Dear healthcare provider:

This person has applied for housing assistance under a program of the U.S. Department of Housing and Urban Development (HUD). HUD requires the housing owner to verify all information that is used in determining this person's eligibility or level of benefits. Please complete the "Relevant Medical Information" and "Certification of Licensure and Qualification" sections.

Purpose of Disclosure:

Housing assistance eligibility under a program of HUD.

Re-Disclosure:

The confidentiality of the information being disclosed is protected by State and Federal law. ORC 5122.31, ORC 3701.243, and 42 CFR part 2 prohibit you from making any further disclosure of it without the specific and informed release of the individual to whom it pertains, his/her authorized representative, or as otherwise permitted by law.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 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 Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

(INCLUDING PSYCHIATRIC RECORDS RELATED TO EMOTIONAL ILLNESS, AND INFORMATION REGULATED BY FEDERAL PUBLIC LAW 930-282, CONFIDENTIALITY OF ALCHOL AND DRUG ABUSE PATIENTS. ALSO INCLUDED ARE RECORDS DOCUMENTING THE DIAGNOSIS AND/OR TREATMENT OF AIDS, ARC, HIV POSITIVE AND OTHER RELATED DISEASE)

Patient authorization for release of information:

- "By signing below, I authorize the release of verification of disability and housing status on this form, in accordance with Federal Regulations 42 CFR part 2 and HIPPA,
  I hereby authorize:_____ to disclose and release Relevant Medical Records Attached to this release to: TLCHB Project Home, (Name of Agency)_____ for the purpose of eligibility in HUD funded housing programs.
- I understand that the information disclosed is protected by law and may not be re-disclosed without my written authorization by law; however, I understand the provider cannot control the recipient's use of the information, and I hereby release the provider from any liability for the recipient's re-disclosure of such information.
- I understand that this authorization will expire in 90 days from date and signature.
- I understand that this authorization may be revoked by me at any time, except to the extent the program or person who is to make the disclosure has already acted in reliance on it. The revocation must be signed and dated by me. Upon revocation of consent, further release of information shall cease immediately."

Patient: _____ SS#: _____

Signature: _____ DOB: _____

Date: _____

*If other than the client/consumer, relationship to the client is:
__Parent __Legal Guardian
__Other_____

Title: _____

Requested by

Contact: _____

Phone: _____ Fax: _____

Organization:_____ Date: _____

Revocation:

Upon revocation of consent, further release of information shall cease immediately. I hereby revoke my consent for the release of the above information.

_____ _____

Signature of Client/Consumer/Guardian/Authorized Representative** *Date*

Relevant Medical Information:

1. **Is the patient diagnosed with acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) (Check One)**
   - ☐ Yes, patient is diagnosed with AIDS
   - ☐ Yes, patient is diagnosed with HIV
   - ☐ No, patient is not diagnosed with AIDS or HIV
   - ☐ Unknown
2. **Does the patient have a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury? (Check One)**
   - ☐ No, patient does not have a physical, mental, or emotional impairment
   - ☐ Yes, patient has physical, mental, or emotional impairment

   a. **If YES, which mental health condition(s) is it related to as a primary diagnosis, if any? (Check all that apply)**
      - ☐ Schizophrenia
      - ☐ Schizoaffective Disorder
      - ☐ Bipolar Disorder (excluding Cyclothymia)
      - ☐ Recurrent Major Depressive Disorder
      - ☐ Substance Dependence
      - ☐ Other: _____

   b. If YES, what medical condition(s) is related to the primary diagnosis, if any? List all that apply)
      - ☐ None
      - ☐ Listed diagnoses:

      _____

   c. If YES, is it expected to be of long-continuing (at least two years) or indefinite duration? (Check One)
      - ☐ Yes, patient's impairment is expected to be of long-continuing or indefinite duration
      - ☐ No, patient's impairment is not expected to be of long-continuing or indefinite duration
      - ☐ Unknown

   d. If YES, do they also have either a Global Assessment of Functioning (GAF) score of 60 or below; or require ongoing pharmacological management to maintain a GAF score above 60? (Check One)
      - ☐ Yes, patient has a GAF score of 60 or below
      - ☐ Yes, patient requires ongoing pharmacological management to maintain a GAF score above 60
      - ☐ No, patient does not have a GAF score of 60 or below and does not require ongoing pharmacological management to maintain a GAF score above 60
      - ☐ Patient's GAF score is unknown

   e. If YES, how does it substantially impede their ability to maintain housing independently? (Check all that apply)
      - ☐ Reasonable interaction with neighbors and landlord
      - ☐ Management of personal finances, including creation and adherence to a household budget, gaining and maintaining necessary income, and timely payment of household bills and expenses
      - ☐ Management of health needs, such as medications, other therapies, and appointments
      - ☐ Performance of basic housekeeping, personal hygiene, food preparation, or parenting
      - ☐ Self-exclusion from criminal activity or harm to self, others, or property

☐ Other behavioral item related to the impairment which, without intervention, is likely to result in the patient abandoning or being evicted from housing within one year:_____

f. If YES, does it substantially impede their ability to perform activities of daily living (ADL) outside a group home, assisted facility, or other institutional care? (Check One)

☐ Yes, patient's impairment substantially impedes their ability to perform ADL
☐ No, patient's impairment does not impede their ability to perform ADL

3. Is the patient developmentally disabled according to the Developmental Disabilities Assistance Act of 2000 (42U.S.C. 15002)? (Check One)

☐ Yes, patient is developmentally disabled
☐ No, patient is not developmentally disabled
☐ Unknown

4. Additional Comments:

Certification of Licensure and Qualification

I, the undersigned, certify that I am licensed and qualified to make the listed diagnosis or diagnoses as a:

☐ Licensed physician

License #: _____ State: _____

☐ Licensed independent social worker

License #: _____ State: _____

☐ Licensed professional clinical counselor

License #: _____ State: _____

☐ Other healthcare professional qualified to render the listed diagnosis

Credential: _____

License #: _____ State: _____

Signature: _____ Date: _____

Print Name: _____ Phone: _____

Title: _____ Organization: _____

Patient MACSIS ID (if known): _____

Primary Mental Health Agency Case Manager_____

FOR TLCHB Project Home USE ONLY

Based on the information provided by the client and through this form, the client's disability status is:

- ☐ **Disabled**; this client meets HUD's definition of a disabling condition.
- ☐ **Not disabled**; this client does not meet HUD's definition of a disabling condition.

Signature: _____ Date: _____

Print Name: _____
Title: _____
Phone: _____