CLIENT CONTACT INFORMATION SHEET

MHA SPEAKOUT SPEAKUP

3012 N Nevada St. #1
Spokane, WA 99207 - 2800

Phone : (509) 385-5286
Fax (509) 206-9500

mhaspeakoutspeakup@gmail.com

Birth Date: ____/____/____ Age:_____

Gender:
- ☐ Male
- ☐ Female

Name:_____ Provider one #_____

Address (Street and Number):_____

City: _____ State: _____ Zip: _____

Home Phone: (____) ____-_____

May We Leave a Message
- ☐ Yes
- ☐ No

Cell/Other Phone: (____) ____-_____

May We Leave a Message
- ☐ Yes
- ☐ No

E-mail:

May We Email You?
- ☐ Yes
- ☐ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Occupation:

Place of Employment:_____

Work Number: (____) ____-_____

If needed, is it OK to call here?
- ☐ Yes
- ☐ No

Emergency Contact:

Name:_____ Relationship:_____

Phone Number: (____) ____-_____

M.H.A SPEAKOUT SPEAKUP

3012 N Nevada St. #1
Spokane, WA 99207 - 2800

Phone : (509) 385-5286
Fax (509) 206-9500

CLIENT RESPONSIBILITES FOR PROGRAM SERVICES

- Must cancel within 2 hours of appointment or it will be marked as a no call /no show
- If assigned a to do or task list, tasks must be completed as stated on service plan or before next appointment.

I understand I will need to be seen once a month to stay active with MHA as well as keeping my state Medicaid active.

I understand in order to receive services I will follow the guidelines above if there are 3 marked no call no shows I will be terminated from services at M.H.A SPEAKOUT SPEAKUP.

X_____

Client signature

X_____

Case Manager

Signature: *Jolie' Knight* -CPC. FCS Case Manager, Director

Printed Name: Jolie' Knight CPC. FCS Case Manager, Director

Professional Title: Certified Peer Counselor

Name of Agency, etc.: M.H.A SPEAKOUT SPEAKUP

M.H.A SPEAKOUT SPEAKUP

3012 N Nevada St. #1
Spokane, WA 99207 - 2800

Phone : (509) 385-5286
Fax (509) 206-9500

Consent of release of information

I, _____ of _____

(print name) (county)

Authorize **MHA SPEAKOUT SPEAKUP** to disclose and/or receive information from

Agency/Person's Name:

_____

Address:

_____

City, State, Zip code: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

I understand that the purpose of this release is to allow **MHA SPEAKOUT SPEAKUP** to exchange information about me in any form including verbal, writing and electronic with the above-named entity to facilitate appropriate treatment, medical care and monitoring; and promote public safety. I also understand that if I decline to sign this or any additional requested releases that I am not eligible to participate in services with MHA SPEAKOUT SPEAKUP.

Types of information that may be shared include, but are not limited to:

- Substance use history, legal issues and license status.
- Diagnostic impression, symptomology, and treatment recommendations or services.
- Rental history
- Medical and/or psychiatric conditions
- Prescribed medications

- Results of urine, blood, hair, ect testing
- Monitoring program compliance and status
- Housing, utilities, employment
- Court records and criminal history
- Other:

_____

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records, 43 CFR Part 2, and cannot be disclosed without my written consent. I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows; specification of the date, event, or condition upon which this consent expires: (initial one)

_____ Ninety (90) days from the date listed below _____Ninety (90) days after program completion

_____ Other (specify length of time)

Signature & Date:

_____

M.H.A SPEAKOUT SPEAKUP

3012 N Nevada St. #1
Spokane, WA 99207 - 2800

Phone : (509) 385-5286
Fax (509) 206-9500

HOUSING INTAKE GUIDELINES

Here at M.H.A Speakout Speakup we are a housing supportive agency; with this we **cannot guarantee** housing placement by a certain time.

We will do everything we can to assist in finding suitable housing in a timely manner but due to the current housing crisis in Spokane and surrounding areas, long wait lists, and requirements for certain properties such as income, credit score, etc.

As a nonprofit agency we strive to help our clients in the most efficient way we can, however we cannot predict unforeseen circumstances such as property availability and are unable to guarantee approval into all properties.

X_____

Client signature & Date

X_____

Case Manager

MHA SPEAKOUT SPEAKUP

3012 N Nevada St. #1 Spokane, WA 99207

(509) 385-5286 Phone (509) 206-9500 Fax

www.mhaspeakoutspeakup.org

Client FCS housing TAP funding

I_____ understand that the FCS (Foundation Community support) housing program can possibly change how and what funds within the program are allocated each year. MHA SPEAKOUT SPEAKUP has no control over what the FCS determines how the funds can be used or when funds will run out.

I also understand the we can never predict when funds will run out for the year.

_____ _____

Client Case Worker

Wellpoint

Foundational Community Supports (FCS) Attestation of Chronic Homelessness

Washington | Medicaid

Those interested in enrolling in the Foundational Community Supports (FCS)supportive housing program must meet one health need and one risk factor to be eligible for the program, in addition to other criteria listed below.

