Five County Association of Governments – Community Action (FCAOG CAP)
1070 West 1600 South, Building B, St. George, UT 84770
https://fivecountycap.org/apply-for-assistance/
Phone: (435) 674-5757 Fax: (435) 673-3540 email: nreeves@fivecounty.utah.gov

Five County Association of Governments Community Action Intake & Consent Form

***PLEASE COMPLETE INFORMATION TO THE BEST OF YOUR KNOWLEDGE**

Five County Community Action Partnership (FCAOG CAP) has funding to help stabilize situation(s) and **improve self-sufficiency** (less dependency on government programs). Five County Association of Governments Community Action Partnership (FCAOG CAP) does not discriminate based on age, disability, genetic information, national origin, pregnancy, family composition, race/color, religion, sex, source of income, marital status, family composition, pregnancy, genetic information, source of income, sexual orientation/preference, and any protected classes outlined by federal and state law. As a department, we also do not discriminate based on sexual orientation or gender preference. However, Five County Community Action reserves the right to reserve service to clients under the following, non-protected circumstances:

- Causes any staff, volunteers, or other clients to feel threaten in any way. This includes sexual harassment, verbal and physical assault, displaying a weapon or a perceived weapon, and issuing threats.
- The client seeks services outside of walk-in hours and without a scheduled appointment.
- The client has been debarred from Five County assistance as a result of fraud, failure to comply with the terms of service, or any other documented reason.

What is REQUIRED of me?

- ✓ Gather all documents identified above. Understand incomplete documentation could delay or disqualify you for the services.
- ✓ Show up to appointment on time. If you are late without notice, you may be asked to reschedule.
- ✓ Report **ALL** income and provide proof of income (*pay stubs, social security, tax returns, or bank statements*), depending on funding source. Other documents may be required.
- ✓ Five County also completes follow-ups to make sure things are going ok with you, please help us with this.

Please understand this application does not qualify and/or guarantee you for any funding

How long does it take? From the application to a check being cut typically takes at least 2 weeks. Five County will be in contact with your potential landlord during this time.

In order to expedite the intake process, submit the household income with your application (the last 30 days of income: *(pay stubs, social security, tax returns, or bank statements)*

Please bring all documents to your scheduled appointment. If documentation is not presented it could delay or disqualify you for the services you need (plan on about 60 minutes for your appointment):

☐ Complete Five County Association of Governments – Community Action Intake Packet
☐ Picture ID for everyone over 18 years old
☐ For gas voucher applicants only: bring the driver's current auto insurance and driver's license
☐ Intake Assessment with Five County Community Action case manager (by appointment only)

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Five County Association of Governments Community Action Intake

PLEASE COMPLETE INFORMATION TO THE BEST OF YOUR KNOWLEDGE AND HONESTLY

Applicant Name: _____
FIRST LAST INITIAL SUFFIX

Address: _____ **City:** _____ **State:** _____

Zip: _____ **Main Phone #:** _____ ☐Cell ☐Home ☐Work **Alternate #:** _____ ☐Cell ☐Home ☐Work

Email: _____ **Contact Person:** if applicable _____

☐ I agree to receive emails regarding community events and resources

Housing Status: *(Check one)*

☐Stably Housed *(Circle one)*: rent own ☐ Renting, is it subsidized? Yes No ☐Emergency Shelter or the streets

☐ Friends/Family, are you paying rent to them? Yes No **Is it a doubled up situation? Yes No**

☐Motel, who's paying for it? _____ ☐ Other, please specify: _____

Length of Stay: *(Check one)*

☐ 1 night or less ☐ 2 – 6 nights ☐ 1 month or more, but less than 90 days
☐ 90 days or more, less than 1 year ☐ 1 week or more, but less than 1 month ☐ 1 year or longer

Answering yes to any of these questions does not eliminate you from funding. Please answer honestly

Are you a survivor of Domestic Violence? ☐ No ☐ past 3 months ☐ 3-6 months ago ☐ 6 months-up to 1 year ago ☐ 1 year ago or more

Are you currently fleeing domestic violence? ☐ No ☐ Yes

Date your homelessness started (not always the date you entered the shelter): ____ / ____ / ____ *(mo/da/year)*

Eviction History: In the past 12 months, have you been evicted? ☐ No ☐ Yes

Are you homeless today because of an eviction? ☐ No ☐ Yes Have you been denied housing due to an eviction ☐ No ☐ Yes

