Missouri Department of Mental Health

Shelter Plus Care Program

Part 1: Program Application

GENERAL INFORMATION

- For help with this application, contact the DMH Housing Unit at housing@dmh.mo.gov or at **573-526-3125**.
- For application processing and wait list information, call **573-751-9206**.
- FAX completed applications to the DMH Housing Unit at **573-526-7797**.
- Download this form as a PDF file at http://dmh.mo.gov/housing/ShelterPlusCare.htm#ApplyingforSPCAssistance.

DETAILED PROGRAM INFORMATION

- For an overview of DMH's Shelter Plus Care programs, visit: http://dmh.mo.gov/housing/ShelterPlusCare.htm.
- For complete information, see the DMH *Housing Manual* at http://dmh.mo.gov/housing/ShelterPlusCare.htm#DMHHousingManual**.**

REQUIRED DOCUMENTS

Applicants and adults in the Applicant's household must have the following in order to receive assistance: a state-issued picture ID; proof of Social Security number; and proof of income, if any. Minors must have a copy of their birth certificate and proof of Social Security number, if applicable. If any of these items are missing, you should begin to work on obtaining them immediately. You don't need to have these documents in order to ***apply for*** Shelter Plus Care.

An incomplete application slows review time and delays assistance for your client.
For the fastest possible determination of eligibility:

- ***Be sure you have the most current version of the application before you begin.*** You can check for the latest version by visiting http://dmh.mo.gov/housing/ShelterPlusCare.htm#ApplyingforSPCAssistance.
- ***Read the instructions found throughout the application*** to be sure you are filling it out correctly. If you have a question or need help, it's better to contact DMH Housing first than to submit an application you're not sure is complete and correct.
- ***Know what your client's housing status is.*** The only persons who may be served by Shelter Plus Care are those who come from the streets, emergency shelters, Safe Havens, institutions, or transitional housing. If your client has not lived in one of these settings within the past 30 days, he or she is not eligible for Shelter Plus Care assistance.
- ***Include documentation*** of the Applicant's homelessness. ***This is required.*** No Applicant can be found eligible for assistance without documentation. See the Instructions (next page) for more information on what constitutes eligible homelessness and how to document it.
- ***Fill out the Service Plan in detail*** (see Attachment B) if you are not submitting a copy of your agency's Service Plan or Treatment Plan**.** Include the names of all practitioners the applicant sees, how often he or she sees them, and all details relevant to the categories listed—even if they describe future plans of action rather than issues currently being worked on. Do not leave any sections blank unless they do not apply to the Applicant.
- ***Sign the form in all areas where required***. Both the Case Manager and the applicant must sign in multiple locations.
- ***Make sure the application is legible*** and will remain so after you fax it to us. **Use only dark-colored ink.**
- ***Save time and paper—don't fill out and fax us pages we don't need*****.** Don't fax us these instructions or the Application Checklist. If you are a single individual applying, don't fill out or fax us the 'Other Adults' and 'Minors' sections.

Missouri Department of Mental Health
Shelter Plus Care Program
Application Instructions

HOW TO DOCUMENT EPISODES OF HOMELESSNESS

In Attachment C, "Verification of Homelessness," you must choose one of three situations that describe the Applicant's current homelessness situation, and then describe in detail any prior episodes of homelessness for the past three years. You must also submit documentation of each episode of homelessness described on Attachment C. Listed below are the situations that will qualify an Applicant as homelessness, and how to document them.

1. **'Street' homelessness**: 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; includes places like a car, a park, an abandoned building, a camping ground, sleeping in a tent in the woods, etc.

   How to document it: The above situation must be personally observed and verified, and described in a letter. Normally this is written by the Applicant's case manager, but a third party may also be able to verify homelessness, such as an outreach worker, law enforcement, or other person who has witnessed the situation. In the letter, include specific locations, dates, and in what way the situation constitutes a place not meant for human habitation. The letter must be on agency letterhead, and must be signed and dated by the author.

2. **Emergency shelter**: a supervised publicly or privately operated shelter designated to provide temporary living arrangements. This includes emergency shelters, domestic violence shelters, Safe Havens, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals.

   Note: "Safe Haven" refers to certain HUD-funded apartment-based programs for chronically homeless disabled individuals; persons living in Safe Havens are considered homeless. There are three Safe Havens in Missouri: Access House in Kansas City; The Haven in St. Joseph; and the Safe Haven in Dunklin County.

