CATHOLIC CHARITIES
of the Archdiocese of Miami, Inc.

RAPID REHOUSING PROGRAM

Are you a Monroe County Resident?
Do you currently have income but need *assistance to move in* and return to a permanent Housing Situation?

For Assistance Please Contact

monroe@ccadm.org
786-526-1954

We serve People not because they are Catholic. We serve People because we are Catholic ©

CATHOLIC CHARITIES
of the Archdiocese of Miami, Inc.

Consent for Service

Consentimiento para Servicios

Konsantman pou Sèvis

I voluntarily consent to receive services from:

Yo, voluntariamente doy consentimiento para recibir servicios de:

Mwen volontèman dakò resevwa sèvis nan:

Program Name/ Nombre del Programa/ Non pwogram lan: **Rapid Re-Housing**

I acknowledge that it is my responsibility to act in response to the service recommendations that are documented on my service plan.

Yo reconozco que es mi responsabilidad seguir las recomendaciones de servicios documentadas en mi plan de servicios.

Mwen rekonèt se responsablite mwen yo aji an repons a rekòmandasyon yo sèvis ki dokimante sou plan sèvis mwen.

____
Staff/ Date
Empleado/ Fecha
Anplwaye/ Dat

____
Consumer/ Parent/ Legal guardian/ Date
Consumidor/ Padre/ Guardian legal/ Fecha
Konsomatè/ Paran/ Responsab Legal/ Dat

Family Intake Form

Household/Family Name: ______________________ **Head of Household's Name:** __________________

Family Relationship: __**Parent** __**Spouse/Domestic Partner** __**Child**

Program Name:______________________________ **COA Service Standard:**_______________

Intake Date:_____________________________________

Why did you come to the program?____

____

Address:____
Street Apt# City State Zip Code

Address:____
Street Apt# City State Zip Code

Social Security or Alien Number (optional):____

Date of Birth:__________________________________ **Age:**____________

Gender: **(Please check one)** ☐ **Male** ☐ **Female**

Country of Origin:________________________________

Racial/Ethnic Composition: **(Please check one)**

☐	Black, African American	☐	American Indian, Alaskan Native
☐	Black, Haitian	☐	Pacific Islander
☐	Black, Other	☐	Asian (non-Pacific Islander)
☐	Hispanic, Latino	☐	White (non-Hispanic/Non-Latino)
☐	Other (please specify): __________________		

Home Phone Number: ____________________________

Work Phone Number: ____________________________

Cell Phone Number: ________________________________

Emergency Contact(s) Information:

Contact Name:___________________________ **Phone Number:**__________________

Family Intake Form

Emergency Contact Relationship: (Please circle one)

Caregiver Extended Family Friend Legal Guardian Parent Sibling

Son/Daughter Spouse Other:________________________

Health Insurance Coverage: (Please check one)

☐ Both Medicaid and Medicare ☐ None

☐ Medicaid ☐ Third Party (Please specify insurance name)

☐ Medicare ______________________________

Do you have any emergency health needs? Yes or No

If yes, please explain.____

____

Fear of safety or imminent danger or harm to self or others? Yes or No

Safety Concerns/Description:

____

____

Gross Annual Household Income:____________________ **Household Size:**__________

What is your first language: (Please circle one) English Spanish Kreyól Other: _______

Are you able to read and write in your own first language? Yes or No

Can you speak and read in English? Yes or No

Religion: (Please circle one)

Catholic Jewish Muslim Protestant None Other Prefer not to answer

Highest level of education: (Please circle one)

None K-5th grade 6th - 8th grade 9th - 11th grade High School Graduate

Some College – Less than a Bachelor's degree Bachelor's degree or higher

Do you have an e-mail address? Yes or No If yes, please specify: ____________________

Consent to receive emails from the agency: (Please circle one) Yes or No

Program Start Date:________________________

Projected End Date (optional):_______________

CATHOLIC CHARITIES

Family Intake Form

Family Member #1

Family Relationship: ___**Parent** ___**Spouse/Domestic Partner** ___**Child**

Consumer's Name: ____

Social Security or Alien Number (optional): ____________________

Date of Birth: __________________ **Age:** ________________

Gender: **(Please check one)** ☐ **Male** ☐ **Female**

Country of Origin:_______________________________

Racial/Ethnic Composition: **(Please check one)**

- ☐ Black, African American
- ☐ Black, Haitian
- ☐ Black, Other
- ☐ Hispanic, Latino
- ☐ Other (please specify): __________________
- ☐ American Indian, Alaskan Native
- ☐ Pacific Islander
- ☐ Asian (non-Pacific Islander)
- ☐ White (non-Hispanic/Non-Latino)

Health Insurance Coverage: **(Please check one)**

- ☐ Both Medicaid and Medicare
- ☐ Medicaid
- ☐ Medicare
- ☐ None
- ☐ Third Party (Please specify insurance name) ______________________________

