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Continuum of Care (CoC) Program Management Information System of the Southeast (PromisSE)

Client's Last Name_____________________ First Name__________________________ MI_______

Date of Birth__________________________ Social Security Number___________________________

*** The Federal Privacy Act of 1974 requires that you be notified that disclosure of your Social Security number is voluntary under this record-keeping System. This System was authorized pursuant to directives from Congress and the Department of Housing and Urban Development (HUD). The Social Security number is used to verify identity, assure timely delivery of services, prevent duplication of services, and generate accurate required reports to HUD.**

PromisSE is a shared, electronic record keeping System that captures information about people experiencing homelessness or near homelessness, including their service needs. Our Agency is participating in PromisSE, a database that collects information on clients served by its member agencies and the services they provide.

I understand that all information gathered about me is personal and private and that I do not have to share information collected in PromisSE. It has been explained to me that all information collected will serve for reporting purposes and as a precaution to prevent duplication of services to ineligible individuals and families. I have had an opportunity to ask questions about PromisSE and to review the identifying information, which is authorized by this release for the PromisSE Member Agencies to share. I also understand that information about non-confidential services provided to me by human service agencies in the CoC may be shared with other participating in PromisSE agencies. This Release of Information will remain in effect for **5 (five) years** and will expire on ____________________ unless I make a formal request to this Agency that I no longer wish to participate in PromisSE.

Upon a life-threatening emergency or death, my System information will be used for identification purposes.

Upon written consent, a community partner that is a non-System participating agency, including many state or local service agencies can utilize your System information to provide additional services. **This is dependent upon the receipt of a signed document verifying your consent to release your information to a Community Partner.**

_____I authorize sharing my data.

_____I do not authorize sharing my data,

The CoC, as PromisSE Member Agency, to share my information between all participating PromisSE agencies. I authorize the use of a copy of this original document to serve as a verification for the purposes stated above.

______________________________	______________________________
Client's (Head of Household) Printed Name	Other Adult in HH Printed Name
______________________________	______________________________
Client's (Head of Household) Signature	Other Adult in HH Signature
______________________________	______________________________
Date (mm/dd/yy)	Date (mm/dd/yy)

Based on the information on the previous page:

_____I authorize sharing my dependent's data.

_____I do not authorize sharing my dependent's data.

The CoC, as PromisSE Member Agency, to share my information between all participating PromisSE agencies. I authorize the use of a copy of this original document to serve as a verification for the purposes stated above.

Dependent's Name	DOB	Dependent's Name	DOB
Dependent's Name	DOB	Dependent's Name	DOB
Dependent's Name	DOB	Dependent's Name	DOB
Dependent's Name	DOB	Dependent's Name	DOB
Dependent's Name	DOB	Dependent's Name	DOB
Dependent's Name	DOB	Dependent's Name	DOB

Legal Guardian's Authorizing Signature

Date (mm/dd/yy)

Agency Representative's Authorizing Signature

Agency Representative's Printed Name

Date (mm/dd/yy)

FOR STAFF USE ONLY	
_____	Staff obtained telephonic consent from client and dependents under 18 as listed above
_____	Staff did not obtain telephonic consent from client and dependents under 18 as listed above.

FOR TEXT FIELDS, USE BLOCK LETTERS. OTHERWISE, MARK APPROPRIATE BOXES WITH AN "X"
Fill out separate form for each household member and attach to project entry template. (* indicates required field)

***PROJECT ENTRY DATE** (e.g., 10/10/2016) *[All clients]*

		/			/				

Month *Day* *Year*

***NAME** (First, Middle, Last Name, Suffix (e.g. Jr, Sr, III) *[All Clients]*

First Name																	
Middle Name																	
Last Name																	
Suffix																	

NAME DATA QUALITY *[all clients]*

- ☐ Full name reported
- ☐ Partial, Street name, or code name reported
- ☐ Client doesn't know
- ☐ Client refused

***SOCIAL SECURITY NUMBER** *[All clients]*

			–			–				

- ☐ Full SSN reported
- ☐ Approximate or partial SSN reported
- ☐ Client doesn't know
- ☐ Client Refused

***DATE OF BIRTH** (e.g., 05/21/1991) *[All clients]*

			/			/				

- ☐ Full date of birth reported
- ☐ Approximate or partial DOB reported
- ☐ Client doesn't know
- ☐ Client refused

***VETERAN STATUS?** *[All clients]* ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

***ETHNICITY** *[All clients]*

☐ Non-Hispanic/Non-Latin(a)(o)(x) ☐ Hispanic/Latin(a)(o)(x) ☐ Client doesn't know ☐ Client refused