   How to document it: For shelters and Safe Havens: include in the application a letter from the facility verifying the date(s) of entry and exit and that the Applicant currently resides there, if applicable; **or** a printout from the ROSIE or MAACLink HMIS systems showing recorded shelter stays.

   For **transitional housing programs**, include a letter from the transitional program verifying the date of entry and current residence of the Applicant; **and** documentation that the Applicant's housing immediately prior to the transitional program was either emergency shelter or a place not meant for human habitation (same documentation as detailed above).

   For an emergency stay in a hotel/motel, include a letter from the agency that paid for the stay, and a copy of the hotel/motel receipt.

   For all the homeless settings described above, the Case Manager must also submit a letter describing personal knowledge of the Applicant's homelessness. This letter must be on agency letterhead and be signed and dated by the Case Manager.

3. **Institutional stays**: a person is considered homeless if he or she is exiting an institution where he or she stayed for 90 days or less and lived in an emergency shelter or place not meant for human habitation immediately before entering that institution. An institution includes a medical or psychiatric hospital; an in-patient treatment program; a nursing home, respite bed situation, or other typically congregate setting; and jail or other correctional facilities.

   How to document it: Attach a signed and dated letter from the institution verifying that the Applicant has lived there for ninety days or less and is about to exit the institution; **and** documentation that the Applicant's housing immediately prior to the institution was either an emergency shelter or a place not meant for human habitation (same documentation as described in 1 and 2, above).

Missouri Department of Mental Health

Shelter Plus Care Program

Application Checklist

The purpose of this checklist is to help you complete an Application for Shelter Plus Care.
Please do not send this page with the application.

- ☐ Sections 1-10 of the Application are filled out completely. Skip Section 3 if there are no other adults in the household; skip Section 4 if there are no minors in the household.
- ☐ The Applicant has signed the Applicant Certifications (Section 9).
- ☐ Attachment A (Disability Verification) is completely filled out with ONE option checked and is signed by a person with the proper credentials.
- ☐ Attachment B (Service Needs and Service Plan): Part 1 is completely filled out; Part 2 is completely filled out if you choose not to submit a copy of your agency's original Treatment or Service Plan.
- ☐ Attachment C (Homelessness Verification) is completely filled out with ONE option checked and is signed by the Case Manager and all episodes of homelessness for the past three years have been described in detail.
- ☐ All episodes of homelessness for the past three years have been documented (*see* Instructions for required documentation).
- ☐ Attachment D—Consent for Disclosure of Applicant's Protected Health Information is completely filled out and signed by the Applicant and a witness.
- ☐ A copy of the Applicant's documentation of legal non-citizen status is attached, if applicable.
- ☐ The Applicant has, or is working on obtaining all required forms of identification and proof of income, if any, for all members of the proposed household.

Application for Shelter Plus Care

DMH Housing Unit | 1706 E. Elm Street | Jefferson City MO 65101
573-751-9206 | FAX 573-526-7797 | housing@dmh.mo.gov | http://dmh.mo.gov/housing/

➢SECTION 1. APPLICANT INFORMATION

Applicant Name:

First: _____ **Middle** _____ **Last:** _____

Social Security Number: _____ - _____ - _____ **Date of Birth:** _____ / _____ / _____

Gender:

☐ female ☐ male
☐ transgendered, male to female
☐ transgendered, female to male

Marital Status:

☐ single ☐ married ☐ same-sex couple
☐ separated ☐ divorced ☐ widowed

➢SECTION 2. CASE MANAGER CONTACT

Case Manager Name: _____

Agency: _____ **City:** _____

Office Phone: (_____) _____ **Fax:** (_____) _____

Alternate Phone: (_____) _____

Email Address: _____ @ _____

Case Manager's Supervisor or alternate agency contact:

Name: _____ **Office Phone:** (_____) _____

DMH Housing Use Only				
Jackson County ☐	St. Louis City ☐	Bootheel ☐	Jefferson-Franklin ☐	Rolla ☐
	St. Louis County ☐	Branson ☐	Kirksville ☐	West Central ☐
Joplin ☐		Central Missouri ☐	Nevada ☐	West Plains ☐
Springfield ☐		Farmington ☐	Outer KC Metro ☐	
St. Joseph ☐		Hannibal ☐	Poplar Bluff ☐	