Do you have any emergency health needs? **Yes** **or** **No**

If yes, please explain.____

____

Fear of safety or imminent danger or harm to self or others? **Yes** **or** **No**

Safety Concerns/Description:

____

____

What is your first language: **(Please circle one)** English Spanish Kreyól Other:____________

Are you able to read and write in your own first language? **Yes** **or** **No**

Can you speak and read in English? **Yes** **or** **No**

Family Intake Form

Religion: (Please circle one)

Catholic Jewish Muslim Protestant None Other Prefer not to answer

Highest level of education: (Please circle one)

None K-5th grade 6th - 8th grade 9th - 11th grade High School Graduate

Some College – Less than a Bachelor's degree Bachelor's degree or higher

Family Intake Form

Family Member #2

Family Relationship: ___**Parent** ___**Spouse/Domestic Partner** ___**Child**

Consumer's Name: ____

Social Security or Alien Number (optional): ____________________

Date of Birth: ________________ **Age:** _______________

Gender: (**Please check one**) ☐ **Male** ☐ **Female**

Country of Origin: ______________________________

Racial/Ethnic Composition: (**Please check one**)

☐ Black, African American
☐ Black, Haitian
☐ Black, Other
☐ Hispanic, Latino
☐ Other (please specify): _________________
☐ American Indian, Alaskan Native
☐ Pacific Islander
☐ Asian (non-Pacific Islander)
☐ White (non-Hispanic/Non-Latino)

Health Insurance Coverage: (**Please check one**)

☐ Both Medicaid and Medicare
☐ Medicaid
☐ Medicare
☐ None
☐ Third Party (Please specify insurance name) ______________________________

Do you have any emergency health needs? **Yes** **or** **No**

If yes, please explain. ____

____

Fear of safety or imminent danger or harm to self or others? **Yes** **or** **No**

Safety Concerns/Description:

____

____

What is your first language: (**Please circle one**) English Spanish Kreyól Other: ____________

Are you able to read and write in your own first language? **Yes** **or** **No**

Can you speak and read in English? **Yes** **or** **No**

CATHOLIC CHARITIES

Family Intake Form

Religion: **<u>(Please circle one)</u>**

Catholic Jewish Muslim Protestant None Other Prefer not to answer

Highest level of education: **<u>(Please circle one)</u>**

None K-5th grade 6th - 8th grade 9th - 11th grade High School Graduate

Some College – Less than a Bachelor's degree Bachelor's degree or higher

Family Intake Form

Family Member #3

Family Relationship: ___**Parent** ___**Spouse/Domestic Partner** ___**Child**

Consumer's Name: ____

Social Security or Alien Number (optional): ____________________

Date of Birth: __________________ **Age:** ________________

Gender: **(Please check one)** ☐ **Male** ☐ **Female**

Country of Origin: ________________________________

Racial/Ethnic Composition: **(Please check one)**

☐ Black, African American
☐ Black, Haitian
☐ Black, Other
☐ Hispanic, Latino
☐ Other (please specify): __________________
☐ American Indian, Alaskan Native
☐ Pacific Islander
☐ Asian (non-Pacific Islander)
☐ White (non-Hispanic/Non-Latino)

Health Insurance Coverage: **(Please check one)**

☐ Both Medicaid and Medicare
☐ Medicaid
☐ Medicare
☐ None
☐ Third Party (Please specify insurance name) ______________________________

Do you have any emergency health needs? **Yes** **or** **No**

If yes, please explain. ____

____

Fear of safety or imminent danger or harm to self or others? **Yes** **or** **No**

Safety Concerns/Description:

____

____

What is your first language: **(Please circle one)** English Spanish Kreyól Other: ___________

Are you able to read and write in your own first language? **Yes** **or** **No**

Can you speak and read in English? **Yes** **or** **No**

CATHOLIC CHARITIES

Family Intake Form

Religion: (Please circle one)

Catholic Jewish Muslim Protestant None Other Prefer not to answer

Highest level of education: (Please circle one)

None K-5th grade 6th - 8th grade 9th - 11th grade High School Graduate

Some College – Less than a Bachelor's degree Bachelor's degree or higher

Consumer Rights and Responsibilities

A. The right to have a private communication with any staff person.
B. The right to have a clear explanation of how to lodge complaints, grievances, or appeals.
C. The right to be provided with sufficient information to make an informed choice about using the organization and its services.
D. The right to receive fair and equitable treatment/services, request review of their care, treatment and service plan.
E. The right to refuse any service treatment, or medication, unless mandated by law or court order; and be informed about the consequences of such refusal, which can include discharge.
F. The right to be treated courteously, fairly and with the fullest measure of dignity.
G. The right to terminate from **Rapid Re-Housing** services at client's request.
H. The right to be fully informed of rules, regulations, expectations and other factors applicable to the client's conduct which may result in the client's discharge or termination services.
I. The right to be informed of their responsibility to provide relevant information as a basis for receiving services and participating in service decisions.
J. Each client shall have impartial access to services, regardless of race, religion, sex, ethnicity, age ancestry, and national origin, medical or mental condition.
K. Each client shall be informed of his or her rights in a language the client understands.
L. Services are available __8__ hours a day, Monday – Friday from ____________.

