Alaska Continuums of Care
CONSUMER NOTICE

This Organization provides services for individuals and families at-risk of or experiencing homelessness. This Organization participates in the Alaska Homeless Management Information System (AKHMIS) and / or the Continuums of Care's Coordinated Entry System (Anchorage or Balance of State CoC).

The AKHMIS is used to collect basic information about clients receiving services from this Organization. This requirement was enacted to get a more accurate count of individuals and families experiencing homelessness, and to identify the need for different services.

The AK CoCs CES is used to connect individuals and families at-risk of or experiencing homelessness to the services they need.

This Organization only collects information that is considered appropriate and necessary. The collection and use of all personal information are guided by strict standards of privacy and security.

This Organization may use or disclose information from the AKHMIS and / or the AK CoCs CES under the following circumstances:

- To provide or coordinate services for an individual or household;
- For functions related to payment or reimbursement for services;
- To carry out administrative functions;
- When required by law;
- For research and / or evaluation; or
- For creating deidentified data.

A copy of the Alaska CoC Privacy Policy, describing allowable uses and disclosures of data collected for the purposes of the AKHMIS and / or the AK CoC's CES, is available to all clients upon request.

Public Notice (Federal Register / Vol. 69, No. 146) / Effective August 30th, 2004

Statewide Alaska Homeless Management Information System (AKHMIS)
Client Informed Consent and Release of Information

Purpose of this form:
Your long-term housing, health, and wellness are important. Signing this form allows for your information to be shared in a statewide database referred to as the Alaska Homeless Management Information System (AKHMIS). The purpose of sharing this information is to assist participating organizations in delivering and coordinating needed services. By agreeing to share your information, it will also help State and Federal entities have a better understanding of the needs in Alaska. The basic information you will share is listed below.

An important part of this Release of Information is the principle of "minimum necessary" use and disclosure. When the minimum necessary standard applies to a use and disclosure, an organization will only request personally identifiable information needed to satisfy a particular purpose or carry out a function to benefit you. A participating organization requesting this information must have and implement policies and procedures to reasonably limit uses and disclosures of your information.

If you choose to share your information, the following information, both current and historical, can be shared:

- Basic demographic and personal information, including your photo;
- Level of vulnerability and/or disabling conditions;
- History of housing and homelessness, and services provided to you;
- Referrals made on your behalf;
- Use of crisis or emergency services;
- Organization notes, including incidents and program bans; and
- Organization assessments, including benefits and income you receive.

AKHMIS operates under a strict Privacy Policy detailing the confidentiality of the information within the system and how it can be used and disclosed. Information about the Privacy Policy can be found at: https://www.icalliances.org/alaska-privacy-governance/.
Additionally:

- Only aggregate (non-identifiable) data will be used in public reports;
- If you have concerns about your privacy rights or the confidentiality of your information in AKHMIS, you can contact the organization where you received services;
- If you have concerns about how the organization serving you is using or disclosing your information, you can visit the website above;
- The list of participating organizations and this list can be found at the website above;
- This form will expire five (5) years from the date of signature;
- You will not lose benefits or be denied services for which you would otherwise qualify if you choose not to share your information; and
- You can choose to opt out of sharing your information at any time by completing and signing the opt-out section of this form at a participating organization or by contacting the website above for further instructions. Note that any information shared up until the time you choose to opt out will remain shared in AKHMIS, where applicable.

A case manager or intake worker from any participating organization can answer any clarifying questions you may have and provide you with a copy of this form or the Alaska CoCs Statewide Privacy Policy.

By signing this form, I agree that:
My collected information, as described above, will be shared to help me access housing, receive supportive services that best fit my needs, and assist in evaluating the quality of services and programs across the State. My consent allows any participating organization with direct access to AKHMIS to add or update my information in the system without asking me to sign another consent form.

