Intake Form

Intake Date: _______________ County Bed: Yes/No Manager's Name:________________________

First Name: _______________________ Middle Name: ________________________Last Name: ________________________

DOB: _________________ Gender: _________________

SSN: _________________ Cell Phone: _________________ eMail: _________________

History of:

[ ] Yes [ ] No - Moderate to severe mental health issues

[ ] Yes [ ] No - Diabetes

[ ] Yes [ ] No - Heart disease/high blood pressure

Other Medical Condition: ____

[ ] Yes [ ] No - Partnership Healthplan of California Member (Medi-Cal)? – If Yes, CIN#: _________________

[ ] Yes [ ] No - Do you have a Medical Home? – If Yes where: _________________

[ ] Yes [ ] No - Do you have a Primary Care Provider?

Do you have any income? ( ) Yes ( ) No - If yes, source/amt.: ____

How many times in the last year have you used the Emergency Department:................ _____ [ ] Unknown/Declined

How many times in the last year have you been admitted to the Hospital: .... _____ [ ] Unknown/Declined

How many times in the last year have you used Orenda Detox: .... _____ [ ] Unknown/Declined

How many times in the last year has an ambulance transported you to the Hospital: ... _____ [ ] Unknown/Declined

Exit Form

Exit Date: ________________

First Name: _________________________ Middle Name: __________________________Last Name: __________________________

DOB: ___________________ Gender: ___________________

SSN: ___________________ Cell Phone: ___________________ eMail: ___________________

History of:

[ ] Yes [ ] No - Moderate to severe mental health issues

[ ] Yes [ ] No - Diabetes

[ ] Yes [ ] No - Heart disease/high blood pressure

Other Medical Condition: ____

[ ] Yes [ ] No - Partnership Healthplan of California Member? – If Yes, CIN#: ___________________

[ ] Yes [ ] No - Do you have a Medical Home? – If Yes where: ___________________

[ ] Yes [ ] No - Do you have a Primary Care Provider?

How many times since PSC have you used the Emergency Department: .... ______ [ ] Unknown/Declined

How many times since PSC start have you been admitted to the Hospital: .... ______ [ ] Unknown/Declined

How many times since PSC have you used Orenda Detox: .... ______ [ ] Unknown/Declined

How many times since PSC has an ambulance transported you to the Hospital: .... ______ [ ] Unknown/Declined

Reason for exiting the program: ____

Destination: ____

Grievance Procedure

It is a participant's right, as well as, a COTS policy, to be informed of and to utilize a formal grievance procedure to resolve any disputes or difficulties that may arise between COTS residents and staff. The following is a description of the grievance procedure:

Step #1

- The first thing you must do is to start the grievance process is to fill out the form on the next page of this document. The form asks you to describe the problem you are having and with whom. **It is very important that you include as many details as possible.**

Step #2

- The second step is to talk face to face with the staff person you are having a problem with and tell them how you feel and what your grievance is about. **Ask the staff person to consider your side of the issue and to try to resolve the grievance at this meeting.**

Step #3

- If the discussion with the staff person has not resolved the problem, let the staff person know that you are requesting a meeting with their supervisor to help resolve the dispute. The staff member will set up the appointment with their supervisor for you. **Be sure to bring your completed Grievance Form with you to the meeting with the staff person's supervisor.**

Step #4

- If the discussion with the staff person's supervisor has not resolved the problem, let the supervisor know that you are requesting a meeting with the Assistant Executive Director. **Please be aware that the Assistant Executive Director may have the Program Director and other staff involved in the meeting.**

Step #5

- If the discussion with the Director of the program does not resolve the dispute, inform the Director that you will be writing a letter of grievance to the Executive Director of COTS and requesting a meeting to resolve the dispute. (Include copy of completed form) **Mail letter of Grievance and completed grievance procedure form to: COTS Executive Director, P.O. Box 2744 Petaluma, CA 94953**

Note: The Board of Directors of COTS will not be involved in the grievance process unless the grievance directly involves the Executive Director of COTS or unless the Executive Director recommends that they hear a particular grievance and it is necessary that they decide the issue.