Zip code where you lived 90 days or more at a rental: _____

FINANCIAL INFORMATION

In order to accurately determine an individual's or household's gross income, the following sources must be considered in the income determination: 1) Gross earnings from employment (wages, salaries, tips, commissions, bonuses etc.), 2) Unemployment compensation (public or private), 3) Workers' compensation, 4) Social security, 5) Public assistance or welfare payments in the form of cash (TANF, SSI, non-federal General Assistance, or General Relief money payments), 6) Veterans' payments, 7) Survivor benefits, 8) Disability benefits, 9) Pension or retirement income, 10) Regular insurance or any type of annuity payments, 11) College or university scholarships, grants, fellowships, and assistantships, 12) Interest income on assets in excess of $10,000, 13) Dividends, 14) Rents, royalties, and estates and trusts, 15) Educational assistance, 16) Alimony, 17) Child support, 18) Financial assistance from outside of the household, 19) Other income (military family allotments or other regular support from an absent family member or someone living in the household, etc.), 20) If a person lives with a family, add up the income of all family members. (Non-relatives, such as housemates, do not count.)

Non-Cash Benefits Received [Last 30 Days]: please provide a copy of your 24-month benefits report from *mycase* on DWS website

☐ Food Stamps or Benefit Card $ _____
☐ WIC (Supplemental Nutrition for Women, Infants, and Children)
☐ Free or Reduced School Lunch
☐ Veteran's Administration (VA) Medical Services
☐ Section 8 Public Housing or Rental Assistance
☐ TANF Services (please specify): _____
☐ Medicare (Health Insurance)
☐ Medicaid (Health Insurance)
☐ SCHIP (State Children's Health Insurance Program)
☐ Indian Health Services Program
☐ PCN (Health Insurance)
☐ Other Non-Cash Benefits (please specify): _____

SIGNED STATEMENT

By signing below, I verify that the information I have provided is true and accurate to my knowledge.

_____ _____
Client (1) Signature Date

FOR OFFICE USE ONLY:

Five County Community Action Case Manager Signature below:	Assessment Date:
	Application Completion Date:

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HOUSEHOLD INFORMATION

According to Community Action Program Legal Services (CAPLAW), **the income of all members of each individual family unit must be** included in determining the income eligibility. A family unit is either (1) related individuals: two or more persons related by birth, marriage, and/or adoption who reside together, or (2) an unrelated individual: an individual who is not an inmate of an institution and who resides alone or with one or more persons who are not related to him/her by birth, marriage, and/or adoption, excluding house mates (renters or leasers).

Family Type: *(Check one)*

☐Single Person ☐Multiple Adults (no children) ☐Single Parent (circle one): Female Male other ☐Two Parent Household

☐Non-Related Adults with Children ☐ Multi-Generational Household ☐ Other, please explain: _____