Client or Guardian Signature: _____ **Date:** _____

Print Name (Client or Guardian): _____

Client Date of Birth: _____ **Client AKHMIS ID#:** _____

Statewide Alaska Homeless Management Information System (AKHMIS)
Client Informed Consent and Release of Information

I agree to have this form cover any minors of which I am the parent/legal guardian (provide child(ren)'s name(s) and date(s) of birth):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Witness Printed Name & Signature: _____

Witness Participating Organization: _____

Date: _____

Client opted out of data sharing (refused or revoked consent):

Client or Guardian Signature: _____ **Date:** _____

Printed Name (Client or Guardian): _____

Client Date of Birth: _____ **Client AKHMIS ID#:** _____

Staff Name: _____

Staff Organization: _____

***** For clients working with organizations remotely ONLY *****

Verbal Consent (Client or Guardian Name): _____

Date Consent Obtained: _____

Staff Name: _____

Staff Organization: _____

AKHMIS COVID-19 Survey

Staff must present AKHMIS Consumer Notice to client(s).

Date information collected: ____/____/_____ **Staff Completing Survey:** _____

Client Name:		
Social Security Number	**Date of Birth**	**Client Phone Number**
	___/___/_____	(____)____-_____
Other ways to reach client:		

Encouraged to be answered for all clients	
Are you seeking assistance due to a COVID-related event (i.e. reduced work hours, job loss, family member sick, self sick, etc.)?	☐ Yes ☐ Doesn't know ☐ No ☐ Refused
Are you experiencing symptoms consistent with COVID-19 (fever, cough, shortness of breath)?	☐ Yes ☐ Doesn't know ☐ No ☐ Refused

Only answer if applicable			
When did your symptoms begin?	___/___/_____	When did you begin your isolation?	___/___/_____
When did you begin your quarantine?	___/___/_____	If hospitalized, what date were you admitted to the hospital?	___/___/_____
If known, what is the COVID-19 test result or confirmed disease status?		☐ Positive: Confirmed to have COVID-19 ☐ Negative: Confirmed to Not have COVID-19	
If tested for COVID-19, when were you tested?	___/___/_____	If tested for COVID-19, what date were the test results provided to you?	___/___/_____
What is your current symptomatic disposition?	☐ Currently symptomatic ☐ Confirmed recovery ☐ No longer symptomatic ☐ Deceased		
What is the date of your current symptomatic disposition?			___/___/_____
Clinical Health Notes:			

Love INC
Love In the Name of Christ

APPLICATION

Physical Address	44410 K-Beach Rd. Soldotna, AK 99669	**Phone:**	Main: 907-262-5140 Executive Director: 907-262-5165
Mailing Address:	PO BOX 3052 Kenai, AK 99611	**Fax**	907-262-5149

***WE BASE ALL NEEDS ON PRIORITY, ELIGIBILITY, MANAGEABILITY AND AVAILABLE FUNDS.**
*** FILL WHOLE APPLICATION OUT- INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED**
*** WE ARE HERE FOR YOU! IF YOU NEED HELP FILLING OUT THIS APPLICATION, PLEASE ASK!**

Name: **Todays Date:**

Phone number: ( ) **# Of Adults:** **# Of Children:**

Physical Address **City** **Zip**

Mailing Address ☐ *Same as above* **City** **Zip**

Please list your needs on the lines below:

1. **2.** **3.** **4.**

On the lines below, please briefly describe your circumstances:

The more details you provide, the better we can serve you. Please remember, Love INC cannot guarantee assistance until application is reviewed and eligibility is determined.

Continued on back...

Do you have a home church? ☐ YES ☐ NO

If yes: Which Church?

If no: Would you like us to assist you in finding one? ☐ YES ☐ NO

Would you like prayer today? ☐ YES ☐ NO

Prayer Need:

HEAD OF HOUSEHOLD (HOH) NAME: _____ HOH DATE OF BIRTH: _____

HOUSING MOVE-IN DATE (housing projects only):	
CONSENT GIVEN FOR HMIS DATA SHARING?	☐ Yes ☐ No

Love INC-
Adult Household
Members Intake

Fill out for each Adult Household member.

First Name	MI	Last Name	Other Names

Social Security Number	US Military Veteran	Date of Birth
_____ - _____ - _____ ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	

Relationship to Head of Household (HoH) Select one.

