COMMUNITY ACTION TEAM (CAT)  
HOUSING SOLUTIONS ASSESSMENT/INTAKE PACKET

Coordinated Entry:  
Funding is limited and financial assistance is not guaranteed. To ensure a fair and equitable process all requests for assistance will be entered through Coordinated Entry. Coordinated Entry is a process developed to ensure that all people experiencing a housing crisis have fair and equal access and are assessed for, referred, and connected to housing and assistance based on their strengths and needs. Contact and demographic information for individuals/households applying for assistance may be maintained on the Coordinated Entry by-name list until which time it is removed.

Client Eligibility:  
• Must prove that the household has ability to financially sustain housing without assistance.  
• Must meet income eligibility.  
• Must be homeless or at risk of homelessness (documentation required).  
• Due to funding restrictions we will not assist with: Unmanaged single room occupancy, halfway house, drug rehabilitation, rent to own, or subsidized rent portions.  
• Must be a Columbia County resident. Some private funding sources may require the applicant to be an established Columbia County Resident for 6 months or longer.

Intake Procedure:  
• After the request for assistance is received, an assessment, review, and a request for any further information/documentation will be made within seven (7) business days of receipt.  
• Eligibility will be determined within three (3) business days of receipt of all required information/documentation.  
• If monetary assistance request is denied, a verbal notification will be attempted as well as a written notice stating the reasons for denial. Said notice will contain a copy of the Grievance Policy and Procedure.

Services for Deaf and/or hearing impaired customers:  
Oregon Telecommunication Relay Service is a service that links Deaf and/or Hearing impaired persons via telephone.  

TTY/Voice 711 or 1-800-735-2900  
Hours: 9 a.m. to noon, 1 p.m. to 5 p.m.

To use this service, dial the number listed above. Give the agent the number you would like to call and he or she will stay on the line to relay the conversation. You can communicate directly with the person you contacted. All calls and information are confidential.

NOTE:  
• Any rental assistance payments from CAT will be directly mailed to landlord, only if the landlord is willing to work with the tenant and CAT. The payable process takes 7 to 14 business days.  
• CAT staff will not steer clients into any particular housing. We may make suggestions and inform you of options based on household needs/barriers but it is the applicant/client(s) responsibility to find/select housing that best fits their needs.

**Please turn in the following documentation when you turn in your packet, additional documentation may be required/requested.**

1) Photo ID for all adults listed  
2) Social Security cards for everyone in the household  
3) Proof of income for the last 30 days for the household (e.g. pay stubs, current year Social Security letter)  
4) Any notices given by landlords, family members, etc. pertaining to your housing situation.  

**Absence of the requested forms may delay evaluation and eligibility determination.**
Pending Assistance:

- [ ] Zero income
- [ ] No contact/disappeared
- [ ] Missing documents/information
- [ ] Other: ____________________

Ineligible due to:

- [ ] Lack of sustainable housing plan
- [ ] Income exceeds eligibility
- [ ] Zero funding available
- [ ] Other: ____________________

Initial Assessment type and date:

- [ ] CAT Office  [ ] Phone/Email  [ ] Outreach  [ ] Other: ________

Date contacted ____/____/____

Referrals:

- [ ] Apartment List
- [ ] Private Landlords
- [ ] Subsidized Housing (Woodland Trails 503-397-4938, Sol Havn 503-728-3169)
- [ ] Senior Subsidized Housing (Columbia Hills 503-397-6131, Victorian 503-987-1842)
- [ ] CityTeam Overnight Shelter Voucher (526 Grand Ave, Portland)
- [ ] Columbia Health Services (503-397-4651)
- [ ] Community Meals (Lutheran Church) Tuesday & Thursday
- [ ] DHS
- [ ] Self Sufficiency (Food Stamps/TANF/Job Program 503-397-1784)
- [ ] Adults and People with Disabilities (503-397-5863)
- [ ] Eisenschmidt Pool Shower Pass
- [ ] Energy Assistance (503-397-3511)
- [ ] Food Bank (St. Helens 503-397-9708, Scappoose 503-543-7495,