Forms:	Applicant ☐	Other Adults ☐	Minors ☐	Disability ☐	Service Plan ☐	Homeless ☐	HIPAA ☐	
Eligibility:	Disabled ☐	Homeless ☐	Income ☐					
Disability:	SMI ☐	CSA ☐	SMI/CSA ☐	PWA ☐	PWOD ☐			
Chronic:	Yes ☐	No ☐						
HMIS:	Notice of Client Rights (BOS, Springfield and Joplin only) ☐							
Referral:			MO					
	Processing Center		*Grant Code*	*HUD Grant Number*		*Date Referred*		

➢SECTION 3. OTHER ADULTS IN THE HOUSEHOLD (Age 18+)

INSTRUCTIONS: Please provide information below about other persons in the Applicant's household. If there are no other adults or minors in the household, skip this section and omit the page from the application when faxing the completed application to DMH. Use an additional copy of this page if the household has more than two other adults or more than three minors.

Other Adult Name:	
Social Security Number:	**Date of Birth:**
Gender: ☐ female ☐ male ☐ transgendered, M to F ☐ transgendered, F to M	**Relationship to Applicant:** ☐ spouse ☐ significant other/partner ☐ parent ☐ step-parent ☐ grandparent ☐ aunt ☐ uncle ☐ brother ☐ sister ☐ son ☐ daughter ☐ step-child ☐ niece ☐ nephew ☐ roommate ☐ other

Other Adult Name:	
Social Security Number:	**Date of Birth:**
Gender: ☐ female ☐ male ☐ transgendered, M to F ☐ transgendered, F to M	**Relationship to Applicant:** ☐ spouse ☐ significant other/partner ☐ parent ☐ step-parent ☐ grandparent ☐ aunt ☐ uncle ☐ brother ☐ sister ☐ son ☐ daughter ☐ step-child ☐ niece ☐ nephew ☐ roommate ☐ other

➢SECTION 4. MINORS IN THE HOUSEHOLD (Age 17 and under)

Minor Name:	
Does the Applicant have legal custody of this minor? ☐ Yes ☐ No **If "yes," please specify:** ☐ full custody ☐ joint custody (minor is with Applicant at least 50% of the time)	
Social Security Number:	**Date of Birth:**
Gender: ☐ female ☐ male ☐ transgendered, M to F ☐ transgendered, F to M	**Relationship to Applicant:** ☐ brother ☐ sister ☐ son ☐ daughter ☐ step-child ☐ niece ☐ nephew ☐ grandchild ☐ other

Minor Name:	
Does the Applicant have legal custody of this minor? ☐ Yes ☐ No **If "yes," please specify:** ☐ full custody ☐ joint custody (minor is with Applicant at least 50% of the time)	
Social Security Number:	**Date of Birth:**
Gender: ☐ female ☐ male ☐ transgendered, M to F ☐ transgendered, F to M	**Relationship to Applicant:** ☐ brother ☐ sister ☐ son ☐ daughter ☐ step-child ☐ niece ☐ nephew ☐ grandchild ☐ other

Minor Name:	
Does the Applicant have legal custody of this minor? ☐ Yes ☐ No **If "yes," please specify:** ☐ full custody ☐ joint custody (minor is with Applicant at least 50% of the time)	
Social Security Number:	**Date of Birth:**
Gender: ☐ female ☐ male ☐ transgendered, M to F ☐ transgendered, F to M	**Relationship to Applicant:** ☐ brother ☐ sister ☐ son ☐ daughter ☐ step-child ☐ niece ☐ nephew ☐ grandchild ☐ other

➢SECTION 5. INCOME

Have you or anyone who will live with you received income from any source in the past 30 days? ☐ Yes ☐ No

If "yes," please specify:

Source of income (do not include non-cash sources such as food stamps and WIC): _____

_____

_____

Total amount received per month: $_____

➢SECTION 6. ASSETS

Please list all checking, savings, and investment accounts below for all persons that will be living in your household.

