

MARIN COUNTY HOMELESSNESS AND WHOLE PERSON CARE (WPC)

Client Consent for Data Collection and Release of Information

A. WHAT IS THE WPC DIVISION?

The County of Marin's Health and Human Services Whole Person Care (HHS WPC) Division is focused on helping people receive resources and services to address their housing and homelessness service needs. HHS WPC contracts homelessness services out to community based organizations (CBOs) and coordinates referrals to services for health and social needs with partner organizations.

- HHS WPC, its contracted CBOs, and partner agencies conduct homeless outreach for people who are currently experiencing homelessness and provide housing case management to assist with the HHS WPC housing process and to support individuals after they have been housed. **Working with HHS WPC Division and our contracted partners does not guarantee access to housing.**
- The HHS WPC Division established a homeless adult and family multidisciplinary personnel team (MDT) to identify, assess, and link homeless individuals to housing and supportive services, and to allow provider agencies and members of the MDT to share confidential information for the purpose of coordinating housing and supportive services to ensure continuity of care.
- These services are also being extended to individuals and families who previously experienced homelessness and who may still need assistance from HHS WPC to receive resources and services to remain stably housed in a Permanent Supportive Housing situation

HHS WPC uses electronic data systems (HMIS and WIZARD) to store information about homelessness and housing services/programs. HHS WPC contracted CBOs and partner agencies also use these systems to record information about the clients they serve. This information helps the provider agencies plan for and provide services to clients and to meet requirements of funders such as the U.S. Department of Housing and Urban Development (HUD). These systems allow agencies to improve services that support people who are homeless by allowing authorized staff to share client information with the permission of the client.

B. WHAT IS THE PURPOSE OF THIS FORM?

HHS WPC manages the HMIS and WIZARD data systems, coordinates case conferences, and contracts homelessness services out to CBOs.

For HHS WPC, contracted CBOs, and Partner Agencies to identify and coordinate services, we request your permission to share information, outlined below, with care and service providers.

By signing this form, you agree to allow your information to be shared between HHS WPC, contracted CBOs, and Partner Agencies. Information may be shared in writing, electronically, and/or verbally. The information shared will be used to help assess your eligibility for housing and services, which includes service coordination, counseling, food, utility assistance, and to improve housing and service programs.

The types of agencies who may exchange your information include Marin County and city departments, housing service providers, clinics and hospitals, mental health providers, and other social service providers. This consent does not allow Substance Use Disorder (SUD) providers to share treatment records subject to 42 CFR Part 2 with any of the Participating Agencies. Your information from the types of agencies above may be shared with SUD providers, and any self-reported SUD information may be shared among HHS WPC, contracted CBOs, and Partner Agencies.

Signing this form is your choice. If you don't sign it, it will not change your ability to receive services directly from either HHS WPC, contracted CBOs, or a Partner Agency. However, it will limit the ability of Marin HHS WPC to help coordinate services for you. If you receive services directly from one of WPC's Partner Agencies that uses either the HMIS or WIZARD data systems, HHS WPC may have access to information that the partner agency records in these systems because of HHS WPC's role as system administrator.

BY SIGNING THIS FORM, I AUTHORIZE Marin County HHS WPC, contracted CBOs and Partner Agencies to collect and share information on my service coordination, counseling, food, utility assistance, and to use my service information to improve the quality of housing and service programs. I understand that the contracted CBOs or Partner Agencies below may change over time and that I may find a current list at <https://housingfirst.marinhhs.org/data-sharing>The list of Contracted CBOs or Partner Agencies is:

Adopt a Family of Marin	County of Marin District Attorney's Office	Marin County Sheriff's Office
Bucklew Programs	County of Marin Probation Department Downtown Streets Team	MarinHealth Medical Center
Catholic Charities of San Francisco Center Point, Inc.	Gilead House	Marin Housing Authority Multicultural Center of Marin
Central Marin Police Authority	Homebase, Center for Common Concerns	North Marin Community Services
City of Novato	Homeward Bound of Marin	Richardson Bay Regional Authority
City of San Rafael	Kaiser Permanente, San Rafael Medical Center	Ritter Center
Community Action Marin	Marin City Health and Wellness	St. Vincent de Paul Society Side by Side Youth

County of Marin County Counsel	Marin Community Clinics	U.S. Department of Veterans Affairs West Marin Community Services
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C. WHAT INFORMATION MAY BE USED AND/OR SHARED?