Rainier 503-556-0701, Clatskanie 503-728-3126, Vernonia 503-429-1414)
- [ ] Healthy Families (Sunday Kamppi 503-366-0800)
- [ ] Mental Health (CCMH 503-397-5211, Medicine Wheel 503-396-5322)
- [ ] Mortgage/Foreclosure Assistance (503-325-8098)
- [ ] OHP (Columbia Health Services 503-397-4651, Medicine Wheel 503-396-5322)
- [ ] Oregon Law Center (503-397-1628)
- [ ] OTAP (1-800-848-4442), Assurance Phone (1-888-321-5880)
- [ ] Parole and Probation (503-397-6253)
- [ ] Pregnancy Center (503-397-6047)
- [ ] SAFE (503-397-6161)
- [ ] Section 8 (NOHA 1-800-927-9275)
- [ ] Self Help Housing (503-366-6550)
- [ ] Senior Services (503-366-6542)
- [ ] Shelter-Community House on Broadway (360-425-8679)
- [ ] Tenant Landlord Hotline (1-877-296-4076)
- [ ] Transitional Housing (Sheriff Department 503-397-6253)
- [ ] Unemployment Office (503-397-1995)
- [ ] Veteran Service Officer (503-366-6380) / VASH (971-200-0351)
- [ ] Vocational Rehab (503-366-8383)
- [ ] Warming Center (503-410-5800)
- [ ] Weatherization (503-366-6552)
- [ ] Weatherization (503-397-4651)
- [ ] Work Source (503-397-6495)
- [ ] Other ____________________

CAT Staff:

- [ ] Heather Johnson 503-366-6559
- [ ] Melissa Kyles 503-366-6561
- [ ] Kayla Davis 503-366-6591
- [ ] Kristen Erickson 503-366-6558
- [ ] Lacy Chamberlain 503-366-6557
- [ ] ____________________

Task List:

- [ ] ____________________
- [ ] ____________________
- [ ] ____________________
- [ ] ____________________
- [ ] ____________________
- [ ] ____________________
- [ ] ____________________
- [ ] ____________________
- [ ] ____________________
- [ ] ____________________
- [ ] ____________________

X – Connected
R – Referred
N – Not eligible

Revised 08/2019
| Name (First, Middle, Last) | Relation to head of household | AGE | D/O/B | SOCIAL SECURITY NUMBER | Gender | Military Experience (Y/N) | Language (E,S,C,J) | Education (K-12/12+) | Disabled? (Y/N) | Pregnant? (Y/N) | Hispanic or Latino? (Y/N) | African American (Y/N) | Am/Indian/Alaska Native (Y/N) | Asian (Y/N) | Nat. Hawaiian/P. Islander (Y/N) | White (Y/N) | Don't Know/Refused (Y/N) | Food Stamps/SNAP (Y/N) | State Health Insurance | Medicaid/OHP (Y/N) | Medicare (Y/N) | VA Medical (Y/N) | Other Health Insurance | TANF Child Care (Y/N) | WIC (Y/N) |
|----------------------------|--------------------------------|-----|-------|------------------------|--------|--------------------------|-------------------|---------------------|----------------|----------------|----------------------------|-------------------|--------------------------|-----------|--------------------------|-----------|--------------------------|------------------|--------------------------|------------------|--------------------------|------------------|--------------------------|------------------|
|                            | Self                           |     |       |                        |        |                          |                   |                     |                |               |                            |                   |                          |           |                          |                  |                          |                   |                          |                   |                          |                   |                          |                   |
|                            |                                |     |       |                        |        |                          |                   |                     |                |               |                            |                   |                          |           |                          |                  |                          |                   |                          |                   |                          |                   |                          |                   |

**Household Contact Info:**

**Phone number:** ____________________________  [ ] Message  [ ] Cell  [ ] Home

**E-Mail Address:** ____________________________@__________________.com

**Physical Address:** __________________________ City:______________ State:_____ Zip:_______  [ ] Same as Mailing Address

