

**HOUSING AND FAMILY SERVICES**  
Housing Information Sheet

Name: \_\_\_\_\_  
 Phone/Message \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 Email Address: \_\_\_\_\_  
 Have you ever gone by any other name than what is written above?  Yes  No  
 If yes, please list: \_\_\_\_\_  
 Are you currently receiving any services through TrueNorth?  Yes  No  
 If yes, please explain: \_\_\_\_\_  
 How did you hear about TrueNorth Community Services? \_\_\_\_\_

**Household Information**

Total Household Monthly Income \_\_\_\_\_  
 Does anyone in your household have a disabling condition?  Yes  No  
 If yes, please name the Household members here: \_\_\_\_\_  
 Do you have a DHS worker?  Yes  No  
 If yes, what is your DHS Case Worker's Name? \_\_\_\_\_

**Required For All Household Members**

Full Name	Relationship to Head of Household	Social Security Number	Active Duty US Military Veteran?	Date of Birth mm/dd/yyyy	Gender	Race (Select all that apply)	Ethnicity
	<input type="checkbox"/> Child <input type="checkbox"/> Spouse or partner <input type="checkbox"/> Other family member <input type="checkbox"/> Other non-family member	_____ _____ OR _____ _____ <input type="checkbox"/> Don't know <input type="checkbox"/> Refuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____/_____/_____ OR _____/_____/_____ <input type="checkbox"/> Don't know <input type="checkbox"/> Refuse	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender male to female <input type="checkbox"/> Transgender female to male <input type="checkbox"/> Other	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White	<input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Don't know <input type="checkbox"/> Refuse
	<input type="checkbox"/> Child <input type="checkbox"/> Spouse or partner <input type="checkbox"/> Other family member <input type="checkbox"/> Other non-family member	_____ _____ OR _____ _____ <input type="checkbox"/> Don't know <input type="checkbox"/> Refuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____/_____/_____ OR _____/_____/_____ <input type="checkbox"/> Don't know <input type="checkbox"/> Refuse	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender male to female <input type="checkbox"/> Transgender female to male <input type="checkbox"/> Other	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White	<input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Don't know <input type="checkbox"/> Refuse
	<input type="checkbox"/> Self (Head of household)	_____ _____ OR _____ _____ <input type="checkbox"/> Don't know <input type="checkbox"/> Refuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____/_____/_____ OR _____/_____/_____ <input type="checkbox"/> Don't know <input type="checkbox"/> Refuse	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender male to female <input type="checkbox"/> Transgender female to male <input type="checkbox"/> Other	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White	<input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Don't know <input type="checkbox"/> Refuse

Full Name	Relationship to Household	Social Security Number	Active Duty US Military Veteran?	Date of Birth mm/dd/yyyy	Gender	Race (Select all that apply)	Ethnicity
	<input type="checkbox"/> Child <input type="checkbox"/> Spouse or partner <input type="checkbox"/> Other family member <input type="checkbox"/> Other non-member <input type="checkbox"/> family member	<input type="checkbox"/> Child <input type="checkbox"/> Spouse or partner <input type="checkbox"/> Other family member <input type="checkbox"/> Other non-member <input type="checkbox"/> family member	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Transgender male to female <input type="checkbox"/> Transgender female to male <input type="checkbox"/> Other	<input type="checkbox"/> American Indian <input type="checkbox"/> or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Islander <input type="checkbox"/> White	<input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse	<input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse
	<input type="checkbox"/> Child <input type="checkbox"/> Spouse or partner <input type="checkbox"/> Other family member <input type="checkbox"/> Other non-member <input type="checkbox"/> family member	<input type="checkbox"/> Child <input type="checkbox"/> Spouse or partner <input type="checkbox"/> Other family member <input type="checkbox"/> Other non-member <input type="checkbox"/> family member	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Transgender male to female <input type="checkbox"/> Transgender female to male <input type="checkbox"/> Other	<input type="checkbox"/> American Indian <input type="checkbox"/> or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Islander <input type="checkbox"/> White	<input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse	<input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse
	<input type="checkbox"/> Child <input type="checkbox"/> Spouse or partner <input type="checkbox"/> Other family member <input type="checkbox"/> Other non-member <input type="checkbox"/> family member	<input type="checkbox"/> Child <input type="checkbox"/> Spouse or partner <input type="checkbox"/> Other family member <input type="checkbox"/> Other non-member <input type="checkbox"/> family member	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Transgender male to female <input type="checkbox"/> Transgender female to male <input type="checkbox"/> Other	<input type="checkbox"/> American Indian <input type="checkbox"/> or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Islander <input type="checkbox"/> White	<input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse	<input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse

**Required for all Adults in the Household**

<p>Full Name</p>	<p>Where did you sleep last night?</p>	<p>How long have you slept in that location?</p>	<p>Have you been continuously homeless for at least one year?</p>	<p>How many times have you been homeless in the past three years?</p>
	<p> <input type="checkbox"/> Emergency Shelter  <input type="checkbox"/> Own Home (Mortgage or Land Contract)  <input type="checkbox"/> Place not meant for human habitation (a vehicle, anywhere outside)  <input type="checkbox"/> Rental  <input type="checkbox"/> Staying or living in a family member's room,  <input type="checkbox"/> apartment, or house  <input type="checkbox"/> Staying or living in a friend's room,  <input type="checkbox"/> apartment, or house  <input type="checkbox"/> Other: _____         </p>	<p> <input type="checkbox"/> One day or less  <input type="checkbox"/> Two days to one week  <input type="checkbox"/> More than one week, but less than one month  <input type="checkbox"/> One to three months  <input type="checkbox"/> More than three months, but less than one year  <input type="checkbox"/> One year or longer  <input type="checkbox"/> Don't know  <input type="checkbox"/> Refuse         </p>	<p> <input type="checkbox"/> Yes  <input type="checkbox"/> No         </p>	<p> <input type="checkbox"/> 0  <input type="checkbox"/> 1  <input type="checkbox"/> 2  <input type="checkbox"/> 3  <input type="checkbox"/> 4 or more            If 4 or more, how many months have you been homeless? _____  <input type="checkbox"/> Don't know  <input type="checkbox"/> Refuse         </p>
	<p> <input type="checkbox"/> Emergency Shelter  <input type="checkbox"/> Own Home (Mortgage or Land Contract)  <input type="checkbox"/> Place not meant for human habitation (a vehicle, anywhere outside)  <input type="checkbox"/> Rental  <input type="checkbox"/> Staying or living in a family member's room,  <input type="checkbox"/> apartment, or house  <input type="checkbox"/> Staying or living in a friend's room,  <input type="checkbox"/> apartment, or house  <input type="checkbox"/> Other: _____         </p>	<p> <input type="checkbox"/> One day or less  <input type="checkbox"/> Two days to one week  <input type="checkbox"/> More than one week, but less than one month  <input type="checkbox"/> One to three months  <input type="checkbox"/> More than three months, but less than one year  <input type="checkbox"/> One year or longer  <input type="checkbox"/> Don't know  <input type="checkbox"/> Refuse         </p>	<p> <input type="checkbox"/> Yes  <input type="checkbox"/> No         </p>	<p> <input type="checkbox"/> 0  <input type="checkbox"/> 1  <input type="checkbox"/> 2  <input type="checkbox"/> 3  <input type="checkbox"/> 4 or more            If 4 or more, how many months have you been homeless? _____  <input type="checkbox"/> Don't know  <input type="checkbox"/> Refuse         </p>





Consent for the Release of  
Confidential Information  
Housing and Family Services

Name: \_\_\_\_\_ Last 4 Digits of SS#: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_

In order to plan for and provide the best possible care for myself and/or my family, various agency professionals will need to share information. I give my permission to share my and/or my family's personal information as needed. I understand that this information will be used to help determine if I and/or my family are eligible for services and benefits and how best to coordinate services. The agencies **I have initialed below** have my permission to share information about myself and/or my family. This consent is valid until I notify TrueNorth Community Services in writing that I wish to cancel consent

**Please initial yes in the appropriate box**

Agency	Yes		Instructions	Agency		Yes	Instructions
				Landlord Name -			
Transitional Supportive Housing I.S.T.							
Community Mental Health				Consumers Energy or Great Lakes			
DHS/ FIA				DTE			
Health Department				Propane Provider Name-			
<b>TrueNorth Community Services</b>				Five Cap			
Local School Districts				Love Inc.			
Webster House				Michigan Works			
Department of Corrections				Salvation Army			
Health Care Provider-				Other -			
United Way				Other -			
Physician				Other -			

**Note: This form does not permit information about AIDS or HIV, TB, Hepatitis or substance abuse to be shared.**

**A separate Authorization to Share Specific Information form must be used for this type of information.**

Consent applies to minors (youth under age 18) living in the household. List names of minor children, initial and date:

- Minor \_\_\_\_\_ Parent/Guardian Initials and Date \_\_\_\_\_
- Minor \_\_\_\_\_ Parent/Guardian Initials and Date \_\_\_\_\_
- Minor \_\_\_\_\_ Parent/Guardian Initials and Date \_\_\_\_\_
- Minor \_\_\_\_\_ Parent/Guardian Initials and Date \_\_\_\_\_

