INSTRUCTIONS for PATH referral:

1. The person being referred **MUST**
    a. Be at least 18 years of age;
    b. Eligible for services in the public behavioral health system;
    c. Have a serious mental illness (SMI). See the attached list of SMI diagnoses; and
    d. Be receiving case management services OR be enrolled in case management services and followed for a minimum of six months following referral to PATH.

2. Individuals eligible for PATH who are receiving financial assistance must sign the attached release/obtain form, due to information being entered into the Homeless Management Information System (HMIS). **Provide individuals with the copy of the Tri-County Alliance/ HMIS notice of Privacy Practices (included in referral packet).**

3. Please complete the attached referral form, the HMIS authorization form and send to the Worcester County Core Service Agency (WCCSA).

4. If an individual is found eligible for PATH, monthly updates will be required by the WCCSA for a minimum of 6 months. (Must include progress of goals, referrals made, housing situation and stability, and services being provided).

PROJECTS FOR ASSISTANCE IN TRANSITIONING FROM HOMELESSNESS (PATH)

INTAKE REFERRAL FORM

Date _____Person completing form: _____

Telephone number: _____Fax: _____

****

Individual Information:

Name: _____
Telephone number:_____
Birth Date: _____ **SSN** _____ **Sex** _____ **Race** _____
Ethnicity: Hispanic Non-Hispanic

Veteran (circle one): YES NO	**Familial status** (circle one): Single Family
Jail/Prison last 12 months (circle one): YES NO	*If family please indicate how many members are in family: _____
Substance Abuse (circle one): YES NO	**Mental health diagnosis** (circle one): YES NO

Housing at first contact:

- □ **Outdoors**
- □ **Jail**
- □ **Fleeing Domestic Violence**
- □ **Short-Term Shelter**
- □ **Long-term Shelter**
- □ **Institution**
- □ **Halfway house/Residential TX**
- □ **Own/someone else apt, room, etc.**
- □ **Imminent Risk of Homeless**
- □ **Client refused**
- □ **Client does not know**
- □ **Data not collected**
- □ **Other: _____**

Length of stay in previous place? _____

Length of time on street, in an emergency shelter (ES), or safe haven (SH)? _____

Number of days or months individual has been on street, ES, or SH in past 3 years? _____

Health insurance? **Y** **N** Type of health insurance? _____

Disability? **Y** **N** Type of disability? _____

Diagnosis:

DSM-5 CODE	DISORDER

Services currently being received:

- □ Community Mental Health
- □ Primary Care
- □ Education assistance
- □ Income Assistance
- □ Employment Assistance □
- □ Job Training
- □ SOAR
- □ Substance Abuse Treatment
- □ Case Management
- □ Relevant Housing services
- □ Housing Placement Assistance
- □ Medical Assistance
- □ Other: _____

Services needed by referred recipient:

□	Community Mental Health	□	Substance Abuse Treatment
□	Primary Care	□	Case Management
□	Education assistance	□	Relevant Housing services
□	Income Assistance	□	Housing Placement Assistance
□	Employment Assistance □	□	Medical Assistance

□ Security Deposit **(copy of lease stating amount of security deposit required)**
□ Rent **(eviction notice required)**
□ Financial Assistance
□ Job Training □ Other: _____
□ SOAR

Please give a summary of the consumer's current circumstances, requested services, and expected outcomes. **(attach additional documentation if needed)**

_____

_____

_____

_____

_____

*** Please be aware that the Core Service Agency must now report on the number of PATH related phone calls and/or face-to-face visits with PATH eligible individuals before final approval for assistance. Please keep track of the contacts and report to CSA once individual has been approved.**

To be completed by Core Service Agency staff

Amount of time spent: _____ Client became enrolled in PATH? Y N

If no, reason not enrolled?

_____

Date of exit: _____ Reason for exit: _____

Destination after exit: _____

APPROVED: _____ COMMENTS: _____

Signature of Director or Designee: _____Date: _____

Tri County Alliance for the Homeless - Homeless Management Information System (HMIS)

Privacy Policy

I. Confidentiality

A. The Agency will uphold relevant Federal and State confidentiality regulations and laws and unless otherwise provided for or allowed pursuant to such regulations or laws, the Agency will only release confidential client records with written consent by the client. A client is anyone who receives services from the Agency.