***RACE** More than one race is permitted. *Client doesn't know* and *Client refused* should only be selected if no other response is selected. *[All clients]*

☐ American Indian, Alaska Native, or Indigenous	☐ Asian or Asian American	☐ Black, African American, or African	☐ Native Hawaiian or Pacific Islander
☐ White	☐ Client doesn't know	Client refused	

***GENDER** *[All clients]*

☐ Female	☐ A gender other than singularly male or female	☐ Questioning	☐ Client refused
☐ Male	☐ Transgender	☐ Client doesn't know	☐ Data Not Collected

DO YOU IDENTIFY AS LGBTQ?

☐ Yes ☐ No

***RELATIONSHIP TO HEAD OF HOUSEHOLD** *[All clients]*

☐ Self (head of the household)	☐ Head of household's other relation member (other relation to head of household)
☐ Head of household's child	☐ Other: non-relation member
☐ Head of household's spouse or partner	

***CLIENT LOCATION** *[All clients]*: **FL-506** (This code identifies the Big Bend CoC region)

***COUNTY OF LAST PERMANENT ADDRESS** *[All clients]*

☐ Franklin	☐ Gadsden	☐ Jefferson	☐ Leon	☐ Liberty
☐ Madison	☐ Taylor	☐ Wakulla	☐ Other: _____	

***ZIP CODE WHERE CLIENT SLEPT LAST NIGHT** *[All clients]*

Total number of months continuously homeless immediately prior to project entry (round up): _____

***RESIDENCE PRIOR TO PROJECT ENTRY** (Mark "x" for the appropriate living condition)

HOMELESS SITUATIONS	INSTITUTIONAL SITUATIONS	TRANSITIONAL AND PERMANENT HOUSING SITUATIONS
___ Place not meant for habitation	___ Foster care home or foster care group home	___ Residential project or halfway house with no homeless criteria
___ Emergency Shelter, including hotel/motel paid for with ES voucher	___ Hospital or other residential non-psychiatric medical facility	___ Hotel or motel paid for without emergency shelter voucher
___ Safe Haven	___ Jail, prison, or juvenile detention center	___ Transitional housing for homeless persons (including homeless youth)
	___ Long term care facility or nursing home	___ Host Home (non-crisis)
___ Client doesn't know	___ Psychiatric hospital or other psychiatric facility	___ Staying or living in a friend's room, apartment or house
___ Client refused	___ Substance abuse treatment facility or detox center	___ Staying or living in a family member's room, apartment or house
		___ Rental by client, with GPD TIP housing subsidy
		___ Rental by client, with VASH housing subsidy
		___ Permanent housing (other than RRH) for formerly homeless persons
		___ Rental by client, with RRH or equivalent subsidy
		___ Rental by client, with HCV voucher (tenant or project based)
		___ Rental by client in a public housing unit
		___ Rental by client, no ongoing housing subsidy
		___ Rental by client, with other ongoing housing subsidy
		___ Owned by client, with ongoing housing subsidy
		___ Owned by client, no ongoing housing subsidy

LENGTH OF STAY IN PREVIOUS PLACE *[Head of household and adults]*

☐ One night or less ☐ 2-6 nights ☐ One week or more; less than one month ☐ One month or more; less than 90 days

☐ 90 days or more; less than one year ☐ One year or longer ☐ Client doesn't know ☐ Client refused

Approximate Date Homelessness Started _____/_____/_____

Number of <u>TIMES</u> the client has been on the streets, in ES or SH in the past three years, including today?

☐ One time ☐ Two times ☐ Three times ☐ Four or more times ☐ Client doesn't know ☐ Client refused

Total number of <u>MONTHS</u> homeless on the streets, in ES, or SH in the past three years?