**Mailing Address:** __________________________ City:______________ State:_____ Zip:_______

**Risk of homelessness:** (check only one)

- Literally Homeless
- 72 hour notice
- 7 days or less
- 7-14 days
- 15-30 days
- More than 30 days

**Where did you stay last night?** (Check only one):

- Rent with no subsidy
- Rent with subsidy
- Section 8/ NOHA
- Own Home with subsidy
- Own home
- Hotel/Motel
- Foster Care/Group Home
- Nursing Home
- Staying/Living with Friends
- Staying/Living with Family
- Substance Abuse Treatment Facility
- Hospital (Non-Psychiatric)
- Psychiatric Hospital/Facility
- Jail,Prison or Juvenile Detention
- Car
- Street
- Camping
- Iron Tribe
- Transitional Housing
- Emergency Shelter

**Length of Stay:**

- One day or less
- Two days to 1 week
- More than 1 week/Less than 1 month
- 1 to 3 months
- 4 to 12 months
- 1 year or longer

**Are you a victim of Domestic Violence?**

- Yes
- No

If yes, how long ago did it occur? ____________

If yes, are you currently fleeing?

- Yes
- No

**Military Service Era:** __________________________
1. Please give us a short summary of your housing situation:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

2. Total Assistance Requested
   a. How much are you requesting from Community Action Team? $ ________________
   b. How much do you have to put towards your rent or deposit? * $______________
      * Our funding is very limited and we are required to utilize every avenue possible when it comes to assistance. Your household may be required to pay a portion towards your rent/deposit.

3. How long have you been a resident of Columbia County? ____________________

4. Complete A or B below:
   a. If Homeless:
      • What caused you to be homeless? ________________________________________________
      • Last Night did you stay in/on the streets, emergency shelter, or safe haven?  Yes/No
      • Approximate date homelessness started: ______/________/_______
      • Can someone document the length of time you have been homeless?  Yes/No
      • Number of times you have been homeless in the past 3 years: ______________
      • If 4 or more times, total number of months homeless in the last 3 years: ____________
      • Total number of months continuously homeless on the street, emergency shelter, or safe haven in the past 3 years: ___________________
   b. If housed:
      • Approximate date you moved into your current place: ______/______/______
      • Landlord information
         1. Name of Landlord: ____________________________________
         2. Landlord Phone number: _______________________________
         3. Address of landlord: ____________________________________
      • Have you received a notice to vacate your current residence?  Yes/No
      • How will you pay your rent next month? ___________________________________________

5. Have you been working with anyone to receive assistance with your housing within the last 12 months?

<table>
<thead>
<tr>
<th>Who:</th>
<th>Amount received this month:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family:</td>
<td></td>
</tr>
<tr>
<td>Friends:</td>
<td></td>
</tr>
<tr>
<td>Church Name:</td>
<td></td>
</tr>
<tr>
<td>Agency:</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

☐ No resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent household from becoming literally homeless.
### Budget and Barriers

