sharing information with each other, agencies are able to simplify service delivery by coordinating services and referrals across agencies.

Maintaining the privacy and safety of those using our services is very important to us. The HMIS runs in compliance with all Federal and State laws and codes, including Health Insurance Portability and Accountability Act (HIPAA). Every person and agency that is authorized to read or enter information into the database has been trained on client confidentiality policies and has signed an agreement to maintain the security and confidentiality of the information. Any person or agency that is found to violate their agreement may have their access rights ended and may be subject to further penalties.

Services will not be denied should you choose not to share information. Information will still be collected and entered because of our federal and state requirements. **Certain minimum client information is shared throughout our HMIS in order to avoid creating duplicate client records.** Authorized HMIS persons at participating community agencies will be able to see the following data elements of all client records:

- First Name
- Last Name
- Date of Birth
- Veteran Status
- Gender
- Social Security Number (required for specific services)

Please read the following statements and consult with your agency staff if you have any questions:

I UNDERSTAND THAT:

- I will not be denied services if I decline to share my data beyond the minimum requirements.
- The release of my information does not guarantee that I will receive assistance.
- The partner agencies will share my basic identifying information (Name, DOB, Veteran Status, Gender, SSN) in order to improve service delivery and reduce duplicate data collection.
- Any details about the programs I participate in or information I share with agency staff will not be disclosed to any third party unless I give written authorization or it is otherwise required by law. We must still report some information because of our federal, state or funder requirements.
- This authorization will remain in effect for 7 years unless I revoke it in writing by signing a written statement or Revocation form.
- I understand that I may cancel my consent to data sharing at any time. However, doing so will not change information that has already been given out or actions already taken. Revocation will be effective as of that date.
- I have the right to see my HMIS record, ask for changes, and to have a copy of my record from this agency upon written request.

- I have the right to file a complaint if I feel I have been harmed in some way by the use of HMIS.
- I have the right to receive a copy of the HMIS Notice to Clients of Uses and Disclosures.

Maintaining the privacy and safety of those using our services is very important to us. Your record will only be shared if you give us permission to do so. There may be risks and/or benefits for you to consider before you decide whether or not to consent to the release of information.

By writing your initials below, you agree to share the following level of information for yourself and all household members listed below with other Rural Oregon Balance of State HMIS partner agencies.

____ 1) In addition to the minimum required data elements (Name, DOB, Gender, Veteran Status, SSN), **I agree to share** additional demographic information (including Race and Ethnicity), program enrollment and exit Information, information about the nature of my situation, services and referrals I receive, and contact information via the Rural Oregon Balance of State HMIS with other Rural Oregon Balance of State HMIS partner agencies.

OR

____ 2). Beyond the minimum required data elements (Name, DOB, Gender, Veteran Status, SSN), **I DO NOT agree to share** any additional information through the Rural Oregon Balance of State HMIS with other Rural Oregon Balance of State HMIS partner agencies.

Please list the names and dates of birth of all household members participating in services:

Client/Parent or Guardian Name (please print)

Client/Parent or Guardian Signature

Date

If applicable:

Additional Adult's Name (please print)

Additional Adult's Signature

Date

Agency Personnel Name (please print)

Agency Personnel Signature

Date

Community Action Team

Mutual Respect Policy



Client Participation

Any individual seeking services will not be denied access to services, if they are unable to answer the questions asked during the assessment process.

Mutual Respect Policy

It is the goal of Community Action Team to provide services of the highest quality, and to provide those services in a manner that is professional, respectful, and based on the dignity and rights of the people we serve. Likewise, we expect our clients to treat staff members and other clients in a manner that is respectful, and based on the dignity and rights of others.

Anti-discrimination Policy

The program will not discriminate against any individual or family because of race, color, national origin, religion, gender, disability, familial status, sexual orientation/gender identity, source of income, or domestic violence. Reasonable accommodations will be offered to all disabled persons who request them at any time during the application or selection process, and throughout program involvement.

Dispute Resolution Process

Community Action Team has the right to deny services or terminate services to any individual who: engages in behavior that presents a danger to other people or disrupts the delivery of services to other clients; creates a hostile environment; or commits acts of fraud, deceit, or trickery. Any individual who is denied services or is terminated from services has the right to appeal that decision and may inquire about the agency's dispute resolution process.

| | | |
|---------------------|------------------|-------|
| _____ | _____ | _____ |
| Client Name (print) | Client Signature | Date |
| _____ | _____ | _____ |
| Client Name (print) | Client Signature | Date |

Community Action Team Inc.

Fraud Policy

Giving false information, failing to provide, or willfully withholding information pertaining to eligibility or continued eligibility will be considered fraud.

Eligibility information includes but it not limited to:

- Housing status
- Household composition
- All sources of income your household receives including but not limited to: wages including under the table work, regular income from recycling, can returns, etc., TANF payments, SNAP benefits, alimony, social security pension, disability, workers compensation, unemployment, tax refunds, tribal benefits, SNAP benefits, bonuses, etc.
- All other assets, to include but not limited to: real property, vehicles, savings, retirement accounts, etc.

If it is determined that you have provided false or willfully withheld information pertaining to eligibility you are subject to the following.

- Denial, reduction of services, disqualification and/or termination from program.
- Potential criminal charges and any penalties associated with such.
- Required repayment of all overpaid assistance.

While applying for or receiving assistance it is your responsibility to ask questions if you are unclear or do not understand any of the information being presented to or required from you.

By signing below you acknowledge that you have read and understand the above.

Participant Signature

Printed Name

Date

Participant Signature

Printed Name

Date