Demographic information needed below	**Household #1** **Name:** First, Middle, Last Name:	**Household #2** **Name:** First, Middle, Last Name:	**Household #3** **Name:** First, Middle, Last Name:
Relationship to head of household	self	Relationship:	Relationship:
Proof of Identity Only for 18 yrs. or older	Expires:	Expires:	Expires:
Phone Number, if different			
Email Address, if different			
Race options:	Am Indian/AK Native/Indigenous Black/African American/African Native Hawaiian/Pacific Islander Asian / Asian American White Multi-race (2 or more)	Am Indian/AK Native/Indigenous Black/African American/African Native Hawaiian/Pacific Islander Asian / Asian American White Multi-race (2 or more)	Am Indian/AK Native/Indigenous Black/African American/African Native Hawaiian/Pacific Islander Asian / Asian American White Multi-race (2 or more)
Hispanic/Latin (a)(o)(x)	Yes No	Yes No	Yes No
Date of Birth Month/Day/Year			
Social Security #			
Gender (circle one)	Male Questioning Female Transgender A gender that is not singularly 'Female' or 'Male"	Male Questioning Female Transgender A gender that is not singularly 'Female' or 'Male"	Male Questioning Female Transgender A gender that is not singularly 'Female' or 'Male"
Education (circle one)	0-3 years old Pre-K – 8th grade Grades 9 – 12 HS graduate Some college GED Graduate degree 2-4 yrs of college	0-3 years old Pre-K – 8th grade Grades 9 – 12 HS graduate Some college GED Graduate degree 2-4 yrs of college	0-3 years old Pre-K – 8th grade Grades 9 – 12 HS graduate Some college GED Graduate degree 2-4 yrs of college
Disabling Condition?	Yes No Unknown	Yes No Unknown	Yes No Unknown
Military Service	Currently serving In the past Not a Veteran	Currently serving In the past Not a Veteran	Currently serving In the past Not a Veteran
Health Insurance	None Private Pay Medicaid Medicare PCN VA Medical Services CHIP COBRA Employer Provided Indian Health Services	None Private Pay Medicaid Medicare PCN VA Medical Services CHIP COBRA Employer Provided Indian Health Services	None Private Pay Medicaid Medicare PCN VA Medical Services CHIP COBRA Employer Provided Indian Health Services
Employment status	Un-Employed (0-6 months) Unemployed (6 months +) Full-Time Part-Time Migrant Seasonal Farm	Un-Employed (0-6 months) Unemployed (6 months +) Full-Time Part-Time Migrant Seasonal Farm	Un-Employed (0-6 months) Unemployed (6 months +) Full-Time Part-Time Migrant Seasonal Farm
Monthly Income Provide income verification with each income	$ _____/ mo. ☐ Tax Return ☐ Pay Stubs ☐ Bank Statement ☐ SSI/SSDI sheet ☐ DWS 24 mo Benefit Report	$ _____/ mo. ☐ Tax Return ☐ Pay Stubs ☐ Bank Statement ☐ SSI/SSDI sheet ☐ DWS 24 mo Benefit Report	$ _____/ mo. ☐ Tax Return ☐ Pay Stubs ☐ Bank Statement ☐ SSI/SSDI sheet ☐ DWS 24 mo Benefit Report
Disconnected Youth? Youth age 14-24 who is neither working nor in school	Yes No	Yes No	Yes No
Barriers currently present	☐ Alcohol Abuse, indefinite? Yes No ☐ Chronic Health Condition, indefinite? Yes No ☐ Developmental Disability, indefinite? Yes No ☐ Substance Abuse (past/current), indefinite? Yes No ☐ HIV / AIDS, indefinite? Yes No ☐ Mental Health, indefinite? Yes No ☐ Physical Disability, indefinite? Yes No	☐ Alcohol Abuse, indefinite? Yes No ☐ Chronic Health Condition, indefinite? Yes No ☐ Developmental Disability, indefinite? Yes No ☐ Substance Abuse (past/current), indefinite? Yes No ☐ HIV / AIDS, indefinite? Yes No ☐ Mental Health, indefinite? Yes No ☐ Physical Disability, indefinite? Yes No	☐ Alcohol Abuse, indefinite? Yes No ☐ Chronic Health Condition, indefinite? Yes No ☐ Developmental Disability, indefinite? Yes No ☐ Substance Abuse (past/current), indefinite? Yes No ☐ HIV / AIDS, indefinite? Yes No ☐ Mental Health, indefinite? Yes No ☐ Physical Disability, indefinite? Yes No

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HOUSEHOLD INFORMATION CONTINUED:

Demographic information needed below	**Household #4** **Name** First, Middle, Last Name:	**Household #5** **Name** First, Middle, Last Name:	**Household #6** **Name** First, Middle, Last Name:
Relationship to head of household	Relationship:	Relationship:	Relationship:
Proof of Identity Only for 18 yrs. or older	Expires:	Expires:	Expires:
Phone Number, if different			
Email Address, if different			
Race options:	Am Indian/AK Native/Indigenous Black/African American/African Native Hawaiian/Pacific Islander Asian / Asian American White Multi-race (2 or more)	Am Indian/AK Native/Indigenous Black/African American/African Native Hawaiian/Pacific Islander Asian / Asian American White Multi-race (2 or more)	Am Indian/AK Native/Indigenous Black/African American/African Native Hawaiian/Pacific Islander Asian / Asian American White Multi-race (2 or more)
Hispanic/Latin (a)(o)(x)	Yes No	Yes No	Yes No
Date of Birth Month/Day/Year			
Social Security #			
Gender (circle one)	Male Questioning Female Transgender A gender that is not singularly 'Female' or 'Male'	Male Questioning Female Transgender A gender that is not singularly 'Female' or 'Male'	Male Questioning Female Transgender A gender that is not singularly 'Female' or 'Male'
Education (circle one)	0-3 years old Pre-K – 8th grade Grades 9 – 12 HS graduate Some college GED Graduate degree 2-4 yrs of college	0-3 years old Pre-K – 8th grade Grades 9 – 12 HS graduate Some college GED Graduate degree 2-4 yrs of college	0-3 years old Pre-K – 8th grade Grades 9 – 12 HS graduate Some college GED Graduate degree 2-4 yrs of college
Disabling Condition?	Yes No Unknown	Yes No Unknown	Yes No Unknown
Military Service	Currently serving In the past Not a Veteran	Currently serving In the past Not a Veteran	Currently serving In the past Not a Veteran
Health Insurance	None Private Pay Medicaid Medicare PCN VA Medical Services CHIP COBRA Employer Provided Indian Health Services	None Private Pay Medicaid Medicare PCN VA Medical Services CHIP COBRA Employer Provided Indian Health Services	None Private Pay Medicaid Medicare PCN VA Medical Services CHIP COBRA Employer Provided Indian Health Services
Employment status	Un-Employed (0-6 months) Unemployed (6 months +) Full-Time Part-Time Migrant Seasonal Farm	Un-Employed (0-6 months) Unemployed (6 months +) Full-Time Part-Time Migrant Seasonal Farm	Un-Employed (0-6 months) Unemployed (6 months +) Full-Time Part-Time Migrant Seasonal Farm
Monthly Income Provide income verification with each income	$ __________/ mo. ☐ Tax Return ☐ Pay Stubs ☐ Bank Statement ☐ SSI/SSDI sheet ☐ DWS 24 mo Benefit Report	$ __________/ mo. ☐ Tax Return ☐ Pay Stubs ☐ Bank Statement ☐ SSI/SSDI sheet ☐ DWS 24 mo Benefit Report	$ __________/ mo. ☐ Tax Return ☐ Pay Stubs ☐ Bank Statement ☐ SSI/SSDI sheet ☐ DWS 24 mo Benefit Report
Disconnected Youth? Youth age 14-24 who is neither working nor in school	Yes No	Yes No	Yes No
Barriers currently present	☐ Alcohol Abuse, indefinite? Yes No ☐ Chronic Health Condition, indefinite? Yes No ☐ Developmental Disability, indefinite? Yes No ☐ Substance Abuse (past/current), indefinite? Yes No ☐ HIV / AIDS, indefinite? Yes No ☐ Mental Health, indefinite? Yes No ☐ Physical Disability, indefinite? Yes No	☐ Alcohol Abuse, indefinite? Yes No ☐ Chronic Health Condition, indefinite? Yes No ☐ Developmental Disability, indefinite? Yes No ☐ Substance Abuse (past/current), indefinite? Yes No ☐ HIV / AIDS, indefinite? Yes No ☐ Mental Health, indefinite? Yes No ☐ Physical Disability, indefinite? Yes No	☐ Alcohol Abuse, indefinite? Yes No ☐ Chronic Health Condition, indefinite? Yes No ☐ Developmental Disability, indefinite? Yes No ☐ Substance Abuse (past/current), indefinite? Yes No ☐ HIV / AIDS, indefinite? Yes No ☐ Mental Health, indefinite? Yes No ☐ Physical Disability, indefinite? Yes No

For additional household members, please print this page again

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SELF-SUFFICIENCY STATEMENT

The below programs require a self-sufficiency plan

☐ **FLEXIBLE GAS VOUCHER** ☐ **MONTHLY BUS PASS**

☐ **STATE ID** ☐ **BIRTH CERTIFICATE**

☐ **DEPOSIT ASSISTANCE** ☐ **WATER ASSISTANCE**

☐ **COURT ORDERED SERVICE WAIVER**

According to the Community Service Block Grant, "Self-sufficiency" is defined as:
The applicant needs to be achieving (or working towards) a set of goals which will result in greater self-sufficiency and will eliminate some of the causes of that family's poverty. What issues is the applicant facing and the resources the family (or community agencies the family is working with) brings to address these issues.

Below, please have a written plan toward self-support created within your family/household:

_____

_____

_____

_____

_____

_____

COVID-19 IMPACT STATEMENT

☐ ONLY for the COVID-19 Rental Assistance Program

1. Did the client experience:
   - ☐ Loss of a job
   - ☐ Reduction in Income
   - ☐ Loss of Childcare
2. Please explain how these things were a result of the COVID-19 pandemic:

   _____

   _____

   _____

3. What is your plan for housing if you, by chance, lose this funding?

   _____

4. Landlord's name and contact information: _____

   (your landlord will NOT be contacted unless you sign a FCAOG ROI AND have been approved for funding)

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Authorization to Release Information

The agencies listed below are designed to assist individuals/families experiencing a housing crisis. The Authorization is designed to permit those agencies to share client information in order to collaborate on services and promote housing stability.