The information to be collected and shared includes:

- Your personal characteristics (e.g., name, date of birth, gender, race, ethnicity, social security number, contact information, veteran status)
- Medical history, including any mental or physical condition(s) you may have and treatment or other services you have received for those conditions, including basic information that you share about disabling conditions caused by medical, mental health, substance use or developmental factors
- Housing information (e.g., type of housing, homeless status, reason for homelessness)
- Employment, income, insurance and benefits information
- Services that have been or are currently provided by contracted CBOs or Partner Agencies
- Your answers to assessment questions, such as the VI-SPDAT questionnaire
- Your photograph or other likeness (if included)
- Other information related to services that you receive or may be eligible to receive
- I understand that law enforcement agencies may be part of the MDT and that law enforcement may share information about me with the MDT. I also understand that HHS WPC and service providers may share limited information about me with law enforcement to determine my eligibility for services. Specifically, HHS WPC and service providers may provide the following information with law enforcement:
 - Whether the individual has had a Coordinated Entry assessment conducted or not (currently, the VISDPAT), but not the assessment’s results;
 - Whether the individual has a WPC case manager or not; and/or
 - the case manager is

_____ Initial here

D. ACNOWLEDGEMENTS

BY SIGNING THIS FORM, I UNDERSTAND THAT I HAVE A RIGHT TO:

- Refuse to sign this consent. My refusal will not change my eligibility for services or benefits.
- Refuse to provide any of this information. My refusal will not change my eligibility for services or benefits.

- Change or revoke (take back) this consent at any time. If you revoke this consent, your information will no longer be shared between agencies in Marin County systems. However, any information that was already shared with current or past providers may still be saved in their records. To change or revoke my consent I can talk with my case manager or other service provider, or I can submit my request in writing to:

Whole Person Care Division – Department of Health and Human Services
 Email: MarinWPCquestions@marincounty.org
 1177 Francisco Blvd E., San Rafael, CA 94901, 415-473-4663

- Receive a copy of this consent.

_____ Initial here

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- Some information shared under this consent may be re-shared with others under certain conditions and may no longer be protected by State and Federal confidentiality laws.
- This consent expires on (date or event): _____. If I do not fill in a date or event above, this consent will remain in effect for three (3) years from the date of my signature or unless I revoke it before the expiration date.
- Marin County, contracted CBOs and Partner Agencies will comply with state and federal privacy laws, as applicable, to ensure my information is kept confidential and secure.
- Marin County HHS and our staff, contracted CBOs and partner agencies use passwords and technology to ensure that information in the system is safe, and each user and contracted CBO or Partner Agency has signed an agreement to maintain the security and confidentiality of information.
- If I have questions about my information, my rights regarding that information, or am concerned that my information has been misused, I can contact HHS WPC at MarinWPCquestions@marincounty.org or 415-473-4663
- My information may be shared to coordinate referral for housing and services.
- My information may be included in reports for auditors or funders who review the work of the contracted CBOs or Partner Agencies, such as HUD, the Department of Veteran Affairs, Marin County HHS, and the California Department of Housing and Community Development. I understand that the list of auditors and funders may change over time.

CLIENT INFORMATION

Client Name (Required): _____

Date of Birth (Required): _____

Cell Phone (Optional): (_____) _____ - _____

Email address (Optional): _____

____ I have been offered a copy of this form

Additional Parties (Optional): I provide permission to share information with the following additional individuals or agencies:

I have read this consent or have listened to it read to me. I authorize the use and sharing of my health and social services information as described above.

Client Signature: _____

Today's Date: _____

Client or Legal Representative (Required)

Month / Day / Year (Required)

Authorization Collected By: _____

Name, Organization (Optional)

FOR AGENCY USE ONLY:

Client Opted Out/Refused Consent: _____ (Staff/Agency Initials)

Witness Staff & Agency

Date

If the client cannot sign in person for themselves, please fill out one of the sections below:

- 1) If the ROI is signed by a person other than the client, please write the name and relationship of the Legal Representative:

Name, Relationship

- 2) If the client cannot read and signs with an X above, please sign below as the witness:

Witness Signature: _____ Today's Date: _____

(Only if the client cannot read and signs with an X above)

Witness Printed Name: _____

If you have questions, please contact marinWPCquestions@marincounty.org