☐ One month (this is the first month) ☐ Client doesn't know ☐ Client refused

☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ More than 12 months

Income from any source? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

Total monthly income (indicate "0" if no income): $_____

Source of Income	Receiving Income Source?	
	Yes (if yes, indicate exact or approximate amount)	No
Alimony or other spousal support	$	
Child support	$	
Earned income (i.e. employment income)	$	
General Assistance (GA)	$	
Other source (if yes, specify):	$	
Pension or retirement income from former job	$	
Private disability insurance	$	
Retirement income from Social Security	$	
Supplemental Security Income (SSI)	$	
Social Security Disability Income (SSDI)	$	
Temporary Assistance for Needy Families (TANF)	$	
Unemployment Insurance	$	
VA Non-Service-Connected Disability Pension	$	
VA Service-Connected Disability Compensation	$	
Worker's Compensation	$	

Non-cash benefit from any source? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

Non-cash Benefit Source	Currently Receiving Benefit?	
	Yes	No
Special Supplemental Nutrition Assistance Program (SNAP)	Amount: $	
Special Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC)		
TANF Child Care Services (or use local name):		
TANF transportation services (or use local name):		
Other TANF-Funded services (or use local name)		
Section 8, Public Housing, or other rental assistance		
Temporary rental assistance. If yes, specify source:		
Other Source (specify):		

Covered by health Insurance?

☐ Yes ☐ No

☐ Client doesn't know

☐ Client refused

[Answer 'yes' or 'no' for each health insurance source with an 'x'. Answer 'no' for sources that are not currently active]

Health Insurance Type	Covered?	
	YES	NO
Medicaid		
Medicare		
State Children's Health Insurance Program		
Veteran's Administration (VA) Medical Services		
Employer-provided Health Insurance		
Health insurance obtained through COBRA		
Private Pay Health Insurance		
State Health Insurance for Adults		
Indian Health Services Program		
Other (please indicate):		

***Does the client have a disabling condition?** *[All clients]* ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

[Mark "x" for all disabilities and respond to last three columns with "yes/no", and a start date]

Disability Type	Disability Determination						
	Yes	**No**	**Client doesn't know**	**Client refused**	**If Yes, expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?**	**Long term condition? (Y/N)**	**Approximate Start Date of condition(s)**
Alcohol Use (only)							
Both Alcohol and Drug Use							
Chronic Health Condition							
Developmental Condition							
Drug Use (only)							
HIV or AIDS							
Mental Health Problem							
Physical Condition							

Domestic Violence Victim/Survivor?

☐ Yes ☐ No ☐ Client doesn't know ☐ Refused

If yes for "domestic violence victim/survivor: **When experience occurred?**

☐ Within the past three months ☐ 3-6 months ago (excluding six months exactly) ☐ 6-12 months (excluding one year exactly)
☐ More than a year ago ☐ Client doesn't know ☐ Client refused ☐ Data Not Collected

If yes for "domestic violence victim/survivor: **Are you currently fleeing?**

☐ Yes ☐ No ☐ Client doesn't know ☐ Refused

Housing Move-in Date (for PSH & RRH Projects Only): _____/_____/_____

WELL BEING SECTION (*CoC-Funded PSH Projects Only - Answer for Head of Household only*)

Client perceives their life has value and worth

☐ Strongly disagree ☐ Somewhat disagree ☐ Neither agree nor disagree ☐ Somewhat agree

☐ Strongly agree ☐ Strongly agree ☐ Client doesn't know ☐ Client refused

Client perceives they have support from others who will listen to problems

☐ Strongly disagree ☐ Somewhat disagree ☐ Neither agree nor disagree ☐ Somewhat agree

☐ Strongly agree ☐ Strongly agree ☐ Client doesn't know ☐ Client refused

Client perceives they have a tendency to bounce back after hard times

☐ Strongly disagree ☐ Somewhat disagree ☐ Neither agree nor disagree ☐ Somewhat agree

☐ Strongly agree ☐ Strongly agree ☐ Client doesn't know ☐ Client refused

Client's frequency of feeling nervous, tense, worried, frustrated or afraid

☐ Not at all ☐ Once a month ☐ Several times a month ☐ Several times a week

☐ At least every day ☐ Client doesn't know ☐ Client refused

General Health Status

☐ Excellent ☐ Very good ☐ Good ☐ Fair

☐ Poor ☐ Client doesn't know ☐ Client refused

School/Education

Current school enrollment and attendance

☐ Not currently enrolled in any school or educational course

☐ Currently enrolled but NOT attending regularly (when school or the course is in session

☐ Currently enrolled and attending regularly (when school or the course is in session

☐ Client doesn't know

☐ Client refused

Client's Emergency Contact Information

(*for Emergency Shelter use only*)

Emergency Contact Name:		
Emergency Contact Address:		
Emergency Contact Phone:		
Emergency Contact Relationship to Client:		
Emergency Medical Information:		
Primary Care Physician:		
What led to homelessness?		
License / ID Number:		
Valid State ID?		
Client Car: Year, Make, Model, Color, Tag#:		
Convicted Sex Offender?		
When are you available to meet with a Case Manager?		