Client Name: _____ Date of Birth: _____

Client Name: _____ Date of Birth: _____

Address: _____ Phone: _____

☐ **by checking this box, I approve all of the below listed agencies**

☐	Five County Association of Governments	☐	The Utah Food Bank & Local Food Pantries
☐	Department of Workforce Services (DWS)	☐	Iron County Care & Share
☐	Southwest Behavioral Health Center	☐	Intermountain Health Care
☐	Cedar City or St. George Housing Authority	☐	Canyon Creek Women's Crisis Center (Domestic Violence)
☐	Family Healthcare / Clinic	☐	DOVE Center (Domestic Violence)
☐	Vocational Rehabilitation	☐	Utility Companies (Questar Gas, Rocky Mountain Power, etc.)
☐	The Division of Child and Family Services	☐	Veteran's Administration & Southern Utah VA Home
☐	County Sheriff Offices in the Service Area	☐	Switchpoint Community Resource Center
☐	LDS Transient Bishop's Office Bishop you are working with: _____	☐	Other agencies/people the team may contact to assist in individual cases: (list):
☐	Iron or Washington County School District	☐	Family Members (list):
☐	Police Departments in the	☐	Hotels (involved with the hotel voucher program)
☐	Adult Protective Services (APS)	☐	Landlord or Mortgage Lender
☐	Adult Probation and Parole (AP&P)/ private parole agency	☐	Other (list):

Information to Be Released: Only authorized personnel will share client information needed for service delivery, program eligibility, to track demographic trends, service patterns and the client outcomes achieved. Non-personally identifying information may also be used for the purposes of research and reporting to other services agencies, current and potential program funding sources, and other programs offered by.

For the Purpose of: (a) providing coordinated housing, medical, social, psychological, and other services to me, (b) evaluating the outcomes related to service delivery, and (c) to improve coordination of services to assist individuals experiencing a housing crisis, and (d) to identify barriers and service gaps that block the path out of homelessness. In the event of the publication of the results of the program, my identity will be kept confidential, although information about my circumstances may be discussed.

Right to Revoke: This authorization is subject to revocation at any time except to the extent that the agencies which are to make the disclosures have already taken action in reliance on those disclosures. Unless otherwise revoked by client, this release expires after 1 year.

Potential Re-disclosure: I understand that information that I authorize to be disclosed may be re-disclosed and not subject to medical privacy regulations. However, federal confidentiality rules (42 CFR, part 2) prohibit recipients from making any further disclosure of alcohol and substance abuse records unless further disclosure is expressly permitted by written consent of the person to whom they pertain or if disclosure is otherwise permitted by 42 CFR, part 2. The Federal rules restrict any use of the information to criminally investigate or prosecute and alcohol or drug abuse client.

By signing below, I authorize the above listed organizations to share information as it relates to my housing needs.

_____ _____

Client (1) Signature Date

_____ _____

Client (2) Signature Date

_____ _____

Case Manager Signature Date

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CSBG Income Guidelines
Department of Health & Human Services Poverty Guidelines

All clients receiving CSBG services must be able to demonstrate that they are eligible for the CSBG Program and the Household income is at or below **200%** of Federal Poverty Guidelines until 12/31/2021.

2022 Poverty Guidelines

Household size	Monthly	Annual
1	$2,147	$25,760
2	$2,903	$34,840
3	$3,660	$43,920
4	$4,417	$53,000
5	$5,173	$62,080
6	$5,930	$71,160
7	$6,687	$80,240
8	$7,443	$89,320
9	$8,200	$98,400
10	$8,957	$107,480

Guidelines are found at: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

Five County Community Action Grievance Procedure

This Grievance Procedure is to be followed by program consumers who are dissatisfied with or are denied services under programs funded by Community Service Block Grant (CSBG), Social Service Block Grant (SSBG), and any other grant or program overseen by the Five County Human Services Council. Attempts will be made to resolve grievances as quickly as possible.

Informal: Consumer will bring issue to attention of the local program provider. If not resolved to consumer's satisfaction, the consumer has the option of pursuing the grievance by issuing a formal complaint.

