ADMINISTRATION

Head of Household First Name:		Head of Household Last Name:	
Date:		Race/Ethnicity:	
Start Time:		Gender Identity (Male, Female, Transgender, Other):	
End Time:		Identifies as LGBTQ2+?	☐ Yes ☐ No
Survey Location - Shelter, Outreach, Drop In, or Other (specify):		Date of Birth:	
Previous VI-SPDAT completed?	☐ Yes ☐ No	Ever served in the military?	☐ Yes ☐ No
Previous VI-SPDAT Score:		Pet(s)?	☐ Yes ☐ No

2nd Head of Household First Name:		2nd Head of Household Last Name:	
Date:		Race/Ethnicity:	
Start Time:		Gender Identity (Male, Female, Transgender, Other):	
End Time:		Identifies as LGBTQ2+?	☐ Yes ☐ No
Survey Location - Shelter, Outreach, Drop In, or Other (specify):		Date of Birth:	
Previous VI-SPDAT completed?	☐ Yes ☐ No	Ever served in the military?	☐ Yes ☐ No
Previous VI-SPDAT Score:		Pet(s)?	☐ Yes ☐ No

Disclaimer:

OrgCode Consulting, Inc. (OrgCode) cannot control the way in which the VI-SPDAT and SPDAT products will be used, applied or integrated by communities, agencies or frontline staff. OrgCode assumes no legal responsibility or liability for the decisions that are made or services that are received in conjunction with the tools.

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OPENING SPEAKING POINTS

Cover the following in the opening explanation of the F-VI-SPDAT each time:

- The purpose of doing this triage with households that have children and are currently experiencing homelessness
- Some of the questions are personal in nature. It is their choice whether or not they want their children present, and if they do choose to have their children present, they can choose to skip questions that they don't want to answer in front of their children that we can try to come back to at the end or another time if someone can watch their children for a few minutes.
- Approximately how long it will take
- How to answer the questions (yes, no or simple one-word answers)
- That they can get clarification if they do not understand a question
- That they can skip or refuse to answer any question
- Where the information is stored
- The importance of being as honest as they feel comfortable being
- That some answers provided may need further verification from other sources (like whether or not they meet the definition of chronic homelessness)
- Consent to participate in the process

SECTION ONE: CHILDREN WITHIN THE HOUSEHOLD

1. How many children under the age of 18 are currently with you? ______
2. How many children under the age of 18 are not currently with your family, but you have reason to believe they will be joining you when you get housed? ______
3. Is any member of the family currently pregnant *(if applicable)*? ☐ Y ☐ N ☐ R
4. Please provide a list of children in your household:

Child 1 First Name:	Child 1 Last Name:
Child 1 Date of Birth:	Child 1 With Family?
Child 2 First Name:	Child 2 Last Name:
Child 2 Date of Birth:	Child 2 With Family?
Child 3 First Name:	Child 3 Last Name:
Child 3 Date of Birth:	Child 3 With Family?
Child 4 First Name:	Child 4 Last Name:
Child 4 Date of Birth:	Child 4 With Family?
Child 5 First Name:	Child 5 Last Name:
Child 5 Date of Birth:	Child 5 With Family?

Score 1 if any of the following conditions are met: ☐

- *If there is a single parent with 2+ children, and/or a child aged 11 or younger, and/or a current pregnancy.*
- *If there are two parents with 3+ children, and/or a child aged 6 or younger, and/or a current pregnancy.*

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SECTION TWO: PRESENTING NEEDS

5. Most days can you and your family:
   a. Find a safe place to sleep ☐ Y ☐ N ☐ R
   b. Access a bathroom when you need it ☐ Y ☐ N ☐ R
   c. Access a shower when you need it ☐ Y ☐ N ☐ R
   d. Get food ☐ Y ☐ N ☐ R
   e. Get water or other non-alcoholic beverages to stay hydrated ☐ Y ☐ N ☐ R
   f. Get clothing or access laundry when you need it ☐ Y ☐ N ☐ R
   g. Safely store your stuff ☐ Y ☐ N ☐ R

