Name: First MI Last: _____

Address1: _____

Address2: _____

City State Zip: _____

Email: _____

Case Manager Email: _____

THIS SECTION FOR APPLICANT:

Date completed: _____

Fax this entire document to GWHC AT 508-753-2271

Fold on this line

THIS SECTION FOR WAITLIST ADMINISTRATOR:

Landlords: IF REJECTING THIS APPLICATION, please email, mail, or fax the form below to HousingWorks. We will pass it on to the applicant. Include this page so we know who the application is for!

We will also update our system, so the changed status of your waitlists will reach many thousands of applicants and their housing advocates. Also, you will boost your Fair Housing and ADA compliance exponentially!

For Landlords Only!
support@housingworks.net
HousingWorks
P.O. Box 231104
Boston, MA 02123
617-536-8561 fax

- ○ **This waitlist is closed. The only waitlists open at present are:**

  _____

  _____

- ○ **This is not the right application. We have enclosed the correct application.**
- ○ **You do not appear to qualify for this property, because:** _____

Name of Waitlist Administrator *optional* _____

Phone of Waitlist Administrator *optional*: _____ - _____ - _____ X _____

Date Time Received. Application will be stamped to show when it was received:

Erase ENTIRE FORM

SMOC Greater Worcester Housing Connection
Rapid Rehousing Referral Form

PLEASE FILL OUT COMPLETELY, ATTACH A COPY OF A GOVERNMENT ISSUED PHOTO ID AND FAX TO GWHC AT 508-753-2271

Date:_____ **Name of person completing this form:**_____

Client Name:_____ **M** **F**
First MI Last

Current Address/Program:_____ **Length of time**:_____

Previous Address: _____ **City/state** _____ **How Long** ___ ___ __

D.O.B. _____ ____ _____ **SS#** _____ **Phone Number** _____

Veteran: Y N **Discharge type:** Honorable Other None **Picture ID Card:** Y N **Type:** _____

Health Insurance: Y N TYPE: _____ **Any Allergies?** Y N list: _____

Referred by (Agency):_____ **Discharge Date**:_____

Contact name:_____ **Phone Number**:_____

Aftercare Plans:_____

Emergency Contact: _____ **Relationship:**_____**Phone:**_____

Have you been homeless for more than 1 year continuously or, 4 episodes in 3 years (documented)? Y N

Ever Convicted Of Violence, Sex, or Arson? Y N Describe: _____

History of Domestic Violence/Describe: _____

Prior Admissions: DETOX_____ RES_____ O/P_____ Methadone_____Suboxone_____

Last needle use: (if any) _____ **Drug(s) Of Choice**: _____

Last Use of any drug/alcohol: _____**What was It:** _____ **In**

Recovery: Y N N/A **Longest period of sobriety:** _____

List Mental Health diagnosis if applicable:_____
(please list any counseling and/or hospitalizations)

Briefly Describe Current/Prior MH Tx: _____

List any medical conditions:_____

List all current Medications:_____

_____

Does client have a 30-day supply of medications? **Y N**

Tested For TB: Y N **Results**: + - **Date of last test**: _____

Receiving Public Assistance: Food Stamps/EAEDC/SSI/SSDI/DEA

Source of Income: _____ Amount: _____**Wk/Mo**_____

Describe Any Legal Issues Pending: _____

Probation:_____ **Which Court? _____**

Race: B W H AS **Marital Status**: S M D NM W **Highest Grade in school**: _____

Services Requested:

- ❑ Sober Housing Referral
- ❑ Emergency Housing
- ❑ Job Search/Workforce Development Assistance
- ❑ Benefits Assistance
- ❑ Mental Health Referral
- ❑ Substance Abuse Referral
- ❑ Domestic Violence Referral

Additional Information:

Please list any other waiting lists and/or describe outcomes of other referrals that may have been submitted. (Residential programs, Sober housing, Etc.)

_____
_____
_____
_____
_____
_____
_____
_____
_____

PLEASE USE ADDITIONAL PAPER IF NEEDED AND ATTACH TO REFERRAL

Please fax referral to (508) 753-2271 with **CORI release**, **release of information and** any available **Psych/Social** Assessment.

Thank you.

SOUTH MIDDLESEX OPPORTUNITY COUNCIL

AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

I _____ _____ _____
(Name) (Date of birth) (SS#)

am currently applying for/receiving services from the South Middlesex Opportunity Council. It is my understanding that my name, date of birth and social security number will be shared with the Worcester Police Department for the sole purpose of checking any outstanding warrants I may have.

