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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.

Complete this form for each client in household

INTAKE FORM

Program Entry Date: _____/_____/_____

CLIENT PROFILE (Complete for ALL Household Members		
First Name:	Middle Name:	Last Name:
Nickname:	Social Security:	Date of Birth:
Relationship to HoH: __Self __Spouse __Child __Non-relation __Other	US Military Veteran? ____Yes ____No	If yes, what branch?

DEMOGRAPHIC INFORMATION (Complete for ALL Household Members)	
Gender (select all that apply): _____Woman (Girl, if child) _____Man (Boy, if child) _____Culturally Specific Identity (eg, Two-Spirit) _____Transgender _____Non-binary _____Questioning _____Different Identity	Race and Ethnicity (select all that apply): _____American Indian, Alaska Native, or Indigenous _____Asian or Asian American _____Black, African American, or African _____Hispanic/Latina/e/o _____Middle Eastern or North African _____Native Hawaiian or Pacific Islander _____White
If different identity, please specify:	Additional race and ethnicity detail:

CONTACT INFORMATION (Complete for Head of Household		
Phone number:	Email address:	
Emergency contact name:	Emergency contact number:	Relationship:

County of Last Permanent Address (Complete for Head of Household)
___Franklin ___Gadsden ___Jefferson ___Leon ___Liberty ___Madison ___Taylor ___Wakulla Other: _____

LIVING SITUATION (Complete for Head of Household & Adults)	
Where did you stay last night:	How long have you stayed there: ____Years _____Months _____Days
When was the last time you were stably housed, including staying with friends or family, for more than 7 days? Enter approximate date: _____/_____/_____	

DISABILITIES (Complete for ALL household members, including children)		
_____Physical	_____Chronic Health Condition	_____Mental Health Disorder
_____Developmental	_____HIV/AIDS	_____Substance Use Disorder

HEALTH INSURANCE (Complete for ALL household members, including children)		
_____MEDICAID	_____Employer-Provided Health Ins	_____State Health Ins for Adults
_____MEDICARE	_____Insurance through COBRA	_____Indian Health Services Program
_____State Children's (CHIP)	_____Private Pay	_____Other
_____VA Medical Services (VHA)		

INCOME (Complete for Head of Household and any adults)					
Source	**Monthly Amt**	**Source**	**Monthly Amt**	**Source**	**Monthly Amt**
Alimony	$	Pension/retirement	$	TANF	$
Child Support	$	Private disability ins.	$	Unemployment	$
Earned Income	$	Retirement from SS	$	VA Non-service connected	$
General Assistance	$	SSDI	$	VA service-connected	$
Other	$	SSI	$	Worker's compensation	$

NON-CASH BENEFITS (Complete for Head of Household and any adults)					
Source	**Monthly Amt**	**Source**	**Monthly Amt**	**Source**	**Monthly Amt**
SNAP (Food Stamps)	$	TANF Child Care	$	Other TANF Source	$
WIC	$	TANF Transportation	$	Other Source	$