1. The Agency will abide specifically by Federal confidentiality regulations as contained in the Code of Federal Regulations, 42 CFR Part 2, regarding disclosure of alcohol and/or drug abuse records. In general terms, the Federal regulation prohibits the disclosure of alcohol and/or drug abuse records unless disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Agency understands that Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patients.
2. The Agency will abide specifically with the Health Insurance Portability and Accountability Act of 1996 and corresponding regulations passed by the U.S. Department of Health and Human Services. In general, the regulations provide consumers with new rights to control the release of medical information, including advance consent for most disclosures of health information, the right to see a copy of health records, the right to request a correction to health records, the right to obtain documentation of disclosures of information may be used or disclosed. The current regulation provides protection for paper, oral, and electronic information.
3. The Agency will abide specifically by Maryland Confidentiality of Medical Records Law, Md. Code Ann. Health-General §§4-301 *et seq*., MCMRA.
4. The Agency will provide a verbal explanation of the Tri County Alliance for the Homeless HMIS and arrange for a qualified interpreter or translator in the event that an individual is not literate in English or has difficulty understanding the consent form(s).
5. Unless permitted by relevant regulations or laws, the Agency will not divulge any confidential information received from the Tri County Alliance for the Homeless HMIS to any organization or individual without proper written consent by the client.
6. The Agency will ensure that all persons who are issued a User Identification and Password to the Tri County Alliance for the Homeless HMIS within that particular agency shall execute and abide by the End User License Agreement, Confidentiality Agreement, including the confidentiality rules and regulations. The Agency will ensure that each person granted Tri County Alliance for the Homeless HMIS access at the Agency receives and abides by a Tri County Alliance for the Homeless HMIS Policy and Procedures manual.
7. The Agency understands that the database server-which will contain all client information, including encrypted identifying client information-will be physically located in Shreveport, Louisiana.

B. The Agency agrees to maintain appropriate documentation of client consent to participate in the Tri County Alliance for the Homeless HMIS.

1. The Agency understands that informed client consent is required before any identifying client information is entered into the Tri County Alliance for the Homeless HMIS for the purposes of interagency sharing of information. Informed client consent will be documented by completion of the standard Tri County Alliance for the Homeless HMIS Client Consent form.
2. The Client Consent form mentioned above, once completed, authorizes basic identifying client data to be entered into the Tri County Alliance for the Homeless HMIS, as well as non-confidential service transaction information. This authorization form permits basic client identifying information to be shared among all Tri County Alliance for the Homeless HMIS Member Agencies and non-confidential service transactions.
3. If a client denies authorization to share basic identifying information and non-confidential service data via the Client Consent form, identifying information shall only be entered into the Client Consent form if the client information is locked and made accessible only to the entering agency program, therefore, precluding the ability to share information.
4. If a client denies authorization to have information beyond basic identifying data and beyond non-confidential service transactions both entered and shared among the Client Consent form, then this record must be locked and made available only to the entering agency program, therefore, precluding the ability to share information.
5. The Agency agrees to place all Client Consent forms related to the Tri County Alliance for the Homeless HMIS in a file to be located at the Agency's business address and that such forms are made available to the Somerset County Health Department who maintains the Tri County Alliance for the Homeless HMIS system for periodic audits. The Agency will retain these Tri County Alliance for the Homeless HMIS related Authorization for Client Consent forms for a period of 5 years, after which time the forms shall be discarded by the Agency in a manner that ensures client confidentiality is not compromised.
6. The Agency understands that in order to update, edit, or print a client's record, the Agency must have on file a current authorization from the client as evidenced by a completed standard Tri County Alliance for the Homeless HMIS Client Consent form pertaining to basic identifying data, and/or a modified Agency form with a Tri County Alliance for the Homeless HMIS clause pertaining to confidential information.

The information gathered and prepared by the Agency will be included in a HMIS database of collaborating agencies (list available), and only to collaborating agencies, who have entered into an HMIS Agency Participation Agreement and shall be used to:

a) Produce a client profile at intake that will be shared by collaborating agencies
b) Produce anonymous, aggregate-level reports regarding use of services
c) Track individual program-level outcomes
d) Identify unfilled service needs and plan for the provision of new services
e) Allocate resources among agencies engaged in the provision of services
f) Provide individual case management

Homeless Alliance for the Lower Shore Continuum of Care

Homeless Management Information System

AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION

Client's Personal Identifying Information:

Name:_____ Birth Date:☐☐/☐☐/☐☐☐☐

SSN:_____ Phone_____ Sex:☐ Race:_____

Present Address:_____

Former Name (if applicable)_____

In signing this release I authorize the following agencies to share my personal information entered into HMIS for the purposes of improving services to those members of our community who are experiencing homelessness, or who are at risk of homelessness in Wicomico, Worcester and Somerset Counties and the City of Salisbury. Agencies participating in HMIS include but are not limited to: Christian Shelter, Village of Hope, HALO, CESP, HOPE, Inc., Diakonia, Samaritan Ministries, Second Chance Help, Inc., RAHST Ministry Shelter, Joseph House, Salvation Army, each county Department of Social Services, each County Health Department, City of Salisbury, St James AME Zion House Church, and Catholic Charities - Seton Center. I understand that information obtained by these agencies will be entered into the Homeless Alliance for the Lower Shore Program (HALS) Homeless Management Information System (HMIS).