I understand that I need not consent to have this information shared with the Worcester Police Department. Refusal will result in my being denied services.

_____ _____
Client Signature Date

_____ _____
Staff Signature Date

SMOC Greater Worcester Housing Connection

AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

I, _____ _____ _____
(name) (date of birth) (SS#)

am currently applying for/receiving services from _____. It is my understanding that confidential information may need to be released/obtained to aid in case management, evaluation or treatment. This form constitutes authorization for releasing or obtaining information by the above listed agency and releases them from any liability arising from the release of information, provided that the information is released in accordance with applicable law.

I hereby authorize you to release complete information regarding my evaluation and/or treatment including copies of the following specific items:

_____

_____

To:/From:_____

_____

I understand that, by law, I need not consent to release this information; however, I choose to do so voluntarily. I understand that all information released should be held strictly confidential and that with written notification I may revoke this consent at any time except to the extent that action based on it has already begun. The authorization to release information expires six (6) months from the date signed below. A copy of the form shall be valid as an original.

_____ _____
Signature Date

_____ _____
Witness Date

SMOC Greater Worcester Housing Connection

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

When you complete this form, you are authorizing the disclosure and/or use of individually identifiable health information, as set forth below, consistent with state and federal laws concerning the privacy of such information. If you do not provide all the information requested, this Authorization may not be valid.

I authorize the following person(s) and/or organization(s) to disclose my protected health information (as specified below):

Name of Client_____ Maiden, Alias or Other Name _____

Date of Birth__ _____ __ Social Security _____

Number Street Address _____City_____ State_____ Zip _____

☐ **Disclosed From:** ☐ **Disclosed To:** _____

☐ **Disclosed From:** ☐ **Disclosed To:** ☐ **SMOC Greater Worcester Housing Connection (GWHC 1398 Main Street, Worcester, MA 01603, 508-757-0103**

Purpose of Requested Use or Disclosure

☐ Coordination of care or case
☐ At the request of the Client
☐ Response to court order or subpoena
☐ Treatment and follow up
☐ Response to HHS or other government management agency
☐ emergency release of information involving another mental health agency. SMOC may release necessary clinical information to insure appropriate clinical services at another mental health agency
☐ Other_____

Information to Which the Authorization Applies

Scope of Disclosure: PHI (Protected Health Information) that may be disclosed through this Authorization is as follows:

☐ All PHI contained in my Medical Records that have been generated by the Provider.
☐ All PHI (Protected Health Information) in my Medical Records that has been generated by the Provider excluding the following:_____
☐ Specific PHI (Protected Health Information) for the time period From:_____ To:_____ that includes

☐ All clinical information ☐ Admission Summary ☐ Psychiatric Assessment
☐ Treatment Plan ☐ Mental Status ☐ Psychosocial Assessment
☐ Discharge Summary ☐ Medical Examination
☐ Other (explain) Referral information, appointment time, attendance or lack of attendance at intake and follow up appointments.

To the extent that my PHI (Protected Health Information) includes alcohol or drug treatment that is protected by 42 CFR, Part 2:

☐ I specifically authorize its release ☐ I do not authorize its release

Signature: _____

To the extent that my PHI includes AIDS, ARC or HIV information that is protected by MGL Ch. 111 70f:

☐ I specifically authorize its release ☐ I do not authorize its release

Signature: _____

To the extent that my PHI includes STD'S, TB, or HEP C information that is protected

☐ I specifically authorize its release ☐ I do not authorize its release

Signature: _____

This authorization expires (date or event): _____

Notice of Rights and Other Information

I may refuse to sign this Authorization. Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my providing or refusing to provide this Authorization. I may take back ("revoke") this Authorization at any time. To revoke this Authorization, I must send a letter, which has been signed by me or on my behalf to**: Greater Worcester Housing Connection, 1398 Main Street, Worcester, MA 01603.** My revocation will be effective upon receipt, but will not affect disclosures already made in reliance on prior consent.

Except as described above with respect to drug and alcohol abuse records, information disclosed as a result of this Authorization could be redisclosed by the recipient and might no longer be protected by federal confidentiality laws. I may inspect or obtain a copy of the health information to be used or disclosed as permitted under federal or state law

Signature: _____ Date: _____Time: _____ am/pm

Client / Individual/Member/Authorized Representative

Witness : _____ Date: _____Time: _____ am/pm

If signed by someone other than the individual or Member, state your legal relationship to the individual or Member:

- legal relationship _____