#### EXPENSES:

<table>
<thead>
<tr>
<th>ITEM</th>
<th>CURRENT</th>
<th>BACK OWING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rent</td>
<td>$_______</td>
<td>$__________</td>
</tr>
<tr>
<td>Security Deposit</td>
<td>$_______</td>
<td>$__________</td>
</tr>
<tr>
<td>Mortgage</td>
<td>$_______</td>
<td>$__________</td>
</tr>
<tr>
<td>Electric</td>
<td>$_______</td>
<td>$__________</td>
</tr>
<tr>
<td>Natural Gas</td>
<td>$_______</td>
<td>$__________</td>
</tr>
<tr>
<td>Water/Sewer</td>
<td>$_______</td>
<td>$__________</td>
</tr>
<tr>
<td>Garbage</td>
<td>$_______</td>
<td>$__________</td>
</tr>
<tr>
<td>Phone</td>
<td>$_______</td>
<td>$__________</td>
</tr>
<tr>
<td>Internet</td>
<td>$_______</td>
<td>$__________</td>
</tr>
<tr>
<td>TV</td>
<td>$_______</td>
<td>$__________</td>
</tr>
<tr>
<td>Food</td>
<td>$_______</td>
<td>$__________</td>
</tr>
<tr>
<td>Child Support</td>
<td>$_______</td>
<td>$__________</td>
</tr>
<tr>
<td>Child Care</td>
<td>$_______</td>
<td>$__________</td>
</tr>
<tr>
<td>Car Payment</td>
<td>$_______</td>
<td>$__________</td>
</tr>
<tr>
<td>Car Insurance</td>
<td>$_______</td>
<td>$__________</td>
</tr>
<tr>
<td>Gasoline</td>
<td>$_______</td>
<td>$__________</td>
</tr>
<tr>
<td>Car Repair</td>
<td>$_______</td>
<td>$__________</td>
</tr>
<tr>
<td>Household Items</td>
<td>$_______</td>
<td>$__________</td>
</tr>
<tr>
<td>Laundry</td>
<td>$_______</td>
<td>$__________</td>
</tr>
<tr>
<td>Health Insurance</td>
<td>$_______</td>
<td>$__________</td>
</tr>
<tr>
<td>Cigs/Alcohol</td>
<td>$_______</td>
<td>$__________</td>
</tr>
<tr>
<td>Medical Bills</td>
<td>$_______</td>
<td>$__________</td>
</tr>
<tr>
<td>Medication</td>
<td>$_______</td>
<td>$__________</td>
</tr>
<tr>
<td>Court Fees</td>
<td>$_______</td>
<td>$__________</td>
</tr>
<tr>
<td>Credit Cards</td>
<td>$_______</td>
<td>$__________</td>
</tr>
<tr>
<td>Storage Unit</td>
<td>$_______</td>
<td>$__________</td>
</tr>
<tr>
<td>Other: $_______</td>
<td>$_______</td>
<td>$__________</td>
</tr>
</tbody>
</table>

**Total Expenses**: $_______ $_______

#### RESOURCES:

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>MONTHLY AMOUNT:</th>
<th>PERSON RECEIVING:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployment</td>
<td>$_______</td>
<td></td>
</tr>
<tr>
<td>Employment</td>
<td>$_______</td>
<td></td>
</tr>
<tr>
<td>Food Stamps</td>
<td>$_______</td>
<td></td>
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<tr>
<td>TANF</td>
<td>$_______</td>
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<td>SSI</td>
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<td>SSDI</td>
<td>$_______</td>
<td></td>
</tr>
<tr>
<td>Social Security</td>
<td>$_______</td>
<td></td>
</tr>
<tr>
<td>Child Support</td>
<td>$_______</td>
<td></td>
</tr>
<tr>
<td>Pension</td>
<td>$_______</td>
<td></td>
</tr>
<tr>
<td>VA Pension</td>
<td>$_______</td>
<td>(non-svs connected)</td>
</tr>
<tr>
<td>VA Pension</td>
<td>$_______</td>
<td>(Svs Connected)</td>
</tr>
<tr>
<td>Widows Benefits</td>
<td>$_______</td>
<td></td>
</tr>
<tr>
<td>Trust Fund</td>
<td>$_______</td>
<td></td>
</tr>
<tr>
<td>Alimony</td>
<td>$_______</td>
<td></td>
</tr>
<tr>
<td>Tribal Benefits</td>
<td>$_______</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>$_______</td>
<td></td>
</tr>
<tr>
<td>Other: $_______</td>
<td>$_______</td>
<td></td>
</tr>
</tbody>
</table>