☐ Self ☐ HoH's child ☐ HoH's other relation member ☐ HoH's spouse or partner ☐ Other: non-relation member ☐ Unknown

Race Select all that apply. ☐ Client doesn't know ☐ Client refused

☐ American Indian, Alaska Native, or Indigenous
☐ Asian or Asian American
☐ Black, African American, or African
☐ Native Hawaiian or Pacific Islander
☐ White

Ethnicity Select one. ☐ Client doesn't know ☐ Client refused

☐ Non-Hispanic/Non-Latin(o)(a)(x)
☐ Hispanic/Latin(o)(a)(x)

Gender Select all that apply. ☐ Client doesn't know ☐ Client refused

☐ Female
☐ Male
☐ A gender other than singularly female or male (e.g., non-binary, genderfluid, agender, culturally specific gender)
☐ Transgender
☐ Questioning

Sexual Orientation (Head of Household and Adults only) Select one. ☐ Client doesn't know ☐ Client refused

☐ Heterosexual/Straight
☐ Gay
☐ Lesbian
☐ Bisexual
☐ Questioning/Unsure
☐ Other / Additional (choose from additional terms)

Other or Additional Sexual/Relationship Orientation ☐ Client doesn't know ☐ Client refused

☐ Aromantic
☐ Asexual
☐ Demisexual
☐ Pansexual
☐ Queer
☐ Other (Ex: same gender-loving, stud)

COVERED BY HEALTH INSURANCE? Select an answer. ☐ Client doesn't know ☐ Client refused

☐ Yes (If yes, select answer for each type below.) ☐ No (If no, answer No for all types in HMIS.)

	Yes	No
Medicaid	☐	☐
Medicare	☐	☐
State Children's Health Insurance Program	☐	☐
Veteran's Administration Medical Services	☐	☐
Employer-Provided Health Insurance	☐	☐
Health Insurance through COBRA	☐	☐
Private Pay Health Insurance	☐	☐
State Health Insurance for Adults	☐	☐
Indian Health Services Program	☐	☐
Other (specify):	☐	☐

DISABLING CONDITIONS? Select an answer. ☐ Client doesn't know ☐ Client refused

☐ Yes (If yes, select answer for each type below.) ☐ No (If no, answer No for all types in HMIS.)

	Yes	No	Doesn't know	Refused	If Yes, does it	Yes	No	Doesn't know	Refused
Alcohol Use Disorder	☐	☐	☐	☐	affect client's	☐	☐	☐	☐
Both Alcohol and Drug Use	☐	☐	☐	☐	ability to live	☐	☐	☐	☐
Chronic Health Condition	☐	☐	☐	☐	independently?	☐	☐	☐	☐

HEAD OF HOUSEHOLD (HOH) NAME: _____ HOH DATE OF BIRTH: _____

Developmental	☐	☐	☐	☐					
Drug Use Disorder	☐	☐	☐	☐		☐	☐	☐	☐
HIV / AIDS	☐	☐	☐	☐					
Mental Health Disorder	☐	☐	☐	☐		☐	☐	☐	☐
Physical Disability	☐	☐	☐	☐		☐	☐	☐	☐

AK DISABLING CONDITIONS? Select answer for each.

	Yes	No	Doesn't know	Refused
Alzheimer's Disease and Related Dementias	☐	☐	☐	☐
Chronic Alcoholism or other substance use disorder	☐	☐	☐	☐
Intellectual or Developmental Disabilities	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐
Traumatic Brain Injuries	☐	☐	☐	☐

ALASKA NATIVE REGIONAL CORPORATION? Select one.

☐ Client doesn't know
☐ Client refused

☐Not Affiliated ☐Sealaska ☐Doyon Limited ☐Calista ☐Chugach Alaska
☐Bering Straits Native ☐Ahtna ☐13th Regional ☐Koniag ☐NANA Regional
☐Cook Inlet Regional ☐Bristol Bay Native ☐Aleut ☐Arctic Slope Regional

If affiliated with Secondary Corporation, specify:

PRIOR LIVING SITUATION - Where did you sleep last night? Select one.

