

Grant to Benefit Homeless Individuals (GBHI) Program Waitlist Registration

Last Name	First Name	Middle Initial	Relationship	Date of Birth	Sex (M/F)	Social Security Number
			Head of Household			

- If expecting please include unborn child and indicate and anticipated Date of Birth.

Current Mailing Address: _____

Current Phone Numbers: _____ Other _____

Current Email or other Contact information: _____

1. Combined Gross Monthly Income from all sources: \$ _____
2. Does your household meet any of the following preference(s)? Yes _____ No _____
 _____ Current Participate of GBHI _____ Successful completion of ASAC treatment
3. **Verification of homelessness and successful completion of substance abuse treatment within the last 12 months are required for program eligibility and needs to accompany this form. Waitlist registrations returned without verifications will be considered non-eligible households until all documents returned.**
4. How did you find out about this Program? _____ Social Service Referral _____ Resident Referral
 _____ Newspaper _____ Website _____ Other: (Please specify) _____
5. Have you ever participated in any Section 8 Program, Public Housing Program, or any other long term rental assistance program?
 Yes _____ No _____ If yes, where? (City/State) _____ Approximately what year?
 _____ Under what name? _____
6. The following information is required by the Department of Housing and Urban Development (HUD) for statistical purposes only: Please check what is applicable to Head of Household:
 White _____; African American _____; American Indian or Alaskan Native _____;
 Asian or Pacific Islander _____ Ethnicity: (Choose one) Hispanic _____ Non-Hispanic _____

NOTE: If there is a change in household composition, address or phone number *you must notify our office in writing of this change*. Failure to report the above changes or respond to required correspondence in the required time frame will result in your name being removed from the waiting list. At this time we are just placing your name on the waiting list, you will be requested to complete a full application with required documentation when your name approaches the top of the waiting list. Eligibility will be determined at that time. Your application will be screened using the current Tenant Selection Plan, available at the AHNI office. *If you or anyone in your family is a person with disabilities, and you require a specific accommodation in order to fully utilize our programs and services please contact the office at 319-363-1403 to request reasonable accommodations.*

Form completed by: _____ Date _____

If not completed by Applicant, print your name, organization/relationship and contact information.

This form can be dropped off or mailed back to: **Affordable Housing Network, Inc. 3000 J Street SW, Cedar Rapids, IA** Email: TBRA@affordablehousingnetwork.org Fax: 866-908-0198



AREA SUBSTANCE ABUSE COUNCIL (ASAC)

CONSENT TO RELEASE/OBTAIN INFORMATION

I, _____ authorize the release of information as indicated below between the Area Substance Abuse Council (ASAC) and:

Name(s) and Title of Person/Organization

Address of Person/Organization

<p>To be released by ASAC: (Select all that apply)</p> <input type="checkbox"/> Presence in Treatment <input type="checkbox"/> Participation in Treatment/Group Therapy <input type="checkbox"/> Assessment/Evaluation/ASAM Results <input type="checkbox"/> Progress Notes/Summary <input type="checkbox"/> Alcohol and other drug use history <input type="checkbox"/> Drug/Alcohol screening results <input type="checkbox"/> Psychological Evaluation/Notes <input type="checkbox"/> Discharge summary/Information <input type="checkbox"/> Critical Incident Report <input type="checkbox"/> Other (Specify)	<p>To be released to ASAC: (Select all that apply)</p> <input type="checkbox"/> Assessment/Evaluation/ASAM Results <input type="checkbox"/> Participation in Treatment <input type="checkbox"/> Progress Notes/Summary <input type="checkbox"/> Alcohol and other drug use history <input type="checkbox"/> Discharge summary/Information <input type="checkbox"/> Drug/Alcohol screening results <input type="checkbox"/> Medical History/Information <input type="checkbox"/> Critical Incident Report <input type="checkbox"/> Psychological Evaluation/Notes <input type="checkbox"/> Other (Specify)
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Purpose of the Disclosure (Select all that apply):

- Coordination of treatment Services
- Determine eligibility for insurance benefits

Other: (Specify): _____

I understand my records are protected under the Federal Regulations governing Confidentiality of Substance Use Disorder Patient Records Act , 42 CFR Part 2 and HIPAA 45 C.F.R. Part 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and in any event this consent expires automatically twelve (12) months after my last service or as follows below:

Date, event, or condition upon which this consent expires instead of twelve (12) months after last service

Patient Signature Date

Parent/Guardian Signature Date Witness Signature Date

PROHIBITION ON RE-DISCLOSURE

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 information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by written consent of the individual whose information is being disclosed 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 the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 2.12 (c) (5) and 2.65.