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 ©

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**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

CATHOLIC CHARITIES

# 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:**_____

CATHOLIC CHARITIES

# 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):**_____

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

**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:**

_____

_____

**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

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

**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:**

_____

_____

**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

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

**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:**

_____

_____

**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**

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## 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

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# 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**

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## 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.

## 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: _____