Chittenden County Homeless Alliance - Vermont HMIS

HMIS Client Informed Consent and Release of Information

PERMISSION TO SHARE CONFIDENTIAL INFORMATION TO SECURE NECESSARY HOUSING SERVICES

Please read the following notice and authorization (or ask to have it read to you) before signing.

This agency _____ participates in the Vermont's Homeless Management Information System (VTHMIS), ServicePoint. Agencies that participate in VTHMIS belong to an internet-based network. This network is administered by the Institute for Community Alliances.

BENEFITS TO DATA SHARING FOR THE CONSUMER	
Eliminates Duplicate intakes	**Faster access to the Coordinated Entry System, resulting in receiving services more quickly**
Reduces the amount of time spent answering basic questions regarding your situation	**Allows agencies to focus on meeting your unique service needs**
Reduces the amount of times you have to tell your story to service providers	**Multiple Services can be easily coordinated and streamlined**

Vermont HMIS ensures the security of its system. Please see below for detailed information on security measures.

This network is made up of many service providers in Vermont, however the sharing of client level data between agencies is limited. Agencies in the Chittenden County Homeless Alliance are in agreement to share client information intended to improve service delivery to clients. Because of this sharing agreement, you have the option to share your information with other service providers from whom you might be seeking services. Your identity and information collected in VTHMIS will be shared, with your written consent, with the agencies listed in the sharing agreement in the network. VTHMIS includes your demographic information and other essential personal information needed to best determine your housing and service needs. If your information was previously entered into the system and not shared, the historical data will now be shared between the agencies listed.

The computer program used for this purpose has industry standard security protocols, and is updated regularly to meet these security requirements. The information you provide will only be shared with this agency, the agencies listed in the sharing agreement, and limited staff of the Institute for Community Alliances. No personally identifying information will be shared by our network with any department in the State of Vermont or the Federal Government that is not engaged in the provision of direct client services. Information collected is housed in a secure server located at Mediware Information Systems in Shreveport, Louisiana. Limited Mediware Information Systems staff have access to this server and the data for the purposes of network support and

maintenance. Data collected for the network will be maintained for at least seven years from the last date of service.

A current list of Chittenden County Homeless Alliance agencies participating in VTHMIS is included below. The list can also be accessed at www.icalliances.org/vermont-documents. This list may change.

Burlington Housing Authority
Champlain Valley Office of Economic Opportunity-Chittenden County
Pathways Vermont
Community Health Centers of Burlington
Howard Center
Veterans' Inc.
University of Vermont SSVF
Spectrum Youth and Family Services
Champlain Housing Trust
ANEW Place
Vermont Cares
Vermont Coalition for Runaway and Homeless Youth Programs
Committee of Temporary Shelter (COTS)

Please note if you grant permission for your information to be shared it will be in effect for 3 years from the date below. You can contact _____ (agency) at _____ (phone number) to revoke your permission to share data. You may end your agreement verbally or in writing and your personal and service information will no longer be shared from that date going forward. If you revoke this consent, you give permission to the agency to inform the parties indicated in your selection of Option 1 or Option 2 below to ensure there is no further re-disclosure of your information. If you do not give permission for this agency to release your information, no other agency in the network will have access to it.

Maintaining the privacy and the safety of those using our services is very important. Your record will only be shared if you give permission. You cannot be denied services that you would otherwise qualify for if you choose not to share information. Each adult in the household can give permission to share only their own personal information. Any guardian may give permission to share a child's information.

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Type of Information to be shared:

- Personal Identifying Information: Name (First, Middle and Last), Social Security Number, Date of Birth, Ethnicity, Gender, Last Residence Information, Military Status, Contact Information
- Housing/Program Specific: Entry/Exits, Housing related Assessments, Service Transactions related to Housing, Coordinated Entry, Referrals, including if you have disclosed you have a substance use disorder. No information regarding a child's substance use disorder will be shared.
- Assessment Specific: Income, Non-cash Benefits, Disability, Domestic Violence, Health Insurance

Please indicate your choice regarding data sharing:

Option 1:

- _____ By initialing here I agree to share my and my child/children's above specified information and coordinate services with all participating agencies in the network.
  Please indicate Name and Date of Birth of each child below.

  _____ _____
  _____ _____
  _____ _____

Option 2:

- _____ By initialing here, I agree to limit sharing of my and my child/children's above specified information and coordination of services to this agency and the agencies listed below:

  _____ _____
  _____ _____
  _____ _____
  _____ _____

I understand that signing below relates only to data sharing within the VT HMIS and does not guarantee I will receive assistance. Alternatively, I understand that I will NOT be denied services if I refuse to consent to data sharing.

My substance use disorder treatment records are protected by Federal confidentiality rules (42 CFR Part 2) and cannot be disclosed or re-disclosed without my express written consent or as allowed by the regulation.
If applicable, ❑I am ❑I am not authorizing _____to share information about my substance use disorder, treatment or referral for treatment, and HIV status. By signing this form, ❑I am ❑ Iam not authorizing subsequent or re-disclosure of this information.

Client/Parent or Guardian Signature: _____
Date: _____

Print Name: _____

Client/Parent or Guardian Signature: _____
Date: _____

Print Name: _____