Score 1 if NO to Question 5 a, b, c, d, e, f or g. ☐

SECTION THREE: HOUSING HISTORY & CHRONIC HOMELESSNESS DETERMINATION

6. How long has it been since you and your family lived in stable, permanent housing? *(is this in days or months or years?)* ________

7. In the last three years, how many times have you been homeless? ________

8. **IF THE ANSWER TO QUESTION 7 IS 2 OR MORE:**

   Thinking about those last three years and the different times you and your family were homeless, if you add up all the months you were homeless, what is the total length of time your family has experienced homelessness? ________ *months*

9. Do you have any diagnosed, documented, disabling conditions? ☐ Y ☐ N ☐ R

Score 1 if YES to QUESTION 9 and the following conditions are met: ☐
- *If the head of household:*
  - *experienced 1 or more consecutive years of homelessness* ***or***
  - *4+ episodes of homelessness* ***and*** *the total duration of homelessness is 12+ months.*

10. Has your family ever lived in a home that you own or an apartment in your name? ☐ Y ☐ N ☐ R

11. Have you and your family ever been evicted? ☐ Y ☐ N ☐ R

Score 1 if NO to Question 10 and/or YES to Question 11. ☐

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SECTION FOUR: VULNERABILITIES AND HOUSING SUPPORT NEEDS

12. In the last 6 months, how many times have you or anyone in your family: — # of times

a. Gone to the emergency room/department ________

b. Taken an ambulance ________

c. Been hospitalized as an inpatient ________

d. Used a crisis service or hotline for such concerns as family or intimate partner violence or suicide prevention ________

e. Talked to police because you witnessed a crime, were the victim of a crime, were the alleged perpetrator of a crime, or because they asked you to move along because of loitering, sleeping in a public place or anything like that ________

f. Stayed one or more nights in jail, a holding cell or prison ________

If the total number of interactions equals 4 or more, score 1. ☐

13. Since your family has been homeless:

a. Has anyone in your family been beaten up or assaulted ☐ Y ☐ N ☐ R

b. Has anyone in your family threatened to beat up or assault someone else ☐ Y ☐ N ☐ R

c. Has anyone in your family threatened to harm themselves or harmed themselves ☐ Y ☐ N ☐ R

d. Has anyone threatened you or anyone in your family with violence or made any of you feel unsafe ☐ Y ☐ N ☐ R

e. Has anyone tried to control you or anyone in your family through violence or threats of violence whether that be a stranger, friend, partner, relative or someone in your family ☐ Y ☐ N ☐ R

If YES to any of Question 13, score 1. ☐

14. Does anyone in your family have any legal stuff going on right now that may result in any of the following:

a. Being locked up ☐ Y ☐ N ☐ R

b. Having to pay fines or fees that you cannot afford ☐ Y ☐ N ☐ R

c. Impact your family's ability to get housing ☐ Y ☐ N ☐ R

d. Impact where you and your family could live in your housing ☐ Y ☐ N ☐ R

e. Impact your family's ability to stay together ☐ Y ☐ N ☐ R

15. Has anyone in your family ever been convicted of a crime that makes it difficult to access or maintain housing ☐ Y ☐ N ☐ R

If YES to any of Question 14 and/or YES to Question 15, score 1. ☐

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16. Does anyone trick, manipulate, exploit or force anyone in your family to do things they do not want to do? ☐ Y ☐ N ☐ R

17. Where do you and your family sleep most frequently? *(select one response)*

☐ Shelters	☐ Transitional Housing	☐ Couch Surfing
☐ Outdoors	☐ Car	☐ Other ________________

18. Does anyone in your family ever do things that may be considered to be risky or harmful like run drugs, share a needle, do sex work, or anything like that? ☐ Y ☐ N ☐ R

Score 1 if any of the following conditions are met: ☐

- *YES to Question 16;*
- *If the family stays any place other than Shelters or Transitional Housing in Question 17;*
- *YES to Question 18.*