Household Member's Name	Bank/Institution Name	Account Number	Type of Account (checking, savings, investment)	Current Balance

List the value of all stocks, bonds, trusts, pension contributions or other assets: _____

Have you sold or given away any real property or assets in the past two years? ☐ Yes ☐ No

If yes, what is the current market value of the asset: _____

➢SECTION 7. DEBTS

Do you owe money on back rent? ☐ Yes ☐ No **If yes, amount: $**_____

Do you owe money on past utility bills? ☐ Yes ☐ No **If yes, amount: $**_____

➢SECTION 8. VETERAN STATUS

Is anyone in this household a veteran? ☐ Yes ☐ No

If yes, specify name(s): _____

➢SECTION 9. APPLICANT CERTIFICATIONS

Applicant: please read the paragraphs below and then sign to show that you have read the information, understand it and agree to it.

- ✓ I understand that if I am approved to receive assistance from the Department of Mental Health's Shelter Plus Care program, I agree to follow all of the rules of the Shelter Plus Care program.
- ✓ I understand that I must report all increases and decreases in my income to my local processing center agency within 30 days of the change in income;
- ✓ I understand that I must adhere to the Service Plan that I established with the agency that is referring this application to the Department of Mental Health;
- ✓ I understand that if my referring agency can no longer provide case management or supportive services, I will help to identify a new agency of my choice to provide those services.
- ✓ I understand that if I change supportive service agencies I must notify my local processing center agency of the change within 30 days.
- ✓ I understand that as a Shelter Plus Care participant I am required to obey the rules and restrictions of my lease, including paying my share of rent on time, not disturbing fellow tenants, and keeping my unit clean and free of damages.
- ✓ I certify that all information given on this application by me or other parties is accurate and complete to the best of my knowledge and belief. I also understand that making false statements or providing false information is grounds for denial or termination of rental assistance.

➢ _____
(***Print Name of Applicant, or of Parent, Guardian or Legal Representative of Applicant***

➢ _____
(***Signature of Applicant, or of Parent, Guardian or Legal Representative of Applicant***)

➢ _____ / _____ / _____
(***Date***)

SECTION 10. CASE MANAGER CERTIFICATIONS

Case Manager: please read the following and indicate your understanding and agreement by signing below.

- ✓ I understand that by referring this Applicant to the Shelter Plus Care program, my agency is committing to providing case management and/or other supportive services for the Applicant for as long as the Applicant continues to qualify for such services.
- ✓ I will ensure that all children in this household are properly enrolled in school and are connected to the appropriate services within the community, including early childhood education programs.
- ✓ I will attend the initial Shelter Plus Care orientation with the Applicant at the local housing processing center agency, once the applicant has been approved to receive Shelter Plus Care assistance.
- ✓ I will assist the Applicant in his or her housing search once the Applicant is approved for Shelter Plus Care assistance.
- ✓ I will ensure that this Applicant for Shelter Plus Care receives case management services consistent with the Service Plan included in this application, and that those services will be adequate to help him or her maintain stable independent housing. DMH Housing strongly recommends at least one visit per quarter to the Participant's home.
- ✓ I understand that if I leave my position or if this Applicant is assigned to a different Case Manager, I am responsible for ensuring that DMH Housing and the Applicant's local Shelter Plus Care Processing Center are notified of the change in case management and for facilitating the transfer of services to another person or agency.
- ✓ I understand that making false statements or providing false information is grounds for denial or termination of the Applicant's rental assistance.
- ✓ I certify that all information provided on this application is accurate and complete to the best of my knowledge and belief.

➢ _____
(***Print Name of Case Manager***)

➢ _____
(***Signature of Case Manager***)

➢ _____
(***Name of Agency Employing Case Manager***)

➢ _____ / _____ / _____
(***Date***)

➢ATTACHMENT A. VERIFICATION OF DISABILITY

INSTRUCTIONS: This form identifies the Applicant's primary disability that is of long and continuing duration and impedes his or her ability to work and live independently. If the Applicant has multiple disabilities, please choose only the one that most substantially impedes his or her ability to work and live independently.

This form may be filled out only by a person who is licensed by the State of Missouri to make one of the diagnoses listed below. The agency must maintain appropriate documentation related to the diagnosis. Please indicate your professional licensure by checking a box below, and provide your license number.

