**Homelessness Programs Improvement Project**

The Agency of Human Services is conducting a program improvement project to better understand if Vermonters accessed the programs and services available to them, how effective those interventions were to people who did access them, and what tools not available in all regions would be most helpful to further develop as a state.

Participating in our project is **entirely optional** and your participation -- or your decision not to participate -- will not effect in any way our efforts on your behalf to secure housing or any other service. You will not be denied any benefits or assistance if you decide not to participate in the project.

Our plan is to use the information that you give us permission to use to determine which programs, services, and systems you have been involved with in the past three years (examples include emergency rooms, homeless shelters, hospitals, jails, etc,) and how helpful they were to you to help us determine what types of supports and resources may be most helpful for people experiencing homelessness in Vermont.

Any information you share with us about your personal situation will only be seen by the staff and volunteers helping with this program improvement project and will be kept strictly confidential

We hope to publish the results of this systems-improvement project as we believe they will be of great benefit to the State of Vermont, the Vermont legislature, and community organizations in Vermont fighting homelessness. If we publish the results using any of the information you have provided to us or given us permission to use, we will not identify you as a participant. In other words, we will not communicate to anyone that any of the information we obtained during this project came from you. While staff and volunteers working on this project may share your personal information with each other to help us gather and analyze information, any public reporting about the information will only be done in a way that maintains your anonymity.

If you agree to participate, and allow us to share your information for the purposes we have explained above, please complete the permission form on the reverse side.

We know it can be difficult to talk about homelessness. We appreciate your participation and are hopeful that the information you share with us will help us better serve Homeless Vermonters.

**PERMISSION TO SHARE PERSONAL & HEALTH INFORMATION**

A staff member of AHS or a partner organization will review this release with you.

**What’s your legal name and any other names you have gone by in the past three years?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When is your birthday?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check all that apply - do you consider yourself to be: Male: [ ] Female: [ ] Other: [ ]**

**What are the counties or towns in Vermont that you’ve most recently lived in?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Please list any service providers outside of AHS that you have been working with in the past three years that you are comfortable with us contacting to learn more about your situation:**

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| **Is there anything else you’d like to share to help us better understand your situation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  By signing this form, Iauthorize all AHS departments, including the Department of Corrections, the Department of Vermont Health Access, the Department of Mental Health, the Vermont Department of Health, and the Department of Disability Aging and Independent Living, to analyze the data I provide, to analyze which services I have engaged with in the past three years that they have provided or funded, to determine how effective they were, what I was eligible for that I didn't access, and what services might have been helpful if they had been available to me.  **I understand:**   * The reasons I am being asked to release information. * Signing this authorization is voluntary. I understand that ability to receive services or support is not conditioned upon authorizing this disclosure. * While the Agency of Human Services will take every precaution to protect my personal and health information, once it is released pursuant to this authorization, it may be subject to re-disclosure by other parties. * My drug and alcohol treatment records are protected by Federal confidentiality rules (42 CFR Part 2) and cannot be disclosed or re-disclosed without my express written consent or as allowed by the regulation. I am authorizing the Agency of Human Services to access information about my alcohol or drug related diagnosis and treatment or referral for treatment: Yes:  No: * I may revoke this authorization at any time by contacting the Secretary’s Office of the Agency of Human Services at 802-241-0440, except to the extent that it has been acted upon. * If I do not revoke or update this authorization, it will be in effect for one year from the date it is signed. * I will be provided a copy of this form. * All items on this form have been completed and my questions about this form have been answered.  |  | | --- | | **Signature of Individual or Parent/Legal Representative: Date:**  **Name of Person Explaining Authorization Process: Organization/position: Date:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |  |