TENNESSEN WARNING

(Minn. Stat. 13.04, subd. 2)

Client Name:____**Client No.** ______________________

All information and data collected by the Minnesota Assistance Council for Veterans is used in assessing the need, eligibility and appropriateness of your request to enter our program.

It is also used to aid in the development of your recovery plan, for progress checks and future follow-up. Failure to supply the requested information will hinder our ability to determine your appropriateness, eligibility and the planning process for entering our program.

You can refuse to supply the data, however, doing so may keep you from being accepted into our program.

You will be asked to furnish the following information:

Name	Barriers to Housing & Employment
Social Security Number	Race
Service Dates	Sex
Type of Discharge	Last residence prior to registering here
Date of Birth	Sources and Amount of Income
Physical and Mental Health	Services needed
Legal Status	Reason you are seeking assistance

All information is considered confidential by MACV and we must have a "*Release of Information/ Authorization of Communication*", signed by you, prior to releasing any information.

You may be asked to sign Release of Information/Authorization of Communication forms to the following agencies: Wilder Foundation, Veterans Administration Medical Center, State of Minnesota Department of Veterans Affairs, Veterans Administration Regional Office, Minnesota Department of Jobs and Training, Department of Labor, BCA Bureau of Criminal Apprehension (*background check*), and Probation Officer *(if applicable*). If necessary, you may be asked to sign others.

______________________________ ____________ ______________________________ ____________

Staff Signature Date Participant Signature Date

Consent for the Release of Confidential Information
Minnesota Department of Veterans Affairs & DEED

Date of Birth: ________________________________

I,____, authorize the following agencies to disclose /receive information related to housing and employment stability

X Minnesota Assistance Council for Veterans
X Minnesota Department of Veterans Affairs
X MN. Department of Employment and Economic Development (DEED)

The following information:-

- Veteran Eligibility
- Services provided by MDVA, DEED and/or MACV

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g. probation, parole, etc.) and that in any event this consent expires automatically as described below:

Specifications of the date, event or condition upon which this consent expires: ________________

____ Date: ______________________________
(Signature of resident/participant)

____ Date: ______________________________
(Signature of witness)

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT INFORMATION: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including the last four of your Social Security Number (SSN) and Date of Birth (used to locate records for release) is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VHA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10P2 "Patient Medical Record – VA" and in accordance with the VHA Notice of Privacy Practices. VA may also use this information to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

VETERAN'S REQUEST

I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

- ☐ DRUG ABUSE
- ☐ SICKLE CELL ANEMIA
- ☐ ALCOHOLISM OR ALCOHOL ABUSE
- ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

DESCRIPTION OF INFORMATION REQUESTED

Check applicable box(es) and state the extent or nature of information to be provided:

- ☐ HEALTH SUMMARY *(Prior 2 Years)*
- ☐ INPATIENT DISCHARGE SUMMARY *(Dates)*: ____________________
- ☐ PROGRESS NOTES:
  - ☐ SPECIFIC CLINICS *(Name & Date Range)*: ____________________
  - ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: ____________________
  - ☐ DATE RANGE: ____________________
- ☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: ____________________
- ☐ LAB RESULTS:
  - ☐ SPECIFIC TESTS *(Name & Date)*: ____________________
  - ☐ DATE RANGE: ____________________
- ☐ RADIOLOGY REPORTS *(Name & Date)*: ____________________
- ☐ LIST OF ACTIVE MEDICATIONS ____________________
- ☐ OTHER *(Describe)*: ____________________

PURPOSE(S) OR NEED

Information is to be used by the individual for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ OTHER *(Specify below)*

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

AUTHORIZATION

I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION

Without my express revocation, the authorization will automatically expire.

☐ UPON SATISFACTION OF THE NEED FOR DISCLOSURE

☐ ON ________________ *(enter a future date other than date signed by patient)*

☐ UNDER THE FOLLOWING CONDITION(S): ____

____

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE (*if applicable) (Sign in ink*)	DATE *(mm/dd/yyyy)*

PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED	RELEASED BY:

Minnesota Assistance Council for Veterans

Consent for the Release of Confidential Information

Date of Birth: ________________________________

I, , authorize
Minnesota Assistance Council for Veterans to disclose /receive:

________________________________ ____
(Agency Name) (Address of Agency)

The following information:-

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g. probation, parole, etc.) and that in any event this consent expires automatically as described below:

Specifications of the date, event or condition upon which this consent expires: ________________

____ Date: ______________________________
(Signature of resident/participant)

____ Date: ______________________________
(Signature of witness)

North Office	South Office	Metro Office
Phone - (281)722-8763	Phone - (507) 345-8258	Phone - (612) 726-1327
Fax- (218)727-9358	Fax- (507) 345-2008	Fax- (612) 200-9156

Minnesota's HMIS Data Privacy Notice

We collect personal information about the people we serve in a computer system called Minnesota's HMIS (Homeless Management Information System). Many social service agencies use this computer system, including street outreach, shelters, and housing programs.

Why do we collect this information?

- To help keep this program and others like it going. We are required to use HMIS.
- So we know how many people we serve and the types of people we serve at our agency and in the state.
- So we all understand what people need and can plan services to meet these needs.

Who can see information that is in Minnesota's HMIS?