- ☐ **Advanced Practice Registered Nurse**
- ☐ **Licensed Clinical Social Worker**
- ☐ **Licensed Professional Counselor**
- ☐ **Physician**
- ☐ **Psychiatrist**
- ☐ **Psychologist**

License number (*required*): _____

Applicant Name: _____

☐ The Applicant has been diagnosed with **a serious mental illness.**

☐ The Applicant has been diagnosed with **both a serious mental illness** and **a chronic alcohol or drug use disorder.**

☐ The Applicant has **a chronic alcohol use disorder and/or a chronic drug use disorder.**

☐ The Applicant has **a severe and chronic developmental disability** that**:**

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
2. Manifested before the individual attained the age of 22;
3. Is likely to continue indefinitely;
4. Results in substantial functional limitations in three or more of the following areas of major life activity (*please check three or more of the following*):
   - ☐ Self-care
   - ☐ Receptive and expressive language
   - ☐ Learning
   - ☐ Mobility
   - ☐ Self-direction
   - ☐ Capacity for independent living
   - ☐ Economic self-sufficiency; and
5. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

☐ The Applicant has **a diagnosis of HIV and/or AIDS.**

I have personally made the diagnosis specified above. The above individual has a disability that is expected to be of long-continued and indefinite duration; is expected to substantially impede this person's ability to live independently; and is of such a nature that it could be improved by more suitable housing conditions.

➢_____ ➢_____

(Print Name of Person Verifying Disability) ***(Signature of Person Verifying Disability)***

➢_____ / _____ / _____

(Date)

➢ATTACHMENT B. SERVICE NEEDS AND SERVICE PLAN

Applicant Name: _____

Part 1. Service Needs.
Please answer all of the following questions. This information helps DMH assess the Applicant's level of support service needs.

	RESPONSE		DMH USE
What is your age?			
	YES	**NO**	
Do you have a serious mental illness?			
Do you have a drug use disorder?			
Do you have an alcohol use disorder?			
Do you have a developmental disability?			
Do you have HIV or AIDS?			
Do you have Post-Traumatic Stress Disorder (PTSD)?			
Do you have any cognitive impairments resulting from a brain or head injury?			
Do you have a physical disability?			
Do you have any of the following:	**YES**	**NO**	
Kidney disease, end-stage renal disease, or use of dialysis			
History of frostbite, hypothermia, or immersion foot			
History of heat stroke or heat exhaustion			
Liver disease or cirrhosis			
History of heart disease, heart attack, stroke, or irregular heartbeat			
Emphysema or chronic obstructive pulmonary disease (COPD)			
Diabetes			
Severe asthma or bronchitis			
Cancer			
Hepatitis C			
Tuberculosis			
	RESPONSE		
In the past six months, how many times have you been to the emergency room?			
In the past six months, how many times have you used a crisis service such as a suicide hotline?			
In the past six months, how many times have you been hospitalized as an in-patient?			
In the past 12 months, how many separate times have you been in jail or prison?			
In the past three years, how many months total have you been in jail or prison?			
	YES	**NO**	
Do you have any legal stuff going on now that may result in you being locked up or having to pay fines?			
Since becoming homeless, have you ever been attacked or beaten up?			
Since becoming homeless, have you ever engaged in risky behavior, such as sharing needles, having unprotected sex with a stranger, or exchanging sex for money?			

Applicant Name: _____

Option 1: Complete Part 2 to identify the service plan that will help the Applicant achieve stable housing and increase his or her self-sufficiency and job skills. For all types of services that apply, list both the name of the provider and the frequency with which the Applicant receives or attends the service. Please provide as much detail as possible.

Option 2: Attach to this application a copy of your agency's Assessment, Service Plan or Treatment Plan and skip Part 2 of Attachment B.

☐ **Mental Health Services**
- ☐ Doctor, Psychologist or Psychiatrist visits: _____
- ☐ Therapist visits: _____
- ☐ Group therapy: _____
- ☐ Case management: _____

☐ **Substance Use Treatment and Aftercare**
- ☐ Treatment services: _____
- ☐ Aftercare: _____
- ☐ Case management: _____
- ☐ AA/NA meetings: _____
- ☐ Relapse plan and sponsor: _____

☐ **Developmental Disability Services**
- ☐ Doctor visits: _____
- ☐ Therapist visits: _____
- ☐ Case management: _____

☐ **HIV/AIDS Services**
- ☐ Doctor visits: _____
- ☐ Case management: _____

☐ **Employment and Training**
- ☐ Vocational rehabilitation: _____
- ☐ Supported employment: _____
- ☐ Case management follow-ups: _____
- ☐ Employment and training goals: _____

☐ **Income and Benefits**
- ☐ Applied for benefits: _____
- ☐ Appeals for benefits: _____
- ☐ Benefits goals: _____
- ☐ Case management follow-ups: _____