- I understand that my treatment records are protected under state and federal regulations governing confidentiality of patient records.
- The regulations are the Federal Law of Confidentiality for Alcohol and Drug Abuse Patients, (42 CFR, Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 & 164.
- I understand that I may end this consent upon written notice.
- I understand that there may have been information shared and services provided based on this consent when it was in effect. Ending this consent cannot change that. Any notice to end this consent must be in writing.
- I understand that generally TrueNorth Community Services may not condition my assistance on whether I sign a consent form, but in certain circumstances I may be denied assistance if I do not sign a consent form.
- I have read and understand the information and that this information provided is true and accurate. and my signature indicates that I give my full permission to share information.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Signature of parent, guardian, or authorized representative)

## West MI Housing Network MSHMIS CLIENT RELEASE OF INFORMATION & SHARING PLAN

Many Michigan shelters and helping programs use the Michigan Statewide Homeless Management Information System (MSHMIS) to keep information about the people that they help. We collect personal information from you that we need to help us, help you. We have strict rules about sharing your information.

### Why do we collect information about you?

- Work with other agencies to help you.
- Help case managers work together for you.
- Connect you with other helping agencies. You may be eligible for other benefits.
- Reduce the number of times you tell your story.
- Allow agencies to be paid for their work with you and to help them apply for additional dollars that can be used to help you.
- Help agencies meet their legal obligations.

We need additional identifying information so that you are not confused with someone else. We also need to learn more about your situation to make sure you are eligible for services.

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### SECTION 1 – Basic Identifying Information

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So that agencies that use our HMIS system can find your record, agencies can see the following basic identifying information about you:

- Your name
- Your gender
- The last four digits of your Social Security Number
- Your year of birth
- Your veteran status

**We use this information** to select the correct record and to better coordinate services for you. All persons using HMIS are trained and certified in privacy.

If you have a specific reason why other HMIS agencies shouldn't be able to find your record in HMIS you can ask to have this basic identifying information secured so that only our agency can see it.

PLEASE NOTE: If you have received services from other agencies who use HMIS we may not be able to secure this information. PLEASE TALK WITH YOUR CASE MANAGER for more information. A separate document has been attached).

I have reviewed the attached document named “Securing Basic Identifying Information.”  
I understand the implications and I am asking that my client profile be secured.

**Do not initial here unless you have discussed this with your case manager**

Please initial here to secure this basic identifying information \_\_\_\_\_

## SECTION 2 – Acknowledgement of Rights

Many agencies also use the system to improve services delivered to you. The following are your rights concerning your data. Please review and initial in the box next to **each right to show that you understand it. If you have questions, please discuss them with your case manager.**

—	I have received a copy of the Agency’s Privacy Notice/script that explains MSHMIS and my rights and responsibilities. It explains how information is kept and shared through this system.
—	<b>I understand that the confidentiality of my records is protected by law.</b> I understand that this agency will never give information about me to anyone outside the agency without my specific written consent through a Coordination of Care Sharing Plan or as required by law, including the Federal Law of Confidentiality for Alcohol and Drug Abuse Patients, (42 CFR, Part 2), the Health Insurance Portability and Accountability Act of 1996 (HIPAA, 45 CFR, Parts 160 & 164 as revised by the Health Information Technology for Economic and Clinical Health Act of 2009 aka the HITECH Act), and certain Michigan laws.
—	I can withdraw my consent to share at any time, but any information already shared with another agency cannot be taken back. If sharing information on the system poses an imminent health or safety risk I will talk with my case manager.
—	I understand that I have the right to see my information, request changes, and to get a copy of my information by written request. An agency can refuse to change my record but must provide a written explanation of why they refuse the change within 60 days. Agencies may charge for reproducing a record.
—	I understand that agencies included in my Sharing Plan must follow strict privacy guidelines.
—	I understand that my written consent allows the information listed in Section 3 - Coordination of Care Sharing Plan to be shared among the agencies listed in the sharing plan. All sharing agencies where I am receiving services will update that information as I provide new or additional information. The purpose of sharing my information is to better coordinate care for me and my family.
—	I understand that I will not be denied services (emergency assistance, outreach, shelter, housing assistance, etc.) if I refuse to share information in this system.
—	I understand that my name and other identifying information may be used to match records through a trusted partner for academic research purposes or to determine eligibility for other resources. If I am eligible to receive additional resources, my case manager may contact me. None of my additional identifying information outside of my name will be shared with other organizations unless I sign an additional release of information.
—	Prior to academic research being done, my identifying information will be removed, before data analysis takes place.