I attest that I am a duly authorized FCS intake worker and that I have followed my agency's policies and procedures as well as Washington State Health Care Authority policy to establish chronic homelessness for the purposes of the FCS program. I have determined chronic homelessness by one of the following criteria:

- ☐ Homelessness Management Information System (HMIS)
- ☐ A written and signed attestation by an outreach worker
- ☐ A written and signed referral by another housing or service provider
- ☐ The enrollee's signed attestation of duration and frequency of homelessness

I attest that _____ meets the duration and frequency requirements of chronic homelessness; the individual has lived in a place not meant for human habitation, in a safe haven, or in an emergency shelter for at least 12 months, or at least four separate occasions in the last three years as long as the combined occasions equal at least 12 months.

Note: *This definition also includes individuals who previously met the HUD definition of chronic homelessness but have been housed in the last 60 days (time housed may not exceed 60 days).*

*Signature of authorized FCS intake worker:	*Date:

*Agency name:	Address:

Enrollee attestation

I,_____, have experienced being homeless for the last 12 months in which I lived in a place not meant for human habitation, in a safe haven, or in an emergency shelter; or on at least four separate occasions in the last three years, I was homeless for a total of at least 12 months.

Note: *This definition also includes individuals who previously met the HUD definition of chronic homelessness but have been housed in the last 60 days (time housed may not exceed 60 days).*

*Signature:	*Date:

** Indicates a required field.*

OMB Control # 2502-0581
Exp. (02/28/2019)

Supplemental and Optional Contact Information for HUD-Assisted Housing Applicants

SUPPLEMENT TO APPLICATION FOR FEDERALLY ASSISTED HOUSING

This form is to be provided to each applicant for federally assisted housing

Instructions: Optional Contact Person or Organization: You have the right by law to include as part of your application for housing, the name, address, telephone number, and other relevant information of a family member, friend, or social, health, advocacy, or other organization. This contact information is for the purpose of identifying a person or organization that may be able to help in resolving any issues that may arise during your tenancy or to assist in providing any special care or services you may require. **You may update, remove, or change the information you provide on this form at any time.** You are not required to provide this contact information, but if you choose to do so, please include the relevant information on this form.

Applicant Name:	
Mailing Address:	
Telephone No:	**Cell Phone No:**
Name of Additional Contact Person or Organization:	
Address:	
Telephone No:	**Cell Phone No:**
E-Mail Address (if applicable):	
Relationship to Applicant:	

Reason for Contact: (Check all that apply)

- ☐ Emergency
- ☐ Unable to contact you
- ☐ Termination of rental assistance
- ☐ Eviction from unit
- ☐ Late payment of rent
- ☐ Assist with Recertification Process
- ☐ Change in lease terms
- ☐ Change in house rules
- ☐ Other: _____

Commitment of Housing Authority or Owner: If you are approved for housing, this information will be kept as part of your tenant file. If issues arise during your tenancy or if you require any services or special care, we may contact the person or organization you listed to assist in resolving the issues or in providing any services or special care to you.

Confidentiality Statement: The information provided on this form is confidential and will not be disclosed to anyone except as permitted by the applicant or applicable law.

Legal Notification: Section 644 of the Housing and Community Development Act of 1992 (Public Law 102-550, approved October 28, 1992) requires each applicant for federally assisted housing to be offered the option of providing information regarding an additional contact person or organization. By accepting the applicant's application, the housing provider agrees to comply with the non-discrimination and equal opportunity requirements of 24 CFR section 5.105, including the prohibitions on discrimination in admission to or participation in federally assisted housing programs on the basis of race, color, religion, national origin, sex, disability, and familial status under the Fair Housing Act, and the prohibition on age discrimination under the Age Discrimination Act of 1975.

☐ **Check this box if you choose not to provide the contact information.**

Signature of Applicant	**Date**

The information collection requirements contained in this form were submitted to the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3520). The public reporting burden is estimated at 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Section 644 of the Housing and Community Development Act of 1992 (42 U.S.C. 13604) imposed on HUD the obligation to require housing providers participating in HUD's assisted housing programs to provide any individual or family applying for occupancy in HUD-assisted housing with the option to include in the application for occupancy the name, address, telephone number, and other relevant information of a family member, friend, or person associated with a social, health, advocacy, or similar organization. The objective of providing such information is to facilitate contact by the housing provider with the person or organization identified by the tenant to assist in providing any delivery of services or special care to the tenant and assist with resolving any tenancy issues arising during the tenancy of such tenant. This supplemental application information is to be maintained by the housing provider and maintained as confidential information. Providing the information is basic to the operations of the HUD Assisted-Housing Program and is voluntary. It supports statutory requirements and program and management controls that prevent fraud, waste and mismanagement. In accordance with the Paperwork Reduction Act, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information, unless the collection displays a currently valid OMB control number.

Privacy Statement: Public Law 102-550, authorizes the Department of Housing and Urban Development (HUD) to collect all the information (except the Social Security Number (SSN)) which will be used by HUD to protect disbursement data from fraudulent actions.

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ○ Yes ○ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ○ Yes ○ No
3. **In the past week, have you been having thoughts about killing yourself?** ○ Yes ○ No
4. **Have you ever tried to kill yourself?** ○ Yes ○ No

If yes, how? _____

_____

_____

When? _____

_____

If the patient answers Yes to any of the above, ask the following acuity question:

5. **Are you having thoughts of killing yourself right now?** ○ Yes ○ No

If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary *(*Note: Clinical judgment can always override a negative screen).*
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ "Yes" to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation.** Patient cannot leave until evaluated for safety.
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed.** Patient cannot leave until evaluated for safety.
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