☐ **Housing**
- ☐ Other forms of housing assistance applied for:
  - ☐ Section 8 ☐ Subsidized/project-based rental unit ☐ DMH Rental Assistance Program (RAP)
  - ☐ DMH Supportive Community Living (SCL) ☐ Other rental assistance or voucher program
- ☐ Housing search & moving assistance: _____
- ☐ Furniture & household Items: _____
- ☐ Schedule of case management home visits: _____

➢_____ ➢_____ / _____ / _____

(Signature of Applicant) ***(Date)***

➢_____ ➢_____ / _____ / _____

(Signature of Case Manager) ***(Date)***

➢ATTACHMENT C. VERIFICATION OF HOMELESSNESS

Applicant Name: _____

- **FIRST: Choose ONE from the list below.** You must include documentation of the Applicant's homelessness—**see the Instructions at the beginning of the Application for how to document homelessness**. No Applicant can be found eligible for assistance without required documentation.

The Applicant is homeless as defined by HUD because he or she is currently:

☐ 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

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

☐ An individual who is exiting an institution where he or she 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.

- **SECOND: Use the space below to detail the Applicant's housing and homelessness history for the past three years. Be as detailed as possible as to dates and locations. Describe all episodes of homelessness that fit the three categories above ('street' homelessness, shelter stays and transitional housing program stays, and institutional stays). You may record this information on a separate sheet and include it in the application following this form.** You must also include documentation of the Applicant's homelessness history—**see the Instructions at the beginning of the Application for how to document homelessness**.

Time Period	Location (e.g., name of shelter or institution, physical location if 'street' homeless, etc.)
Examples:	
Oct. 1, 2013 – Nov. 30, 2013	Client slept in her car, which was usually parked at or near 10th St. & Main in Grandeville, MO
July 1, 2013 – July 31, 2013	Client resided at Woods Avenue Shelter in Smalltown, MO

DMH Use Only					
☐ Not homeless		☐ Homeless	☐ Chronic history		☐ Currently chronic
~ 1 month	~ 3 months	~ 6 months	~ 9 months	~ 1 year	1 year or more

➢ATTACHMENT D. CONSENT FOR DISCLOSURE OF APPLICANT'S PROTECTED HEALTH INFORMATION

I, (full name): _____,

Social Security Number: _____ - _____ - _____ **Date of Birth:** _____ / _____ / _____

hereby authorize the **MISSOURI DEPARTMENT OF MENTAL HEALTH (DMH)** and the programs, agencies and persons listed below to communicate and disclose to one another written and verbal information regarding my protected health information:

DMH rent subsidy processing center
Homeless management information data system (HMIS)
U.S. Department of Housing and Urban Development (HUD)
local housing authority
rental property owner or manager

The purpose of the disclosure is to obtain information used to secure and/or maintain rental assistance and housing through DMH's rent subsidy programs Shelter Plus Care and/or Rental Assistance Program, or through a local housing authority.

DMH does not have my permission to disclose the following items: _____

_____

I understand that my medical/health information records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and cannot be disclosed without written consent unless otherwise provided for in the regulations. I understand that by signing this authorization, I am allowing the release of my protected health information. The protected health information in my record may include mental/behavioral health information, information relating to acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), alcohol/drug use, and/or a developmental disability.

I understand that I may revoke this consent at any time, except to the extent that disclosures have already been made in reliance on this or any other consent. Revocation may be accomplished by written request and may be for specific items or the entire release. To revoke this consent, mail a signed written request to revoke consent to: Missouri Department of Mental Health, Housing Director, 1706 East Elm Street, Jefferson City, MO, 65101.

I understand that this consent remains effective until I am no longer a participant in the DMH rent subsidy program, unless I specify expiration on the following date, or based on the following event or special condition: _____

_____

I understand that while signing this consent form is not a precondition to being declared eligible for housing assistance, DMH cannot complete the process of delivering such assistance to me unless I sign this consent form. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Would you like a copy of this consent form? Please initial: ( ) **YES** ( ) **NO**

Signature of Consumer: _____ **Date:** _____ / _____ / _____

Signature of Witness: _____ **Date:** _____ / _____ / _____

Signature of Parent/Guardian/Representative:

_____ **Date:** _____ / _____ / _____

Guardian/Representative: please include a description of authority to act on Consumer's behalf: _____

_____