**SECTION 3 – Coordination of Care Sharing Plan**

**The information** (listed below) can be seen by the following agencies to help coordinate your care. These agencies can share your information with each other:

*Community Mental Health (PSH)*  
*Goodwill Industries of West MI*  
*Mid MI Community Action Agency*  
*Oceana’s Home Partnership*  
*The Salvation Army*

*Staircase Youth Services (TLP)*  
*TrueNorth Community Services*  
*Youth Attention Center*  
*Northwest MI Community Action Agency*

In addition to the Basic Identifying Information listed in Section 1 above, additional shared information also includes:

Date of birth	Race and ethnicity	Contact information
Household members and relationships	Employment	Household income and benefits
Physical, developmental, and/or mental disability	General health status	Chronic health conditions (HIV/AIDS)
Type of health insurance and/or medical assistance	Alcohol and/or drug abuse	Housing status, homeless history and move-in date
Military service information	Domestic violence history	VI SPDAT/Housing Screening Tools
Services and financial assistance with dates	Project exit and destination	Referrals and service connections

**Instructions:** Check the box next to the statement that you understand and agree to:

I agree to have my information visible to all of the helping agencies listed above.

- a.  Yes, I agree to share according to the Coordination of Care Sharing Plan.
- b.  No, I do not agree to the Coordination of Care Sharing Plan (only our agency will be able to see all your detailed information).

## SECTION 4 – Outreach Sharing Plan

We partner with Michigan community programs to see if you might qualify for housing or income supports. **Please read each statement below and circle your response.**

1. **Veteran Affairs:** If you have served in the military, the VA Medical Center may contact you about potential housing. With your permission, they may use the information you give this agency to contact you.

Information that will be shared includes: Name, date of birth, homeless status, veteran status, military service information, housing history, contact information, chronically homeless status.

**Yes - I agree to share my HMIS data for the Veteran's Project: (circle response): Yes/No/NA**

2. **MDHHS Income and Benefits:** Income and benefits are important to staying housed. The Michigan Department of Health and Human Services (MDHHS) may assist with obtaining Social Security Income and/or other state benefits, if you qualify. With your permission, they may use the information you give this agency to contact you, if you are eligible for benefits.

Information that will be shared includes: Name, date of birth, coordinated assessment information, homeless status, housing history, contact information, chronically homeless status.

**Yes - I agree to share my HMIS data for the Social Security or other state benefits: (circle response): Yes/No/NA**

3. **Housing Review Committee/Housing Prioritization:** If you are homeless, you may be eligible for housing in our community. We have a housing review committee made up of representatives from our service providers. To participate in this process, these providers may need to see your information. With your permission, an agency may contact you if your information shows that you may be eligible for local housing services.

A list of service providers involved in this process is available on request.

Information that may be shared includes: Name, coordinated assessment information, homeless status, chronically homeless status, veteran status, disability and any additional information that may be used to connect you with appropriate housing options.

**Yes - I agree to share my information with the housing review committee: (circle response): Yes/No/NA**

4. **Homeless history:** We may need to document your homeless history throughout the state of Michigan to see if you are eligible for specific community programs. Your case manager may contact the Michigan Coalition Against Homelessness (MCAH, the MSHMIS lead agency) to view data recorded in HMIS to complete a housing history document. With your permission, MCAH will complete the document and give it to your case manager. This document may be uploaded to your client record and shared according to the coordination of care sharing plan.

Information that will be shared includes: HMIS number, name, and a 3-year statewide homeless history that includes service provider names and dates of service.

**Yes - I agree that MCAH may share data with my Case Manager: (circle response): Yes/No/NA**

**SECTION 4 – Outreach Sharing Plan (continued)**

**Sharing Plan to improve outreach to individuals who may qualify for benefits**

5. **For Young Adults:** For clients that received services prior to age 18, we may need to document your homeless history to see if you are eligible for specific community programs. Your case manager will contact a Representative from the Michigan Coalition Against Homelessness (MCAH) to view data recorded in the MSHMIS in order to complete a housing history document. **If you are youth under the age of 24 and have received services from a youth provider while you were under the age of 18**, do you give permission for these Representatives to complete the housing history document to be given to your case manager?

Information that will be shared includes: *HMIS number, name, date of birth, Social Security Number, and housing history.*

**Yes - I agree that MCAH may share data with my Case Manager: (circle response): Yes/No/NA**

**This Release is active for one year effective the date of Signature.**

Client signature (head of household): \_\_\_\_\_, Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Adult Household Member signature: \_\_\_\_\_, Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Adult Household Member signature: \_\_\_\_\_, Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Adult Household Member signature: \_\_\_\_\_, Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of guardian or authorized-representative (when required): \_\_\_\_\_

Relationship to client: \_\_\_\_\_ Date signed by guardian/authorized representative: \_\_\_\_\_