**Total Resources**: $_______

#### BARRIERS:

- **Physical Disability**
  - √ (if applies)
  - Name: ____________________________
  - Owe money to Past Landlord ______
- **Mental Health Disability**
  - ______
  - ______
  - Damages to past rentals ______
- **Developmental Disability**
  - ______
  - ______
  - Evictions/Last 10 yrs ______
- **Alcohol Abuse**
  - ______
  - ______
  - Mortgage Foreclosure ______
- **Drug Abuse**
  - ______
  - ______
  - Bankruptcy/Last 10 yrs ______
- **Chronic Health Condition**
  - ______
  - ______
  - Illegal Chemical Conviction ______
- **Companion/Service Animals**
  - ______
  - ______
  - Misdemeanor Convictions ______
- **HIV Positive**
  - ______
  - ______
  - Sex Offender ______
- **Lack of rent/mortgage**
  - ______
  - ______
  - Felony Convictions/last 10 yrs ______
- **Lack of Screening Fees**
  - ______
  - ______
  - Theft Convictions ______
- **Lack of Security deposit**
  - ______
  - ______
  - Assault Convictions ______
- **Lack of Day Care**
  - ______
  - ______
  - ______

Revised 08/2019
Housing Options/Resource Eligibility/ Asset Worksheet

Applicant:

Name: ______________________________________________________ Date: ________________________

➢ Are there any financial or support networks available to your household that can be used to help you remain in your current housing or to obtain other appropriate housing? ○ YES ○ NO

  If yes, please explain: __________________________________________________________

➢ Does anyone in the household have a checking or savings account? ○ YES ○ NO

  If yes, please note account balances and attach bank statement for last 30 days.

  Checking $ ________________ Savings $ __________________

➢ Non Cash Assets:

<table>
<thead>
<tr>
<th>TYPE OF ASSET</th>
<th>TOTAL VALUE</th>
<th>FEES OR PENALTIES</th>
<th>CASH VALUE (TOTAL VALUE MINUS PENALTIES)</th>
<th>INTEREST RATE</th>
<th>ACTUAL ASSET INCOME (MULTIPLY CASH VALUE BY INTEREST RATE)</th>
</tr>
</thead>
</table>

TOTALS:

☐ To the best of my knowledge, I have no assets to report.

By signing these forms, I declare that all of the information provided to Community Action Team, Inc. Housing Solutions is true and correct to the best of my knowledge. I understand that if it is discovered that I have provided false information I could be denied services.

________________________________________________________________________________

Applicant Signature        Date

CAT Staff:

Subsequent Housing Options: Please assess with the applicant what appropriate subsequent housing options might be available to the household.

➢ Are there any appropriate subsequent housing options for this household? ○ YES ○ NO

  If yes, please explain: __________________________________________________________

➢ Have you verified that no other appropriate subsequent housing options are available? (I.e. Friends/family/ hotel/motel/other agencies) ○ YES ○ NO

Financial Resources and Support Networks: Please assess with the participant all financial resources and support networks that might be available to the household.

➢ Have you verified that the household lacks the financial resources and support networks to maintain housing? ○ YES ○ NO

Staff Signature ____________________________________________ Date: __________________
COMMUNITY ACTION TEAM, INC. INCOME VERIFICATION
(Only for new income prior to receiving the first paycheck)

Applicant’s Name: __________________________________________ Last 4 digits of SSN: ________________

Applicant’s Signature Date

Employer Agency: ___________________________ Phone: ___________________ Fax: _______________

Employer Address: ___________________________ City: ______________________ Zip: ______________

Dear Employer:

The person listed above is applying for assistance through CAT. Part of the criteria for this process includes income verification to determine this household’s financial eligibility. We are required by Federal regulations to verify the income of all program participants. Please complete all the information below. Thank you for your assistance.

