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 Brittany Rodriguez at 319.519.6321

Shelter House
More than a roof and a bed

PRE HOUSING APPLICATION

PLEASE PRINT. PLEASE ANSWER ALL QUESTIONS. Do not leave any space or blanks, write "NO or N/A" where appropriate.

Applicant Name: _____

Phone:_____ **Email:**_____

Current Mailing Address: _____

Please complete the following questions:

1. Would you benefit from a handicapped-accessible unit? If yes, explain:_____	☐ Yes ☐ No
2. Would you benefit from any other special living accommodations? If yes, explain:_____	☐ Yes ☐ No

Income and Assets

Total Monthly household Income: $_____ Value of household assets: (assets include bank accounts, cash, retirement, etc.) $_____	Income Source(s): Check all that apply ☐ Wages ☐ SSI/SSDI ☐ VA Benefit ☐ Other: _____	Asset Source(s): Check all that apply: ☐ Checking Account ☐ Savings Account ☐ Prepaid Debit Card ☐ Cash ☐ Pension/IRA/Retirement ☐ Other: _____

APPLICANT RESPONSIBILITIES:

It will be your responsibility to provide management will all the necessary information to properly process your application and in the future, to verify your on-going eligibility as required. If your pre-application is approved and an offer to rent is made you will be required to go through an income verification process. You will be asked to provide the names, addresses, phone number and fax numbers, account numbers (where applicable) and any other information that may be necessary in order to expedite the verification process.

Upon review of the information management receives, you will be provided with a separate verification form for each source that requires verification that you will need to sign and date. You will not be asked to sign a blanket verification form nor will you be asked to sign any blank verification forms.

Shelter House
More than a roof and a bed

SIGNATURE: All Applicants must sign application

I understand that management is relying on this information to prove my eligibility which is required by the funding sources under which this property operates. I certify that all information and answers provided are true and complete to the best of my knowledge. I consent to release the necessary information to determine my eligibility. I further understand that providing false information or making false statements may be grounds for denial of my application. I also understand that such action may also result in criminal penalties.

I consent to have management verify the information contained in this application for the purposes of proving my eligibility for occupancy. I also authorize (if required) management to perform a criminal background check for purposes of further proving my eligibility for occupancy. I will provide all necessary information and expedite this process in any way possible. I understand that my occupancy is also contingent on meeting management's resident selection criteria.

Signature: _____ Date: _____

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): _____
___ University of Iowa Counseling Psychology Program	___ 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

CONSENT TO RELEASE OF INFORMATION

Hosp. #_____

University of Iowa Hospitals & Clinics (UIHC) – Psychiatry

Health Information Management Department, Release of Information Office, 200 Hawkins Dr., Iowa City, IA 52242

Telephone: 319-353-6102; Fax: 319-353-7831; Email: phim-consentform@uiowa.edu

Please use blue or black ink, neatly PRINT (except signature) and provide complete information in each section.

Patient's Legal Name: _____ **Birth Date:** _____

List any previous names (maiden, married, legal changes) _____

By signing this form, I am allowing UIHC to release medical information concerning the above named patient to the person or facility listed below. Information may be shared by: ___Verbal ___Copies ___CD ___CareLink ___MyChart ___ To File Only

(Please note, burning to a CD is only possible when transferring electronic information. Copies of paper documents will be provided on paper.)

Name of Person and/or Institution	Name of Person and/or Institution
Complete Mailing Address/Street/P.O. Box	Complete Mailing Address/Street/P.O. Box
City, State, Zip Code	City, State, Zip Code
Name of Person and/or Institution	Name of Person and/or Institution
Complete Mailing Address/Street/P.O. Box	Complete Mailing Address/Street/P.O. Box
City, State, Zip Code	City, State, Zip Code

Check the information to be disclosed (include dates where indicated): ___ Minimum necessary, or specify as follows:

___ Most recent medical / psychological report or specify date(s)_____

___ Most recent inpatient discharge summary or specify date(s)_____

___ Most recent treatment history / case plan or specify date(s)_____

___ Medication list ___ Other (specify)_____

Please check the reason for release below; and provide a date by which the info is needed: _____

Moving out of area _____ Rehab/disability _____ Insurance _____ 2nd opinion _____ Legal _____

Personal file* _____ Medical care _____ Transferring care _____ Other (specify) _____

*Payment may be required (check only).

This consent is voluntary. If I cancel this consent at a later date, I must send written notification to the Director of Health Information Management at the above address. If this consent is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the Director of Health Information Management at the above address. I have been offered a copy of this authorization.

UIHC does not require completion of this form as a condition of evaluation or treatment. However, when the requested evaluation or treatment is solely for the purpose of creating a medical report for a third party, if authorization to release the information to that third party is not provided, it may result in the cancellation of those services. I understand that the information may be released electronically, and may include information in the following categories unless I specifically deny the release **(*initial* any category *not* to be released)**.

Substance Abuse**_____ Mental Health _____ HIV-related information _____ Genetic tests/info***_____

****Information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2 prohibits unauthorized disclosure of these records). *****Refers to genetic testing to screen for possible future health issues, does not refer to testing to diagnose or treat current health conditions.

This agreement allows release of past and future information and will expire two years from the date of signature, or as indicated (specify number of days or months) _____ unless cancelled by the patient/guardian.

Signature of Patient or Legal Guardian	Printed name	Date
Complete Mailing Address/Street/P.O. Box	City, State, Zip Code	
Relationship, if Not the Patient	Witness Signature	

UIHC use only: *Upon satisfying this release, date & sign; record on the Release of Information Tracking (ROIT) system and scan the form in to Epic.* ***If unable to satisfy this release or if unable to enter/scan this information on the ROIT system, complete the following as appropriate and then forward to the Release of Information Office, Health Information Management (HIM) Department, at address above.***

Information sent by: _____ _____ _____

Name Department Date

MERCY HOSPITAL, IOWA CITY, IOWA

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

#9-19 (03/05/21 updated)

Health Information Management 500 E. Market St. Iowa City Iowa 52245 Phone: 319-339-3609 Fax: 319-339-3785

PATIENT IDENTIFICATION

Name: _____
Last First M.I.

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

Address: _____
Street City State/Zip

Telephone Number: _____ _____
Home Other

FROM PROVIDER (Who is to release the information?)

Name: _____ Mercy Hospital, Iowa City _____
Street Address _____ 500 E. Market Street _____
City, State, Zip _____ Iowa City, Iowa 52245 _____
Phone #: _____ Fax #: _____

TO RECIPIENT (Who is to receive the information?)

Name: Shelter House
Street Address 429 Southgate Avenue
City, State, Zip Iowa City, IA, 52240
Phone #: 319-519-6315 Fax #: 319-519-6321

TYPE OF INFORMATION BEING REQUESTED

For date(s) of service: _____ / _____ / _____ to _____ / _____ / _____

- ☑ Discharge Summary
- ☑ History & Physical Report
- ☑ Emergency Room Report
- ☐ Other (Specify): _____
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Laboratory Report
- ☐ X-Ray Report
- ☐ Consults
- ☑ Abstract Summary
- ☑ Medication/Allergy List
- ☐ Image

****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

- ☑ Patient Care
- ☐ Insurance Claim
- ☐ Other: (Specify): _____
- ☐ Personal Use (Fees Apply)
- ☐ Legal Review (Fees Apply)

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

_____ _____
Signature (Patient or Legal Representative) Date

_____ _____
Relationship, if not patient Witness