☐ Client doesn't know
☐ Client refused

Homeless Situation
- ☐ Place not meant for habitation (for example: car, park, abandoned building, bus station, airport, tent)
- ☐ Emergency shelter
- ☐ Hotel/motel paid for by a shelter

Institutional Situation
- ☐ Foster care home
- ☐ Group home
- ☐ Hospital/Residential medical facility
- ☐ Jail
- ☐ Prison
- ☐ Juvenile detention
- ☐ Long-term care facility/Nursing home
- ☐ Psychiatric hospital/facility
- ☐ Substance abuse treatment/Detox center

Temporary or Permanent Housing Situation
- ☐ Staying/living at friend's house
- ☐ Staying/living at family's house
- ☐ Perm. Housing (not RRH)
- ☐ Residential/halfway house
- ☐ Hotel paid for by you/family/friend
- ☐ Trans. housing for homeless youth
- ☐ Host Home
- ☐ Owned, with a subsidy
- ☐ Owned, no subsidy
- ☐ Rental, with a subsidy
- ☐ Rental, with a voucher
- ☐ Rapid Rehousing, or similar
- ☐ Public housing unit
- ☐ Rental, no subsidy/voucher

If Subsidy or Voucher, specify type:

Length of stay in prior living situation (Homeless/Institutional/Temporary or Permanent)?

☐ Client doesn't know
☐ Client refused

☐ One night or less
☐ Two to six nights
☐ One week or more, but less than a month
☐ One month or more, but less than 90 days
☐ 90 days or more, but less than one year
☐ One year or longer

Before that, where were you staying and how long were you there? Specify place and period of time.

Specify place:

☐ One night or less
☐ Two to six nights
☐ 1 week or more, but less than 1 month
☐ 1 month or more, but less than 90 days
☐ 90 days or more, but less than 1 year
☐ 1 year or longer

Before that, where were you staying and how long were you there? Specify place and period of time.

Specify place:

☐ One night or less
☐ Two to six nights
☐ 1 week or more, but less than 1 month
☐ 1 month or more, but less than 90 days
☐ 90 days or more, but less than 1 year
☐ 1 year or longer

Before that, where were you staying and how long were you there? Specify place and period of time.

HEAD OF HOUSEHOLD (HOH) NAME: _____ HOH DATE OF BIRTH: _____

Specify place:

- ☐ One night or less
- ☐ Two to six nights
- ☐ 1 week or more, but less than 1 month
- ☐ 1 month or more, but less than 90 days
- ☐ 90 days or more, but less than 1 year
- ☐ 1 year or longer

When was the last time you were in a Temporary or Permanent Housing situation for 7+ days, or in an Institutional situation for 90+ days?

Approximate Date this current episode of homelessness started: _____/_____/_____

How many times (episodes*) have you been homeless in the past 3 years? Select one.

☐ Client doesn't know ☐ Client refused

☐ 1 time ☐ 2 times ☐ 3 times ☐ 4 or more times

***An episode of homelessness:** a period of time experiencing homelessness without a break**

****A break in homelessness:** 7+ days in temporary or permanent situation, or 90+ days in an institutional situation

Total number of months (within a month) you have been homeless in the past 3 years?

☐ Client doesn't know ☐ Client refused

- ☐ 1 month (1st month in the past 3 years)
- ☐ 2 months
- ☐ 3 months
- ☐ 5 months
- ☐ 6 months
- ☐ 7 months
- ☐ 8 months
- ☐ 9 months
- ☐ 10 months
- ☐ 11 months
- ☐ 12 months
- ☐ More than 12 months

DOMESTIC VIOLENCE VICTIM/SURVIVOR? Select an answer.

☐ Client doesn't know ☐ Client refused

☐ Yes (If yes, select answer for each question below.) ☐ No

When did the last experience occur? Select one.

☐ Client doesn't know ☐ Client refused

- ☐ Within past 3 months
- ☐ 3 to 6 months ago
- ☐ 6 to 12 months ago
- ☐ More than a year ago

Are you currently fleeing? Select one.

☐ Client doesn't know ☐ Client refused

- ☐ Yes
- ☐ No

INCOME FROM ANY SOURCE? (HUD TABLE) Select an answer.