19. Is there anybody that thinks that you or anyone in your family owes them money like a family member, friend, past landlord, business, bookie, dealer, bank, credit card company, utility company or anyone like that? ☐ Y ☐ N ☐ R

20. Do you or anyone in your family get any money from the government, a job, alimony, child support, working under the table, day labour, an inheritance or a pension, or anything like that? ☐ Y ☐ N ☐ R

21. Do you or anyone in your family ever gamble with money they cannot afford to lose or have debts associated with gambling? ☐ Y ☐ N ☐ R

Score 1 if any of the following conditions are met: ☐

- *YES to Question 19;*
- *NO to Question 20;*
- *YES to Question 21.*

22. Does everyone in your family have planned activities, other than activities for survival, at least four days per week that make them feel happy and fulfilled? ☐ Y ☐ N ☐ R

If NO to Question 22, score 1. ☐

23. Does your family have a collection of belongings that gets in the way with your ability to access services or housing? ☐ Y ☐ N ☐ R

If YES to Question 23, score 1. ☐

24. Would you say that your family's current homelessness was caused by any of the following:

    a. A relationship that broke down ☐ Y ☐ N ☐ R

    b. An unhealthy or abusive relationship ☐ Y ☐ N ☐ R

    c. Because family or friends caused your family to lose your housing ☐ Y ☐ N ☐ R

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25. Do most of your family and friends have stable housing? ☐ Y ☐ N ☐ R

If YES to <u>any</u> of Question 24, and/or NO to Question 25, score 1. ☐

26. Is anyone in your current household 60 years of age or older? ☐ Y ☐ N ☐ R

27. Does anyone in your family have any physical or mental health issues or cognitive issues including a brain injury, that might require assistance to access or keep housing? ☐ Y ☐ N ☐ R

If YES to Question 26 and/or YES to Question 27, score 1. ☐

28. Does anyone in your family use alcohol or drugs in a way that it:
    a. Impacts their life in a negative way most days ☐ Y ☐ N ☐ R
    b. Makes it hard to access housing ☐ Y ☐ N ☐ R
    c. Might require assistance to maintain housing ☐ Y ☐ N ☐ R

If YES to <u>any</u> of Question 28, score 1. ☐

29. Are there any medications that, for whatever reason:
    a. A doctor said someone in your family should be taking but they are not taking ☐ Y ☐ N ☐ R
    b. The medication gets sold instead of being taken ☐ Y ☐ N ☐ R
    c. The medication is used other than how it is prescribed ☐ Y ☐ N ☐ R
    d. The medication is impossible to take, forgotten, or chosen not to take it ☐ Y ☐ N ☐ R

If YES to <u>any</u> of Question 29, score 1. ☐

30. Has your family's homelessness been caused by any recent or past trauma or abuse? ☐ Y ☐ N ☐ R

If YES to Question 30, score 1. ☐

31. Are there any children that have been removed from the family by a child protection service in the last six months? ☐ Y ☐ N ☐ R

32. Do you have any family legal issues like child custody, protection issues, divorce, or anything like that being resolved in court or needing to be resolved in court that would impact your housing or who may live within your housing? ☐ Y ☐ N ☐ R

If YES to Question 31 and/or Question 32, score 1. ☐

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33. At any point in the last six months, have any of your children been separated from you to live with another family member or friend? ☐ Y ☐ N ☐ R

34. In the last six months, have any of the children experienced abuse or trauma? ☐ Y ☐ N ☐ R

35. ***If there are school-aged children:*** Do your children attend school more often than not each week? ☐ Y ☐ N ☐ R

Score 1 if any of the following conditions are met: ☐
- *YES to Question 33;*
- *YES to Question 34;*
- *NO to Question 35.*

36. In the last six months, have the adults in the family changed because of a new relationship, a separation, incarceration, military deployment, or anything like that? ☐ Y ☐ N ☐ R

37. Do you anticipate any other adults or children coming to live with your family in the first six months after you and your family get housed? ☐ Y ☐ N ☐ R