I HAVE READ AND UNDERSTOOD THE ABOVE GRIEVANCE PROCEDURE.

Signature: ______________________________________ Date: __________

Note:

Blank Grievance Forms are available at the front desk of the Mary Isaak Center in the lobby on the first floor.

Policy on Americans with Disabilities Act

The Americans with Disabilities Act (ADA) sets forth certain requirements with respect to persons with disabilities. Committee on the Shelterless will strive to confirm to applicable federal, state, or local laws regarding protections for clients with disabilities. COTS' Mary Isaak Center is ADA compliant.

COTS will seek to provide reasonable accommodation for all clients with disabilities, provided that such accommodation does not cause unreasonable hardship to the organization.

Any persons with questions or concerns about COTS' ADA compliance or who feel they have been or are being discriminated against by COTS or COTS staff should contact the Executive Director of COTS at (707) 765-6530 Ext. 101.

I have read, understood and agree to the above criteria.

X ______________________ X _______________

Participant Signature Date

Non-Discrimination Statement

In order to ensure equal access to COTS' programs by all individuals, COTS does not discriminate based upon race, color, creed, religion, gender, age, marital status, source of income, sexual orientation, national origin, handicap or familial status.

Any persons with questions or concerns about any type of discrimination or who feels they have been or are being discriminated against by COTS or a COTS employee should first contact the Director of MIC Programs at 707-765-6530 x130 and, if a satisfactory response is not received within 24 hours, contact the Executive Director of COTS at 707-765-6530 x101.

X_______________________ X________________

Resident Signature Date

Authorization Form

What is HMIS?
COTS participates in a county-wide project called the Homeless Management Information System (HMIS), which collects information on people who are homeless or at risk of homelessness. HMIS is administered by the Sonoma County Continuum of Care. We enter the information into a secure computerized database for storage and analysis. All persons having access to HMIS information have agreed to keep the information strictly confidential.

What is the Sonoma County Continuum of Care?
The Continuum of Care is a collection of agencies in the county who provide services to benefit homeless persons. As of the date of this policy, the following Agencies are members who participate in the HMIS: Buckelew Programs, Catholic Charities, Committee on the Shelterless (COTS), Community Action Partnership of Sonoma County, Community Service Network, Interfaith Shelter Network, Cloverdale Community Outreach Committee, Sonoma County Housing Authority, Social Advocates for Youth, Women's Recovery Service, The Living Room and Vietnam Veterans of California.

Personal Identifying Information:
There four items of information about you that are known as "personal identifying information"; they are your name, social security number, date of birth and gender. We use these items of information to uniquely identify you from everyone else in our system. You do not have to provide permission to share personal identifying information for use in HMIS however; you may be required to provide personal identifying information to prove your eligibility for a program or service. You will receive services from us whether or not you agree to provide permission to share personal identifying information for use in HMIS. However, your cooperation in providing permission to share information will assist us and other agencies to provide services and housing to you and others more effectively. **We are required to report in HMIS that you received services whether or not you provide permission to share personal identifying information.**

Why is information collected for HMIS?
Information collected for HMIS will help us and other agencies providing services to the homeless to better understand what types of services you need, to assess what services are available to you, to develop new services, to monitor whether your needs are being met, and to improve the quality of care and services for homeless individuals and families. It will also help us and other agencies to understand the extent, nature, and causes of homelessness in Sonoma County. We also collect information that is required by law or by organizations that give us money to operate this program.

How will information you give us be used and disclosed?

Information you consent to give to us for use in HMIS will be used in the following ways:

- By the Continuum of Care, tem is accurate and valid, to fix problems in the computer system, and to test the system; to administer the HMIS, to ensure the data in the sys
- By the Continuum of Care, to prepare reports that contain "de-identified" information for the purpose of sharing data and preparing reports for HMIS users, government agencies and policy-makers, and the public generally. "De-identified" means that your name, social security number, address, zip code, or any other information that could be used to identify you personally will **not** appear in any of the data or reports released by an HMIS user or the SCCDC;
- By us, to verify the accuracy of information entered by the SCCDC into the HMIS database;
- By other agencies participating in HMIS, in order to assist those agencies to more effectively provide and coordinate services for you.