☐ Client doesn't know ☐ Client refused

☐ Yes (If yes, select answer for each type below.) ☐ No (If no, answer No for all types in HMIS.)

	Yes (specify $)	No
Alimony/Other spousal support	☐ $_____	☐
Child support	☐ $_____	☐
Earned income	☐ $_____	☐
General assistance	☐ $_____	☐
Other: AK Permanent Fund Dividend (PFD)	☐ $_____	☐
Other: AK Native Corp. Dividend	☐ $_____	☐
Other (specify):	☐ $_____	☐
Pension/Retirement income	☐ $_____	☐
Private disability insurance	☐ $_____	☐

	Yes (specify $)	No
Retirement income from social security	☐ $_____	☐
SSDI	☐ $_____	☐
SSI	☐ $_____	☐
TANF	☐ $_____	☐
Unemployment insurance	☐ $_____	☐
VA non-svc connected disability pension	☐ $_____	☐
VA svc connected disability compensation	☐ $_____	☐
Worker's Compensation	☐ $_____	☐

Total Monthly Income: $

NON-CASH BENEFITS FROM ANY SOURCE? (HUD TABLE) Select an answer.

☐ Client doesn't know ☐ Client refused

☐ Yes (If yes, select answer for each type below.) ☐ No (If no, answer No for all types in HMIS.)

	Yes	No
TANF Child Care Services	☐	☐
Special Supp. Nutrition Program for WIC	☐	☐
TANF Transportation Services	☐	☐

	Yes	No
SNAP (Food Stamps)	☐	☐
Other TANF-Funded Services	☐	☐
Other (specify):	☐	☐

HEAD OF HOUSEHOLD (HOH) NAME: _____ HOH DATE OF BIRTH: _____

Love INC
Love In the Name of Christ

AUTHORIZATION FOR RELEASE OF INFORMATION

Head of Household: _____ **Spouse/Other Adult Household Member:** _____

Love INC of the Kenai Peninsula any information or materials needed to complete and verify my application for, or participation in any assistance program. Verifications and inquiries that may be requested include, but are not limited to:

*ID/Drivers license
*Police records an criminal history
*Employment income
*Income from any source
*Agencies in regards to family size
*Medical or child care allowances
*Residences and rental history

Groups or Individuals that Love INC may Contact

*USDA-Aurora Vista
*Past & present Landlords
*Individuals providing references
*Dept. of Health and Social Service
*Job Center/Employment Specialists
*Kenaitze
*Law Enforcement agencies
*AK PFD agency
*Private and Social Agencies
*Past and Present Employer
*Public Assistance
*Utility Companies
*Alaska Housing Finance Corp.
*Medical Providers
*Office of Children Services
*Kenai Peninsula Health Centers
*Other Alaska Native Social Serves.
*Payees, Trustees

Conditions:

I understand that this authorization cannot be used to obtain information about me that is not pertinent to my eligibility for, and continued participation in an assistance program. I agree that a photocopy of this authorization may be used for the purposes stated above. This authorization will stay in effect for 15 months from the date signed.

H/O/H-Print	Sign	Date
S/O-Print	Sign	Date
Witness Print	Sign	Date

Love INC
Love In the Name of Christ

LIST OF AGENCIES WORKING WITH YOUR FAMILY

Caseworker: _____ Voc Rehab: _____
Name Name

Kenaitze: _____ Disability Agency: _____
Name Name

Salvation Army: _____ Other Agency: _____
Name Name

Statement of Truth

I/We acknowledge by signing this form we are agreeing we have read and understand the following statements and agree they are true to the best of our knowledge:

*The information provided is true and correct
*Giving false information/documentation is ground for termination of assistance
*The information I provide is subject to verification
*Any approved assistance will be paid directly to the landlord, property management, utility companies, ECT
*Any deposit paid on the behalf of my/our household will be returned to Love INC
*Love INC does not do relocations based on wanting to move to a better or bigger place, or wanting to move into or out of town.
*Love INC is not Responsible for monthly payments to landlords or utility companies. I understand it is up to me to make my payments as scheduled.
*Love INC will not interfere in any decision made buy the landlord about you, the client.

H/O/H print Sign Date

S/O Print Sign Date