If YES to Question 36 and/or Question 37, score 1. ☐

38. Does your family have a support network for when you need help with your children or other things that come up? ☐ Y ☐ N ☐ R

39. ***If there are children 12 and younger as well as 13 and over:*** In your household, do the older kids spend two or more hours on a typical day helping their younger siblings with things like getting ready for school, homework, dinner, bathing them, or anything like that? ☐ Y ☐ N ☐ R

If NO to Question 38 and/or YES to Question 39, score 1. ☐

TOTAL SCORE

☐

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SCORING RANGE	RECOMMENDED COURSE OF ACTION
0-3	Assess for least intensive service supports
4-8	Assess for moderate and often time-limited supports
9+	Assess for high intensity supports lasting for a longer duration of time and perhaps even permanently

CONTACT INFORMATION

On a typical day, what is the best way to reach you?

____

____

____

If that is unsuccessful, what is the next best way to reach you?

____

____

____

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MARIN COUNTY HOMELESS MANAGEMENT INFORMATION SYSTEM (HMIS)

Client Consent for Data Collection and Release of Information

WHAT IS THE HMIS?

The HMIS is a data system that stores information about homelessness and housing services and programs. The purpose of the HMIS is for homeless provider agencies to record information about clients that 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). HMIS also allows agencies to improve services that support people who are homeless by allowing authorized staff to share client information with the permission of the client. Marin County Health & Human Services manage the HMIS for Marin County.

WHAT IS THE PURPOSE OF THIS FORM?

With this form, you can give permission to have information about you collected and shared with the different Partner Agencies that provide housing and services in Marin County. A current list of Partner Agencies is at http://marin.clarityhs.help. At this time, the Partner Agencies include:

Adopt A Family of Marin
Buckelew
Center Point
Community Action Marin
Downtown Streets Team
Gilead House
HomeBase
Homeless Outreach Team (HOT)
Homeward Bound of Marin
Marin City Health & Wellness
Marin County Behavioral Health & Recovery Services
Marin County Health & Human Services
Marin Housing Authority
St. Vincent de Paul Society
Side by Side Youth (formerly Sunny Hills)
Ritter Center
U.S. Department of Veterans Affairs (VA)

BY SIGNING THIS FORM, I AUTHORIZE Marin County and Partner Agencies to share my information entered into the HMIS. The HMIS information shared will be used to help provide housing and services, which includes care coordination, counseling, food, utility assistance, and to evaluate and improve the quality of housing and service programs. I understand that the Partner Agencies may change over time and that I may find a current list at http://marin.clarityhs.help.

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- The information to be collected and shared includes:
  - Name, birthday, gender, race, ethnicity, social security number, contact information, veteran status
  - Basic information on self-reported disabling conditions caused by medical, mental health, substance use or developmental factors, including self-reported HIV/AIDS status.
  - Housing Information
  - Employment, income, insurance and benefits information
  - Services provided by Partner Agencies
  - My answers to assessment questions, including the VI-SPDAT questionnaire

- My photograph or other likeness (if included)

- I may refuse to provide any of this information. If I refuse, I will not lose any benefits or services.
- I may refuse to sign this Consent. If I refuse, I will not lose any benefits or services.
- Marin County and Partner Agencies will keep my HMIS information private using strict privacy policies. I have the right to review the privacy policies that govern this information.
- Marin County Health & Human Services and BitFocus use passwords and encryption technology to ensure that information in the system is safe, and each HMIS User and Partner Agency has signed an agreement to maintain the security and confidentiality of HMIS data. However, there is always a small risk of a security breach, and someone might obtain my information and use it inappropriately. Marin County and Partner Agencies are required to alert me if they know of a breach.
- If I have questions about my HMIS information, my rights regarding that HMIS information, or am concerned that my information has been misused, I can contact my HMIS systems administrator at [contact info].
- I can receive a copy of this Consent and the Client Information Sheet.
- This Consent will expire 3 years from my last HMIS recorded activity.
- I may revoke this Consent at any time by sending a written request to [email] or by contacting the Partner Agency that is providing this Release of Information.
- My HMIS information may be shared to coordinate referral and placement for housing and services.
- My HMIS information may be further shared by the Partner Agencies to other agencies if needed for care coordination, counseling, food, utility assistance, and other services.
- My HMIS information may be included in reports for auditors or funders who review the work of the Partner Agencies, including HUD, the Department of Veteran Affairs, the Marin County Department of Health and Human Services, and the California Department of Housing and Community Development. I understand that the list of auditors and funders may change over time. My identity will not be shared in these reports.
- My HMIS information may be used for research; however, my identity will remain private.