Place of employment: _________________________________________________________________

Employee’s title, position or type of work: _________________________________________________

Date employment began: _______________ Date employment ended: ___________________

Number of hours worked per week (use average if inconsistent): ____________________________

Hourly wages: $________________________ or Annual gross salary: $____________________

Gross year-to-date earnings: $____________________ as of what date: _____/_____/_______

Number of weeks employed each year: _____________________

Tips, commission, other: Year $____________ Week $_____________ Month $____________

Expected change in pay: $__________ hourly/monthly/annually Effective date: ___________

(circle one)

Employer Signature Date Company

Employer Name (Printed) Phone Number

Record of Oral Verification: CAT Staff: ___________________________

Person Contacted: ______________________ Representing: ______________________

Information supplied: Date and time: ___________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

Please return to: CAT, Inc. Housing Solutions Programs, 125 N. 17th St. Helens, OR. 97031
(Phone) 503-397-3511 (FAX) 503-397-3290

Revised 08/2019
COMMUNITY ACTION TEAM, INC.
HOUSING SOLUTIONS
GENERAL RELEASE OF INFORMATION

Consent: I give permission for Community Action Team, Inc. to share and exchange information with other staff at the agencies listed below for the purpose of providing assistance to me.

Information Covered: I understand that depending on the program policies previous or current, information regarding my household or myself may be needed. Verification and inquiries that may be requested include but are not limited to:

- Identity Verification
- Social Security/Disability Status
- Employment/Income/Asset Verification
- Marital Status
- Criminal/Credit/Rental History
- Medical/Mental Health Information

Groups or Individuals that may be asked: The groups or individuals that may be asked to release the about information (depending on program requirements) include but are not limited to:

- Potential Landlords
- Previous Landlords
- Medical and Mental Health Providers
- Current Landlords
- Past and Present Employers
- Department of Human Services & their contractors
- Utility Companies
- Social Security Administration
- Oregon Housing and Community Services (OHCS)
- Foods Banks
- Courts and Probation & Parole
- Northwest Oregon Housing Authority (NOHA)
- Homeless/DV shelters
- Law Enforcement Agencies
- Federal, State and/or local Tribal Benefits Agencies
- Continuum of Care
- Support and Alimony Providers
- Credit Report Providers and Credit Bureaus
- Public Health Agencies
- Child Care Providers
- Veteran’s Administration
- Retirement Systems
- Vocational Rehabilitation (DHS)
- Housing and Service Providers
- Financial Institutions
- Community Action Agencies
- Drug and Alcohol Treatment Facilities
- Schools and Colleges
- Other __________________________
- Other __________________________

Computer Matching HMIS Notice and Consent: I understand and agree that CAT, Inc. may conduct computer-matching programs (OPUS & ServicePoint) to verify the information supplied for my application rectification. If a computer match is done, I understand that I have a right to notification of any adverse information found and a chance to dispose of incorrect information. CAT, Inc. may in the course of its duties, exchange automated information with other Federal, State, County or Local agencies, including but not limited to: State Employment Security Agencies, Department of Defense; Office of Personnel Management; the US Postal Service; The Social Security Administration and State Welfare and Food Stamp agencies; OHCS-OPUS partner Agencies.

Conditions: I understand that this authorization cannot be used to obtain any information about me that is not pertinent to my eligibility for, and/or continued participation in a CAT, Inc. housing assistance program. I understand this release is valid for the duration of my program/assistance or one year unless otherwise noted. I understand that I can revoke this consent at any time, by notifying Community Action Team, Inc. (Note: If this occurs, client could write revoked on bottom of this form with date).

All adults over the age of 18 must sign this release of information.

______________________________        ________________________        ________________________
Printed Name                        Signature                          Date

______________________________        ________________________        ________________________
Printed Name                        Signature                          Date

______________________________        ________________________        ________________________
Printed Name                        Signature                          Date

Revised 08/2019
Columbia County Homeless Management Information System (HMIS)
CLIENT CONSENT FOR DATA COLLECTION AND RELEASE OF INFORMATION

What is the HMIS? HMIS is a computer data system that collects and stores information on individuals and families using services. The data will be used to describe the number and characteristics of program clients. It tracks the type of service given and how often services are used. HMIS is used to assess local service needs and to assist our community to make informed decisions about the most effective service delivery models.

What is the purpose of this form?
With this form, you can give permission to have information about you collected and shared with partner agencies that help Community Action Team provide housing and services. Partner agencies are listed below.