I have read a copy of my rights and responsibilities as a recipient of Rapid Re-Housing services and they have been explained to my satisfaction.

______________________________ ________________
Client Signature **Date**

GRIEVANCE PROCEDURE FOR CONSUMERS

The Organization has a grievance process that allows consumers to grieve and resolve the actions of program staff, and/or conditions or circumstances that violate their rights without interference or retaliation. All grievances will be recorded using the *Grievance Form* to be completed by the consumer, and by submitting an *Incident Report,* to be completed by program staff.

Initially, efforts are made to resolve consumer conflicts and/or complaints informally and verbally by discussing with their case manager, program coordinator, or designee (position will vary by program service type). If those discussions do not lead to a satisfactory resolution, than he/she has the right to initiate a grievance process by following the steps below:

Step 1: If the grievance is not resolved through initial discussion, the consumer will have three (3) business days **from the date the incident occurred which is the cause for their grievance** to complete the *Consumer Grievance Form* and submit to the Program Director. The Program Director will submit an Incident Report within 24 hours and will schedule a meeting with the consumer within 3 business days from the date the Grievance Form was submitted to them. If the consumer is not satisfied with the outcome of this meeting, he/she has the right to appeal and proceed with step 2 of the grievance process.

Step 2: If the grievance is not resolved through the meeting with the Program Director, then the Consumer has three (3) business days from the meeting date in step 1 to request, **in writing**, a meeting with the person delegated to review grievances, the agency's Risk Manager. The Risk Manager will schedule a meeting with the consumer within three (3) business days of receiving this written request. The decision of the Risk Manager is final and will be provided to the consumer in writing within 3 business days from their meeting date.

I acknowledge that I have been given a copy and understand the Organization grievance procedure.

__________________________	__________________________
Print Name (consumer)	Signature (consumer) & Date

Attachment H

CATHOLIC CHARITIES OF THE ARCHDIOCESE OF MIAMI, INC.
AUTHORIZATION FOR RELEASE OF INFORMATION

Name: ______________________ ______________________ ____
Last First MI

Address: ______________________ ______________ ______ ______
Street City State Zip

Birth Date: ______________ Telephone Number: ______________

I authorize Catholic Charities of the Archdiocese of Miami, Inc. to release information to the following individuals and/ or organizations:

Name: ______________________ Relationship/Organization: ______________

Name: ______________________ Relationship/ Organization: ______________

Name: ______________________ Relationship/ Organization: ______________

Information to be released includes those related to:
For the following purpose:

I understand that if the person(s) and/ or organization(s) listed above are not health care providers, health plans or health care clearinghouses that are subject to the federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may rediscover my health information without obtaining my authorization.

This authorization does not exceed 90 days from when the authorization is given for one(1) time releases and does not exceed one(1) year, or as the law or court order requires .

I understand that my records may be subject to re-disclosure by recipients and unprotected by federal or state law, and that this Authorization remains effective for the time specified above, until you actually receive a signed revocation or until the records retention period required under federal and Florida law has expired, whichever first occurs. I have been given an opportunity to ask questions and have received a copy of the signed Authorization. I understand that I may inspect a copy of my protected health information to be used or disclosed under this Authorization, that you have not conditioned provision of services to or treatment of me upon receipt of this signed Authorization, and that I may refuse to sign this Authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided on this form. If the purpose of this Authorization is for the use and/or disclosure of health information for a research study, and I refuse to sign this Authorization, you reserve the right to deny treatment associated with such research. If the purpose of this Authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this Authorization, you reserve the right to deny that health care. I understand that I may inspect or copy the information that is used or disclosed. With regard to my right of revocation discussed above, I may revoke this Authorization except to the extent that action has been taken in reliance on this Authorization or if this Authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

A copy of this signed form will be provided to the individual.

______________________ ______________________
Consumer Signature and Date Caregiver Signature and Date (if applicable)

Authority of Authorized Representative *(e.g.,* health care power of attorney, guardian. other statutory authorization) (if applicable)

____

Expiration Date: ______________

____
Witness Signature and Date

If any of the following statements apply, please sign:

I understand that information concerning drug or alcohol abuse will be released.

Consumer Signature: ______________ Date: ______________

I understand that information concerning my psychiatric and/or psychological diagnosis will be released.

Consumer Signature: ______________ Date: ______________

I understand that information regarding the diagnosis of AIDS and/or HIV laboratory test results will be released.

Consumer Signature: ______________ Date: ______________

Agency personnel providing information: ______________________