____ I have been offered and declined a copy of this form

____ I have received a copy of this form

SIGNATURE: Date:

______________________________________ ______________________________________

Printed Name:

____

FOR AGENCY USE ONLY:

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

____ ________________________

Witness Staff & Agency Date

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- The information to be collected and shared includes:
    - Name, birthday, gender, race, ethnicity, social security number, contact information, veteran status
    - Basic information on self-reported disabling conditions caused by medical, mental health, substance use or developmental factors, including self-reported HIV/AIDS status.
    - Housing Information
    - Employment, income, insurance and benefits information
    - Services provided by Partner Agencies
    - My answers to assessment questions, including the VI-SPDAT questionnaire

    - My photograph or other likeness (if included)
- I may refuse to provide any of this information. If I refuse, I will not lose any benefits or services.
- I may refuse to sign this Consent. If I refuse, I will not lose any benefits or services.
- Marin County and Partner Agencies will keep my HMIS information private using strict privacy policies. I have the right to review the privacy policies that govern this information.
- Marin County Health & Human Services and BitFocus use passwords and encryption technology to ensure that information in the system is safe, and each HMIS User and Partner Agency has signed an agreement to maintain the security and confidentiality of HMIS data. However, there is always a small risk of a security breach, and someone might obtain my information and use it inappropriately. Marin County and Partner Agencies are required to alert me if they know of a breach.
- If I have questions about my HMIS information, my rights regarding that HMIS information, or am concerned that my information has been misused, I can contact my HMIS systems administrator at [contact info].
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- My HMIS information may be shared to coordinate referral and placement for housing and services.
- My HMIS information may be further shared by the Partner Agencies to other agencies if needed for care coordination, counseling, food, utility assistance, and other services.
- My HMIS information may be included in reports for auditors or funders who review the work of the Partner Agencies, including HUD, the Department of Veteran Affairs, the Marin County Department of Health and Human Services, and the California Department of Housing and Community Development. I understand that the list of auditors and funders may change over time. My identity will not be shared in these reports.
- My HMIS information may be used for research; however, my identity will remain private.

____ I have been offered and declined a copy of this form

____ I have received a copy of this form

SIGNATURE: Date:

______________________________________ ______________________________________

Printed Name:

____

FOR AGENCY USE ONLY:

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

____ _________________________

Witness Staff & Agency Date

The County of Marin's WPC program helps people receive resources and services to improve health and wellbeing. This includes coordinating health-related assistance and social services with partner organizations such as:

- Doctors and healthcare providers
- Mental health providers
- Social services
- Health plans
- Housing support
- Community resource organizations

_____*Initial here*

Purpose: For WPC Participating Entities to identify and coordinate services, we need your permission to share relevant information with your care and service providers. By signing this form, you agree to allow your health information, records, homelessness status, benefits information, and other data to be shared between WPC Participating Entities to coordinate, collaborate, and assess appropriate medical, housing and/or supportive services, such as:

- Case management
- Benefits assistance
- Medical and/or behavioral health services
- Outreach
- Housing assistance
- Life skills support
- Employment services

Signing this form is your choice. If you do not sign this form, you can still receive medical services, treatment, or other services, but WPC will not be able to help you coordinate them.

_____*Initial here*

Who can use and/or share your information?