In addition to the uses above, we may also use and disclose information you provide us in the following ways:

- For functions related to payment or reimbursement for services;

Authorization Form

- To carry out internal administrative functions;
- To create “de-identified” statistical reports;
- To report abuse, neglect, or domestic violence, but only to the extent that such reports are required by law;
- To prevent or lessen a serious and imminent threat to the health or safety of a person or the public, including the target of a threat, if permitted by applicable law;
- In response to a warrant, subpoena, summons, or lawful court order, or in response to a written or oral requests by a law enforcement official under certain circumstances;
- To a law enforcement official, if we in good faith believe a crime has occurred on our premises;
- To an individual or institution for academic research purposes;
- To authorized federal officials for the conduct of certain national security or certain activities associated with the protection of certain officials.

What rights do you have regarding your information?

You have the right to see and receive a copy of the information that we maintain about you, except for information compiled in anticipation of litigation, information about another individual, information obtained under a promise of confidentiality, or information that would, if disclosed, endanger the life or safety of another. We will consider changing any information about you if you believe the information in our records is inaccurate.

What should you do if you think your privacy rights have been violated? We take your privacy rights seriously. If you believe that your privacy rights have been violated, you may send a written complaint to this Agency or to the HMIS Administrator at the address listed below. This Agency and the Continuum of Care are prohibited from retaliating against you for filing a complaint.

Can this notice change in the future? We and the Continuum of Care may amend this Notice at any time, and the amendment may affect information obtained by us before the change. The revised Notice will be posted at the Sonoma County Housing Authority at all times and may be obtained by contacting the Agency in writing and asking for a copy of any new Notice.

If you have further questions about the notice or about your rights, please contact this Agency or the SCCDC. Note, however, that the Agency and SCCDC cannot give legal advice to you regarding your rights.

Participant’s Signature: X________________________________ **Date:** X_______________________

COTS – Committee on the Shelterless	HMIS Administrator
P.O. Box 2744	Sonoma County Community Development Commission
Petaluma, CA 94953-2744	1440 Guerneville Road, Santa Rosa, CA. 95403
707-765-6530	707-565-7500

Authorization Form

Petaluma Sober Circle

Authorization for Disclosure of Health Information

Alcohol addiction and recover needs the support of a community. The Petaluma Sober Circle invites clients with addiction to join a program that collaborates with the community, assists clients with in-patient treatment, housing or shelter options, transportation, case management services, and contacts for support

The purpose of this program is to identify people who have not been able to maintain their sobriety and as a result have had multiple encounters with police, hospital, and emergency services. We hope that with additional support, clients will find success in maintaining sobriety and achieving a better quality of life.

Information disclosed will be used by the Petaluma Sober Circle to provide needed background information on individual program participants in order to better support their path to sobriety and to evaluate and improve the effectiveness of the program.

Client Name: ____ Date of Birth: _____/_____/_______
Address: _______________________________ City: _____________________ State: _______ Zip: _________
E-mail Address: ____________________ Phone: ____________________ Last four digits of SSN: ___________

I request that my personal health information (listed below)		
Be Disclosed From		**Be Disclosed To**
Petaluma Valley Hospital	Sonoma County Mental Health	Petaluma Sober Circle
Santa Rosa Memorial Hospital	Sonoma County Behavioral Health	PO Box 2744
Sutter Community Hospital	Petaluma Fire Department	Petaluma, CA 94953
Kaiser Permanente	Center Point DAAC	PH: (707) 794-2472
Petaluma Health Center	Committee on the Shelterless	FAX: (707) 776-4778
Santa Rosa Community Health Centers	Catholic Charities of Santa Rosa	**Admin@PetalumaSoberCircle.org**
Other:________________________	Petaluma Police Department	

