Shelter House
More than a roof and a bed

Cross Park Place
A HOUSING FIRST PROJECT

Individual Name: _____ **DOB:** _____

Other Names Used: _____

Cell Phone # or best way to reach you: _____

Number of people in household: _____ 1 _____more than 1

Type of Living Situation (check only 1)

__ Safe Haven
__ Interim Housing
__ Long term care facility/nursing home
__ Place not meant for habitation
__ Substance abuse treatment facility or detox center
__ Jail or prison
__ Psychiatric hospital/facility
__ Hospital or other residential non-psychiatric medical facility
__ Emergency Shelter (including hotel/motel paid for with voucher)

Length of Stay at Above Living Situation (check only 1)

___ 1 night or less
___ 2-6 nights
___ 1 week or more, but less than 1 month
___ 1 month or more, but less than 90 days
___ 90 days or more, but less than one year
___ 1 year or longer
___ Individual doesn't know
___ Individual refused

Approximate Date Homelessness started: ____/_____/_____

Regardless of where individual stayed last night, how many times has the client been on the streets or in Emergency Shelter in the past three years:

__ One Time
__ Two Times
__Three Times
__Four or more times
__Individual doesn't know
__ Individual refused

Diagnosed Disability(s): _____

_____

To the best of my knowledge this individual meets the definition of chronically homeless
*a person with a disability that has been literally homeless for 12 consecutive months or on at least 4 separate occasions in the last 3 years. The qualifying disability is a diagnosable substance use disorder, mental illness, developmental disability, cognitive impairment from a brain injury, or a chronic physical disability.***

_____ Yes _____No

Staff Name/Agency: _____

Ph/Email: _____

Date of referral:_____

P.O. Box 3146
Iowa City, IA 52244-3146
319.351-0326

Please fax to Laura at 319.358.7132

United Way
United Way of Johnson & Washington Counties

AUTHORIZATION TO OBTAIN/RELEASE PROTECTED HEALTH INFORMATION

Name: _____Date of Birth or other identifier: _____

I, _____, hereby authorize the following agencies to obtain from and release my protected health information to Shelter House in the manner described below

Shelter House
429 Southgate Ave
Iowa City, IA 52240 **is authorized to obtain and disclose information with:**

___ Johnson County Jail/Sheriff's Office (or designee)	___ Free Medical Clinic
___ Johnson County Attorney's Office.	___ Free Mental Health Clinic
___ State of Iowa Public Defender's Office	___ Prelude Behavioral Services
___ Johnson County Jail Alternatives	___ Shelter House
___ Johnson County Courts/Clerk of Court	___ Mercy Hospital – Iowa City
___ Johnson County Ambulance Service	___ Chatham Oaks
___ Dept of Correctional Services/Dept of Corrections	___ Builders of Hope
___ Abbe Center Inc.	___ Optimae
___ Iowa City Police Department	___ Successful Living
___ Iowa City Housing Authority	___ The Crisis Center
___ University of Iowa Hospital and Clinics	___ Salvation Army
___ Iowa City Veterans' Administration	___ Other (specify): _____
___ Mental Health & Disability Services of the East Central Region	___ Other (specify):_____

I hereby authorize the release of the following information: (check all that apply)

____ Intake/social history information
____ Mental Health Assessments
____ Medical Records
____ Costs of Services
____ Legal/Court Related Information
____ Treatment Plans
____ Diagnosis and/or IQ
____ Verbal Exchanges
____ Substance Abuse Treatment Information
____ Other: _____

The purpose of the release of this information is for gathering information and data in regards to Housing First Program.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to:

____ Mental Health ____ Substance Abuse ____ HIV Related

I know that I do not have to complete this form in order to receive treatment. I know that I have the right to revoke or cancel this authorization in writing at any time. Cancellation will take effect when the program receives my written revocation, except to the extent action has already been taken based on my authorization. I may revoke consent orally for federally assisted drug and alcohol abuse programs. I understand that I may inspect or copy the information to be used or disclosed, unless access is restricted by law. Information regarding my heath care, including payment for health care, is protected by federal laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and the confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R Part 2). Persons and programs are not allowed to re-disclose alcohol and drug abuse treatment information without my written consent unless permitted to do so by law. Iowa Code chapter 228 and other laws prohibit re-disclosure of mental health, alcohol and drug abuse treatment, HIV/AIDS and other confidential information without my written consent except in certain circumstances. I understand that not every organization that may receive a record is required to follow the rules governing use and disclosure of confidential information; in that circumstance, the information will no longer be protected by law and may be re-disclosed without my consent. This authorization will expire one year from signed date, unless I revoke it in writing.

_____ _____
Signature of Individual Consenting Date

_____ _____
Individual Authorized to Sign in Lieu of Individual Date

_____ _____
Witness Signature Date

Copies: Individual or Guardian Accepted ____ Declined ____
A photocopy of this signed authorization shall have the same force and effect as this original

MERCY HOSPITAL, IOWA CITY, IOWA

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

#9-19 (7/11 revised)

PATIENT IDENTIFICATION

Name: _____
Last First M.I.

Birth Date: _____ Social Security #: _____ Medical Record #: _____

Address: _____
Street City State/Zip

Telephone Number: _____ _____
Home Other

INFORMATION BEING SENT TO/FROM
(CHECK ONLY ONE)

[X] This information is to be released **FROM** Mercy Iowa City to the facility or individual specified below:

Shelter House
Name of facility or individual

429 Southgate Ave Iowa City, IA 52240
Address

_____ Initial to permit for fax release for immediate or emergency patient care needs

319-358-7132
Fax Number

[ ] This information is to be released **TO** Mercy Iowa City _____
Department Name

_____
Name of facility or individual

_____
Address

_____
Phone Number

_____
Fax Number

TYPE OF INFORMATION BEING REQUESTED

For date(s) of service: 01 / 01 / 2015 to present

- [x] Discharge Summary
- [ ] Laboratory Report
- [ ] Pathology Report
- [x] Other (Specify): demographics, diagnosis, visit list, billing statements
- [x] History & Physical Report
- [ ] X-Ray Report [ ] Image
- [ ] Physical Therapy Report
- [ ] Consults
- [ ] Emergency Room Report
- [ ] Operative Report
- [x] Abstract "Summary" Data *
- [ ] Medication/Allergy Lists

****SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION FURTHER PROTECTED BY STATE OR FEDERAL LAW****

Initial any category NOT to be released

_____ Acquired immunologic syndrome (AIDS) or human immunodeficiency virus (HIV)
_____ Alcohol and drug abuse treatment
_____ Behavioral or mental health services

PURPOSE FOR DISCLOSURE

- [x] Patient Care
- [ ] Insurance Claim
- [ ] Other:
- [ ] Second opinion
- [ ] Transferring care
- [ ] Personal Use (Fees Apply)
- [ ] Legal Review

TIME LIMIT

I understand that I may cancel (revoke) this authorization at any time by sending a written notice to Mercy's Health Information (Medical Records) department and that my cancellation will take effect when the written notice is received and it will not apply to information that has already been released in response to this authorization. This authorization will automatically expire one year from the date of signature except as specified. (Specify expiration date, event, or condition: _____.)

I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to receive treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by federal privacy regulations unless otherwise prohibited from re-disclosure under other federal and/or state laws or regulations.

SIGNATURE AND DATE

(A copy of this signed form will be offered to the patient.)

[ ] Copy made

_____ _____
Signature (Patient or Legal Representative) Date

_____ _____
Relationship, if not patient Witness

MERCY USE ONLY: Information processed and sent Initials _____ **Date** ___ / ___ / ___ [ ] **Received Fees Sheet**