Formal Complaint

a. Consumer will submit written grievance to local program provider within five (5) working days of the incident or of knowledge of the incident. The local Program Provider will respond in writing within ten (10) working days. If not resolved to consumer's satisfaction, they have option to proceed.
b. If the issue is still not resolved to consumer's satisfaction, consumer may submit written grievance within ten (10) working days to Director of Community Action, Five County Association of Governments, 1070 West, 1600 South, Building B, St. George, Utah 84770. The Director of Community Action will respond in writing within ten (10) working days. If not resolved to consumer's satisfaction they have option to proceed.
c. If the issue is still not resolved to consumer's satisfaction, consumer may submit written grievance within ten (10) working days to the Executive Director of the Five County Association of Governments, 1070 West 1600 South Building B, St. George, Utah 84770. The Executive Director will utilize support staff or Human Services Council support as deemed necessary to investigate information and render a decision regarding the grievance. The Executive Director will respond in writing within ten (10) working days. If not resolved to consumer's satisfaction, they have option to proceed.
d. If the issue is still not resolved to consumer's satisfaction, consumer will be provided with address and telephone number(s) for the Chairperson of both the Five County Human Services Council and Five County Association of Governments Steering Committee. A hearing before the Human Services Council will offer the next level of grievance and help remedy appropriate action(s) regarding the complaint. The nature of the complaint and the investigation shall be properly documented. The response to the consumer will address the complaint received and relevant action taken. If any member of Human Services Council has involvement in the grievance, those members shall exclude themselves from the grievance procedure.
e. If the decision is not to the satisfaction of the consumer, the consumer shall be referred to the appropriate state agency's grievance procedure. In most instances, this will be the Utah Department of Workforce Services or the Utah Department of Human Services.

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Utah Homeless Management Information System: Informed Consent Release Form What is UHMIS?

FCAOG participates in the **U**tah **H**omeless **M**anagement **I**nformation **S**ystem (UHMIS), an online database that collects information about persons in Utah who are experiencing homelessness, those at risk of homelessness, and those who are formerly homeless.

What type of information is asked of me?

UHMIS asks for identifying information including, but not limited to, basic demographics (i.e., Name, Date of Birth, etc.), limited health data (i.e., disabling condition), and financial information. Each question has been carefully reviewed to ensure only the minimum required information necessary is collected.

Who is it shared with?

FCAOG must collect client information in UHMIS for program participation, even if the client does not sign this form. However, information is shared with other providers only **after** the client signs this consent form to release that information (providers are listed at UtahHMIS.org/Participating-Agencies). For more information on how client information is protected and shared, please refer to the UHMIS Privacy Posting (found at all HMIS data collection points) or the UHMIS Privacy Policy; both are available at UtahHMIS.org/Governance.

What happens if the client refuses to sign this form?

- Clients may refuse, and they will not be denied services unless a specific funding source for those services requires client information to be shared in UHMIS.
- Clients may refuse to share their information with only one or all other providers.
- Clients may choose not to share any specific data element even after signing this consent form.
- For **FCAOG** to serve clients with this UHMIS participating project, client information will still be entered into UHMIS and is visible by the users who work for this agency. It will also be visible to a small group of people not employed with this agency who provide security, oversight, data analysis, and research to improve services for those served by UHMIS.

When does client consent end?

Client consent will end seven years after the signature date by default; however, clients may also change their consent to share at any time. Due to the nature of UHMIS, when client consent ends, this agency will share no new information, but this agency will not remove anything already shared within the system.

Client Rights

- Clients may request this document in a format better suited for their needs and understanding.
- Clients may request to see information for themselves and their legal dependents and to change it if incorrect.

I understand the above statements and consent to the inclusion of personally identifying information in UHMIS about me and any dependents listed below and authorize information collected to be shared with other providers. I understand that my personal identifying information will not be made public and will only be used with strict confidentiality. I also understand that I may withdraw my consent at any time by submitting a UHMIS Informed Consent Revocation Form, which can be provided to me by this agency. I understand that I may obtain a copy of my signed consent form from this Agency.

Dependent children under 18 in the household, if any (please print first and last names):

_____ _____ _____

_____ _____ _____

_____ _____ _____

Client Signature (Parent/Guardian) Client Name (Print Clearly) Date

_____ _____ _____

Agency Staff Signature Agency Staff Name (Print Clearly) Date

(Agency use, as needed) ☐ The client provided verbal consent ☐ Client refused ☐ Client restricts some sharing (specify agencies on the form)

2021.07.01 UHMIS Standard Operating Procedures