The types of agencies who may participate in the WPC program include Marin County and city departments, housing service providers, clinics and hospitals, mental health providers, and other social service providers. Your information will be shared with (to and from) these organizations for the purposes stated above. This authorization does not allow Substance Use Disorder (SUD) providers to share treatment records subject to 42 CFR Part 2 with any of the participating entities. Your information from the types of organizations above may be shared with Substance Use Disorder (SUD) providers.

A complete and current list of participants, individuals and entities is available on the Whole Person Care webpage (scroll to the bottom): https://www.marinhhs.org/whole-person-care
You can scan this code with your phone to go to the webpage.

_____*Initial here*

What information may be used and/or shared?

Information that may be shared includes:

- Your personal characteristics e.g., name, date of birth, gender
- Your medical history, including any mental or physical condition(s) you may have and treatment or other services you have received for those conditions
- HIV status, if applicable
- Your housing information e.g., type of housing, homeless status, reason for homelessness
- Your social services information that you receive or may be eligible to receive

_____*Initial here*

What happens if you don't sign the form?

State and Federal laws may allow for sharing of some protected health information between some organizations without a signed authorization. Signing this form does not change what can be shared under these laws. For example, healthcare organizations may share your health information for treatment purposes, payment for services, and other healthcare operations. However, they cannot share information with housing care managers without this consent.

_____*Initial here*

What happens next if you do sign the form?

Signing the form allows the WPC team to do two things: 1) review your use of local healthcare systems and 2) share other information with participating organizations to see if you are eligible for services that might be available and fit your personal needs. Signing the ROI may allow us to identify WPC and other services you might be eligible for. _____*Initial here*

Client Information

Client Name: ____
(Required)

Medi-Cal CIN: _____________________ **Date of Birth:** ________________
(Required) *(Required)*

Cell Phone: (_____ **)** ______ - ________
(Optional) I agree to receiving calls or texts at this number to establish contact with program staff. Standard data rates may apply.

Sex:
- Male
- Female
- Other______________________
- Decline to answer / Unknown

Gender Identity:
- Male
- Female
- Transgender Male / Trans Man / Female-to-Male (FTM)
- Transgender Female / Trans Woman / Male-to-Female (MTF)
- Genderqueer (Neither exclusively male nor female)
- Other ________________________
- Decline to answer / Unknown

Race:
- American Indian or Alaska Native
- Asian
- White
- Black or African American
- Native Hawaiian / Pacific Islander
- Multiple Races
- Other ________________________
- Decline to answer / Unknown

Housing Status:
- Housed
- Homeless
- Precariously housed
- Decline to answer / Unknown

Ethnicity:
- Hispanic or Latinx
- Not Hispanic or Latinx
- Decline to answer / Unknown

I understand that I have a right to:

▶ Refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or services or eligibility for benefits otherwise available to me.

▶ Change or revoke (take back) this Authorization at any time. Any information previously shared with current or past treating providers cannot be recalled and my revocation of sharing only applies to information shared after I notify you of the cancellation. I can have my case manager or other service provider contact WPC to revoke my consent or I can submit my revocation request in writing to the following address:

Compliance Program - Department of Health and Human Services,
E-Mail: HHSCompliance@marincounty.org
20 N. San Pedro Rd, San Rafael, CA 94903

▶ Receive a copy of this Authorization and the current list of participating entities. I can also inspect or obtain a copy of my health and social services information that is shared by this Authorization. _____*Initial here*

I understand that:

▶ Some information shared under this Authorization may be re-shared with others under certain conditions and may no longer be protected by State and Federal confidentiality laws. Certain information may require my written permission to be redisclosed, unless specifically permitted or required by law.

▶ I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on my signing of this authorization. However, I understand that the WPC may not be able to coordinate my services without a valid authorization signed by me.

▶ This Authorization expires on (date or event):_________________________
If I do not fill in a date or event above, this authorization will remain in effect for three (3) years from the date of my signature or until I revoke authorization.

Additional Parties: I provide permission to share relevant information with the following additional individuals or organizations:

____

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

Client Signature: ______________________________ **Today's Date:** __________________

Client or Legal Representative (Required) *Month / Day / Year (Required)*

Authorization Collected By: ____

Name, Organization (Required)

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 indicate 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:____

3) Are you gathering **verbal consent** due to emergency measures?