I request and authorize that the following personal information be provided. ☐ Demographic Information (age, race, address, etc) ☐ Household Information ☐ Disability Information ☐ Services Needed and Obtained ☐Shelter Stay ☐Length of homelessness ☐ Income Information ☐ Non Cash and Health Insurance Benefits ☐ Other Information , please specify

_____

Except for the following which expressly may NOT be disclosed (If none, write "NONE"):

_____

If the information which a program has includes records or information from another entity,

I ☐ DO or ☐ DO NOT wish to have that information released under this authorization. No service will be withheld if you do not authorize release of information attained by a program from another agency.

Conditions For Exchange of Authorized Information

Expiration: **This authorization will expire two years from date below unless revoked in writing:**

DATE ☐☐/☐☐/☐☐☐☐

RIGHT TO REVOKE: **I understand that I may revoke this authorization at any time by giving written notice in good faith. (CRIMINAL JUSTICE SYSTEM REFERRALS – RULES: "Revocation of consent" An individual whose release from confinement, probation, or parole is conditioned upon his participation in a treatment program may not revoke a consent given by him in accordance with paragraph (a) of this section until there has been a formal and *effective termination or revocation of such release from confinement, probation or parole." FEDERAL REGISTER, VOL 40, No 127, TUESDAY, July 1, 1975.)***

USE SPACE BELOW ONLY IF CLIENT REVOKES CONSENT

☐☐/☐☐/☐☐☐☐ _____

Date Consent Revoked by Client **Signature of Client**

CONFIDENTIALITY: **If the request for information concerns a person's treatment of alcohol or drug abuse, the confidentiality of this information is protected by federal law: (42CFR Part 2) which prohibits any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A General Authorization for the release of medical or other information is NOT sufficient for this purpose.**

REDISCLOSURE: **Any individual or agency receiving Homeless Alliance for the Lower Shore (HALS) client information is prohibited from making further disclosure of the medical record based on this authorization. This is prohibited as provided by the annotated Code of Maryland 4-303 (b) (5) (ii).**

PHOTOSTAT/FACSIMILE: **A photostat or facsimile of this authorization is considered as effective and valid as the original.**

_____ _____

Signature of Client **Date**

_____ _____

Signature of Guardian or Legal Representative **Date**

Relationship to Client: _____(Attach copy of document granting legal authority)

_____ _____

Signature of Witness (Agency Staff) **Date**

_____ _____

Signature of Counselor (if applicable) **Date**

Appendix C – Priority Population – Adults

SEVERELY MENTALLY ILL

PRIORITY POPULATION DEFINITION - ADULTS (SMI)

Revised *9/1/03, 3/10/14*

Reviewed *05/10/07, 1/25/10*

INCLUDED DIAGNOSES (*DSM-5 – including ICD-9 and ICD-10 diagnosis codes):*

295.90/F20.9	Schizophrenia
295.40/F20.81	Schizophreniform Disorder
295.70/F25.0	Schizoaffective Disorder, Bipolar Type
295.70/F25.1	Schizoaffective Disorder, Depressive Type
298.8/F28	Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
298.9/F29	Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
297.1/F22	Delusional Disorder
296.33/F33.2	Major Depressive Disorder, Recurrent Episode, Severe
296.34/F33.3	Major Depressive Disorder, Recurrent Episode, With Psychotic Features
296.43/F31.13	Bipolar I Disorder, Current or Most Recent Episode Manic, Severe
296.44/F31.2	Bipolar I Disorder, Current or Most Recent Episode Manic, With Psychotic Features
296.53/F31.4	Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe
296.54/F31.5	Bipolar I Disorder, Most Recent Episode Depressed, With Psychotic Features
296.40/F31.0	Bipolar I Disorder, Current or Most Recent Episode Hypomanic
296.40/F31.9	Bipolar I Disorder, Current or Most Recent Episode Hypomanic, Unspecified
296.7/F31.9	Bipolar I Disorder, Unspecified
296.89/F31.81	Bipolar II Disorder
301.22/F21	Schizotypal Personality Disorder
301.83/F60.3	Borderline Personality Disorder

INCLUDED DIAGNOSES (DSM-IV):

295.10 Schizophrenia, Disorganized Type

295.20 Schizophrenia, Catatonic Type

295.30 Schizophrenia, Paranoid Type

295.40 Schizophreniform Disorder

295.60 Schizophrenia, Residual Type

295.70 Schizoaffective Disorder

295.90 Schizophrenia, Undifferentiated Type (*includes ICD-9 diagnoses 295.10-295.95)