I authorize the following personal health information to be released from my medical record (NO MEDICAL OR MENTAL HEALTH DIAGNOSTIC INFORMATION BEYOND THE FOLLOWING): ER admissions dates, psychiatric emergency service admissions dates, Detox admissions dates, Drug/Alcohol Treatment programs dates, ambulance transport dates.
Other: ____

Covering the period from: Specific Date(s): ________________ to ______________ **OR** All past, present and future encounters/visits

By signing this authorization form, I understand that:

- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Petaluma Sober Circle at the following address: ***PO Box 2744, Petaluma CA 94953***. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition:
  ________________________________.
  If I fail to specify an expiration date/event/condition, this authorization will expire ***one year*** from the date signed.

____________________________________ ____________________________________
Client Authorized Signature Date

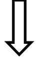
____
Print Client Name

PSC 12/16/2015

Authorization Form

Initial Contact

- If made by police/EMS, captured in Field Interview Card by PPD and ambulance transport dates by EMS
- If made by ED, captured in ER admission information
- If made by COTS/HOST, captured in the HMIS system
- If made by probation, captured in ______________________



Orenda – Detox

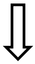
- Introduction to PSC by Outreach Lead at regularly scheduled intervals
- Coordinated intake by DAAC Detox Counselor
- Authorization form signed and hand delivered or mail by DAAC to COTS (Repository)
- Arrangements for Turning Point made by DAAC Counselor

- If individual departs after signing up, DAAC will inform COTS

Turning Point

- Introduction to PSC by Outreach Lead at regularly scheduled intervals
- Shelter options id'd and signed up by DAAC Counselor
- Second coordinated intake by DAAC Counselor

- If individual departs after signing up, DAAC will inform COTS



Housing

- Housing, transportation coordinated by DAAC and COTS
- Housing status maintained by COTS and CC

On-going Support

- Coordinated of on-going support by COTS and CC
- Status of individual maintained by COTS and CC

PSC Enrollment Touchpoint – Intake

Petaluma Sober Circle Enrollment

Intake Date 3/1/2016 Exit Date mm/dd/yyyy

Partnership Healthplan of California Yes

CIN#

Notes

History of moderate to severe mental health issue -- Select --

Diabetes -- Select --

Heart Disease/High Blood Pressure -- Select --

Other medical condition

How many times in the last year have you used the Emergency Department:

How many times in the last year have you been admitted to the Hospital

How many times in the last year has an ambulance transported you to the Hospital

How many times in the last year have you used Orenda Detox

Medical home at intake

Has primary care provider at intake -- Select --

Reason for exiting the program

Destination

PSC Enrollment Touchpoint – Exit

Petaluma Sober Circle Enrollment

Intake Date 2/1/2016 | Exit Date 3/24/2016

Reason for Exit

Partnership Healthplan of California: Yes | CIN#

Notes

History of moderate to severe mental health issue: -- Select --

Diabetes: -- Select --

Heart Disease/High Blood Pressure: -- Select --

Other medical condition

How many times in the last year have you used the Emergency Department:

How many times in the last year have you been admitted to the Hospital

How many times in the last year has an ambulance transported you to the Hospital

How many times in the last year have you used Orenda Detox

Medical home at intake

Has primary care provider at intake: -- Select --

How many times since program intake have you used the Emergency Department

How many times in the last y since program intake have you been admitted to the Hospital

How many times since program intake have you used Orenda Detox

How many times since program intake has an ambulance transported you to the Hospital

Medical home at exit

Has primary care provider at Exit: -- Select --

Reason for exiting the program

Destination

PSC Demographics

Edit Participant

Audit Report | Program History | Enroll | View Bill Fake's Dashboard

Status: Currently Enrolled

Case Number

54592

First Name *

Bill

Middle Name

Last Name *

Fake

SSN *

___-__-____

DOB *

Alert

Neighborhood

Cell Phone

(___) ___-____

Email

Save