Yes. If yes, please fill out the section below.
No

Signature of person gathering verbal consent:__________________________________

Printed Name and Organization:____

Today's Date: _____________

I was able to confirm the client's identity, using:
DOB
Address
Last 4 digits of the SSN
Other ___________________
I was NOT able to confirm the client's identity

I went through all sections of the ROI with the client and initialed each section as we reviewed it.
The client had the following questions during our conversation (please note any questions they had below):

Instructions for gathering Verbal Consent during the COVID-19 Emergency stay at home order:

1) It is still preferred that you discuss the ROI in person and gather a client signature on the WPC ROI if possible. The option of gathering verbal consent should only be used when absolutely necessary. When the COVID-19 crisis is determined to be over, verbal consent will no longer be accepted.

2) If you are not able to discuss the WPC ROI with your clients in person, please make sure you verify the client's identity on the phone. You should ask them to confirm identifying information that you know. This could be their date of birth, their address (if they have one), the last 4 digits of their social security number, or any other information you may know. Please fill out how you were able to confirm the client's identity on page 5. If you were not able to confirm their identity, please check that box on page 5.

3) Read through and discuss each section of the ROI carefully. Make sure they understand what types of information may be shared and which organizations are participating in WPC.

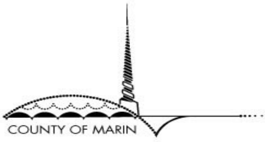
4) Initial each section as you review it with the client. Document any questions they have at the end of the ROI form.

5) Please mark an X on the client signature line on page 4. Then fill out the verbal consent section on page 5:
   a. Sign and print your name as the person gathering the consent
   b. Indicate which organization you work with
   c. Fill out today's date
   d. Indicate how you were able to verify their identity over the phone
   e. Check that you reviewed and initialed all sections of the ROI
   f. Document if the client had any questions during your conversation

6) Once the ROI is complete, fill out a candidate form and upload it to WIZARD the way you normally would at your organization.

7) If you have an address for the client, please mail them a copy of the form after gathering verbal consent with instructions to sign it and return it to you. If you do receive the signed copy back, please scan that copy and upload to WIZARD.

Please contact marinWPCquestions@marincounty.org or Keira Armstrong at keira@intrepidascent.com or 510-919-7861 if you have any questions about the ROI or gathering verbal consent.



The County of Marin's WPC program helps people receive resources and services to improve health and wellbeing. This includes coordinating health-related assistance and social services with partner organizations such as:

- Doctors and healthcare providers
- Mental health providers
- Social services
- Health plans
- Housing support
- Community resource organizations

_____*Initial here*

Purpose: For WPC Participating Entities to identify and coordinate services, we need your permission to share relevant information with your care and service providers. By signing this form, you agree to allow your health information, records, homelessness status, benefits information, and other data to be shared between WPC Participating Entities to coordinate, collaborate, and assess appropriate medical, housing and/or supportive services, such as:

- Case management
- Benefits assistance
- Medical and/or behavioral health services
- Outreach
- Housing assistance
- Life skills support
- Employment services

Signing this form is your choice. If you do not sign this form, you can still receive medical services, treatment, or other services, but WPC will not be able to help you coordinate them.

_____*Initial here*

Who can use and/or share your information?

The types of agencies who may participate in the WPC program include Marin County and city departments, housing service providers, clinics and hospitals, mental health providers, and other social service providers. Your information will be shared with (to and from) these organizations for the purposes stated above. This authorization does not allow Substance Use Disorder (SUD) providers to share treatment records subject to 42 CFR Part 2 with any of the participating entities. Your information from the types of organizations above may be shared with Substance Use Disorder (SUD) providers.

A complete and current list of participants, individuals and entities is available on the Whole Person Care webpage (scroll to the bottom):
https://www.marinhhs.org/whole-person-care
You can scan this code with your phone to go to the webpage.