<table>
<thead>
<tr>
<th>Oregon Housing and Community Services (OHCS)</th>
<th>Rural Oregon Continuum of Care (ROCC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northwest Oregon Housing Authority (NOHA)</td>
<td>Department of Human Services (DHS)</td>
</tr>
<tr>
<td>Medicine Wheel Recovery Services (MWRS)</td>
<td>Clatsop Community Action Team (CCA)</td>
</tr>
<tr>
<td>Community Action Resource Enterprise (CARE)</td>
<td>Department of Veteran’s Affairs (VA)</td>
</tr>
<tr>
<td>Housing and Urban Development (HUD)</td>
<td>Columbia Community Mental Health (CCMH)</td>
</tr>
</tbody>
</table>

BY SIGNING THIS FORM, I AUTHORIZE Community Action Team to share HMIS information with partner agencies. The HMIS information shared will be used to help me get housing and services. It will also be used to better understand and improve housing and homeless service programs. I understand that the partner agencies may change over time. The information to be collected and shared includes:

<table>
<thead>
<tr>
<th>Name, birthday, gender, race, ethnicity, social security number, phone number, address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic medical, mental health, substance use, and daily living information</td>
</tr>
<tr>
<td>Housing Information</td>
</tr>
<tr>
<td>Employment, income, insurance, and benefits</td>
</tr>
</tbody>
</table>

BY SIGNING THIS FORM, I UNDERSTAND THAT:
- Community Action Team and partner agencies will keep my HMIS information private using strict privacy policies. I have the right to review their privacy policies.
- I can receive a copy of this Consent and the Client Information Sheet
- I may refuse to sign this Consent. If I refuse, I will not lose any benefits or services.
- This Consent will expire 10 years from my last HMIS recorded activity.
- I may revoke this Consent at any time in writing. The revocation will take effect upon receipt, except to the extent others have already acted under this Consent, and after partner agencies and Community Action Team have been notified so that revocation does not interfere with care or service coordination.
- My HMIS information may be shared by the partner agencies with other agencies for care coordination, counseling, food, utility assistance, and other services.
- My HMIS information may be viewed by auditors or funders who review work of the partner agencies, including HUD, the Dept. of Veteran Affairs, the Dept. of Health and Human Services, and Oregon Housing and Community Services (OHCS). I understand that the list of auditors and funders may change over time.
- My HMIS information may be used to help evaluate the quality of services provided. It may also be used for research purposes that align with Community Action Team’s goals and mission.

SIGNATURE:

Printed Name: ___________________________  Signature of Client or Representative: ___________________________  Date: ______________

Printed Name: ___________________________  Signature of Client or Representative: ___________________________  Date: ______________

Community Action Team HMIS – CLIENT CONSENT TO DATA CLIENT COLLECTION AND ROI – 08/2019
Community Action Team  
Mutual Respect Policy

Client Participation

Any individual seeking services will not be denied access to services, if they are unable to answer the questions asked during the assessment process.

Mutual Respect Policy

It is the goal of Community Action Team to provide services of the highest quality, and to provide those services in a manner that is professional, respectful, and based on the dignity and rights of the people we serve. Likewise, we expect our clients to treat staff members and other clients in a manner that is respectful, and based on the dignity and rights of others.

Anti-discrimination Policy

The program will not discriminate against any individual or family because of race, color, national origin, religion, gender, disability, familial status, sexual orientation/gender identity, source of income, or domestic violence. Reasonable accommodations will be offered to all disabled persons who request them at any time during the application or selection process, and throughout program involvement.

Dispute Resolution Process

Community Action Team has the right to deny services or terminate services to any individual who: engages in behavior that presents a danger to other people or disrupts the delivery of services to other clients; creates a hostile environment; or commits acts of fraud, deceit, or trickery. Any individual who is denied services or is terminated from services has the right to appeal that decision and may inquire about the agency’s dispute resolution process.

___________________________________  _____________________________________  _____________  
Client Name (print)    Client Signature     Date

___________________________________  ______________________________________  ______________  
Client Name (print)    Client Signature     Date