- People who work for this agency will use it to help provide services to you or your family.
- Other agencies like this agency that provide services and have received permission from you to see your information. The agencies that participate in Minnesota's HMIS may change from time to time. A copy of the current list of participating agencies is available upon request.
- Auditors or funders who have legal rights to review the work of this agency, such as the U.S. Department of Housing and Urban Development and other state or local government entities.
- Organizations that run, administer, and work on the system, such as the Institute for Community Alliances or Local System Administrators. When these organizations work on the system, they may see information about you.
- People using HMIS information to do research and write reports, including, but not limited to, the Minnesota Department of Human Services (DHS). Your personally identifiable information will **never** appear in research reports.
- The law says we have to report physical or sexual abuse of children and vulnerable adults. If we think there is abuse or neglect in your household, we will report it to Child or Adult Protection.
- We may release your information to protect the health or safety of you or others as required by law.
- Others as required by law, including officials with a valid subpoena, warrant, or court order. We will not release your information for any other use unless you permit us in writing.

How is your privacy protected?

- All users of data must sign an agreement to protect your privacy and comply with state and federal laws and policies before seeing any information.
- The computer program used for this purpose has industry standard security protocols and is updated regularly to meet these security requirements.

What are your rights?

- **If you do not want your name, social security number, or date of birth entered in HMIS, tell the intake worker.** This agency will **not** refuse to help you for denying this. However, federal and state regulations may require limited data collection for funding purposes.
- You have the right to request a copy of the Minnesota's HMIS information about you.
- You have the right to correct mistakes in HMIS information about you.
- If you think this agency or Minnesota's HMIS violated your privacy rights, you have the right to complain or appeal. Ask a staff person for a complaint and appeal form.

Minnesota's HMIS Data Privacy Notice & Client Release of Information 10-01-16

Minnesota's HMIS Release of Information

For: ____ ______________

Print First, Middle, and Last Name (Complete one form for each adult) Date of Birth

Your personal information will be collected in Minnesota's HMIS and, with your consent, shared with other service providers/homeless agencies. If you do not give permission for this agency to share your information, no other agency in the network will have access to it.

Why share your information?

- Sharing reduces the amount of time you have to spend answering basic questions about your situation.
- Sharing allows agencies to focus on meeting your unique needs more quickly.
- Sharing makes it easier for multiple agencies to coordinate housing and services for you and your family.

What information might be shared?

- Family/Household information
- Name, birthdate, Social Security Number
- Gender, race, ethnicity
- Reasons for seeking services
- Living situation and housing history
- Services you receive
- If you are homeless or not
- Your income and income sources
- Public benefits you receive
- History of domestic violence
- Educational background
- Employment information
- Military history
- Health information, including physical health, HIV, behavioral health

Please check ( ) a box:

☐ **SHARE**: I consent to have the information collected about me to be shared through Minnesota's HMIS with other partner agencies in order to improve services to me and the services offered to others.

☐ **DO NOT SHARE**: I do **not** want **any** of the information about me in Minnesota's HMIS shared with any other service providers/homeless agencies. I understand that not sharing my information may affect the ability to quickly and appropriately identify services for me.

When you sign this form, it shows that you understand the following.

- We will **not** deny you help if you do not want us to share your personal information. At the same time, sharing data does not guarantee that you will receive assistance.
- If you permit us to share your information, this consent is valid until canceled by you.
- If you permit us to share your information, you may change your mind and cancel this consent at any time. If you cancel this consent, your information will no longer be shared from that date forward.

SIGNATURE OF CLIENT OR GUARDIAN	Date	Signature of agency witness	Date

Consent for research uses of information in Minnesota's HMIS. Please check **( )** one:

☐ **Yes**, include in research. I understand that information about me that is in Minnesota's HMIS may be used to conduct research related to homelessness and housing programs, service needs, income supports, education and employment, and program effectiveness. My name, social security number or other information that would identify me personally will **never** appear on a research report.

☐ **No**, do not include in research. I do not want my information used for research purposes.

☐ Please treat information about my children age 17 or younger the same as mine.

Minnesota's HMIS Data Privacy Notice & Client Release of Information 10 - 01 -2016

Minnesota Assistance Council for Veterans

CLIENT PROGRAM AGREEMENT

As a participant in the MACV program, I

____

Agree to

- Complete an initial intake and assessment with my assigned case manager.
- To answer all questions
- To be an active participant in the development and follow through of my service plan
- Work collaboratively with my case manager and other MACV and service provider staff to maintain my housing stability
- Meet regularly in person or over the phone with my case manager

I further understand that failure to comply with the above mentioned statements could result in the following:

- A meeting with MACV staff to receive continues services
- A halt in the provision of financial resources and/or services
- A termination of financial resources and/or services

I agree with the terms and requirements to receive services from MACV. I also understand that providing false information may result in disqualification/termination from the program. If I have a grievance with termination of services, I have the right to submit a written grievance to the MACV Program and Outreach Manager. A written response will be provided within 5 working days. If not satisfied, I may submit a written grievance to the Statewide Program Director at the headquarters office and a written response will be provided within 5 working days.

I understand that this is not an entitlement program. Decisions on participation are based on a review of information about a household and whether that household meets criteria that are outlined in program regulations, the availability of funds, and my level of participation in my own housing stability plan.

_________________________________ _______________

Client Signature Date