_____*Initial here*

<u>What information may be used and/or shared?</u>

Information that may be shared includes:

- Your personal characteristics e.g., name, date of birth, gender
- Your medical history, including any mental or physical condition(s) you may have and treatment or other services you have received for those conditions
- HIV status, if applicable
- Your housing information e.g., type of housing, homeless status, reason for homelessness
- Your social services information that you receive or may be eligible to receive

_____*Initial here*

<u>What happens if you don't sign the form?</u>

State and Federal laws may allow for sharing of some protected health information between some organizations without a signed authorization. Signing this form does not change what can be shared under these laws. For example, healthcare organizations may share your health information for treatment purposes, payment for services, and other healthcare operations. However, they cannot share information with housing care managers without this consent.

_____*Initial here*

<u>What happens next if you do sign the form?</u>

Signing the form allows the WPC team to do two things: 1) review your use of local healthcare systems and 2) share other information with participating organizations to see if you are eligible for services that might be available and fit your personal needs. Signing the ROI may allow us to identify WPC and other services you might be eligible for. _____*Initial here*

Client Information

Client Name: ____
(Required)

Medi-Cal CIN: ____________________ **Date of Birth:** ________________
(Required) *(Required)*

Cell Phone: (_____ **)** ______ - _______
(Optional) I agree to receiving calls or texts at this number to establish contact with program staff. Standard data rates may apply.

Sex:
- Male
- Female
- Other_____________________
- Decline to answer / Unknown

Gender Identity:
- Male
- Female
- Transgender Male / Trans Man / Female-to-Male (FTM)
- Transgender Female / Trans Woman / Male-to-Female (MTF)
- Genderqueer (Neither exclusively male nor female)
- Other _______________________
- Decline to answer / Unknown

Race:
- American Indian or Alaska Native
- Asian
- White
- Black or African American
- Native Hawaiian / Pacific Islander
- Multiple Races
- Other _______________________
- Decline to answer / Unknown

Housing Status:
- Housed
- Homeless
- Precariously housed
- Decline to answer / Unknown

Ethnicity:
- Hispanic or Latinx
- Not Hispanic or Latinx
- Decline to answer / Unknown

I understand that I have a right to:

▶ Refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or services or eligibility for benefits otherwise available to me.

▶ Change or revoke (take back) this Authorization at any time. Any information previously shared with current or past treating providers cannot be recalled and my revocation of sharing only applies to information shared after I notify you of the cancellation. I can have my case manager or other service provider contact WPC to revoke my consent or I can submit my revocation request in writing to the following address:

Compliance Program - Department of Health and Human Services,
E-Mail: HHSCompliance@marincounty.org
20 N. San Pedro Rd, San Rafael, CA 94903

▶ Receive a copy of this Authorization and the current list of participating entities. I can also inspect or obtain a copy of my health and social services information that is shared by this Authorization. _____*Initial here*

I understand that:

▶ Some information shared under this Authorization may be re-shared with others under certain conditions and may no longer be protected by State and Federal confidentiality laws. Certain information may require my written permission to be redisclosed, unless specifically permitted or required by law.

▶ I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on my signing of this authorization. However, I understand that the WPC may not be able to coordinate my services without a valid authorization signed by me.

▶ This Authorization expires on (date or event):_________________________
If I do not fill in a date or event above, this authorization will remain in effect for three (3) years from the date of my signature or until I revoke authorization.

Additional Parties: I provide permission to share relevant information with the following additional individuals or organizations:

____

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

Client Signature: _____________________________ **Today's Date:** __________________

Client or Legal Representative (Required) *Month / Day / Year (Required)*

Authorization Collected By: ____

Name, Organization (Required)

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 indicate 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:____

3) Are you gathering **verbal consent** due to emergency measures?

Yes. If yes, please fill out the section below.
No

Signature of person gathering verbal consent:__________________________________

Printed Name and Organization:____

Today's Date: _____________

I was able to confirm the client's identity, using:
DOB
Address
Last 4 digits of the SSN
Other ___________________
I was NOT able to confirm the client's identity

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