Oregon Health Authority

Oregon Housing Opportunities in Partnership Program (OHOP)
Client Referral Form

Submit via FAX to your local housing coordinator.

To: ____________________ From: ____________________

FAX: ____________________ Pages: ____________________

Phone: ____________________ Date: ____________________

Client URN *(from CAREWare)*: ____________________

Client mental health acuity *(from the most recent acuity form)*: ____________________

Your short-term housing plan for the client and any other comments *(this should be detailed in the client's current care plan)*:

Include with this referral:

- ☐ Client Referral form
- ☐ Signed DHS Authorization for Use and Disclosure of Information
- ☐ Any documentation of client's household income
- ☐ Other pertinent payment documents *(rental agreement, utility bills, etc…)*

This referral packet is indicated only for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination or distribution of this communication to other than the intended recipient, is strictly prohibited. If you have received this communication in error, please notify the program manager for the sender listed above immediately by telephone at 971-673-0144 and return the original message to us via the U.S. Postal Service at the following address: OHOP Program, 800 NE Oregon St., Suite 1105, Portland, OR 97232.

If you do not receive all of the indicated pages, please contact the sender by telephone AS SOON AS POSSIBLE.

Some things you should know:

What is OHOP?

The Oregon Housing Opportunities in Partnership (OHOP) program is a housing program that helps people who have low or no income and who are living with HIV.

The OHOP program may be able to help you with:

- Referrals to emergency shelters or other emergency housing
- Referrals to temporary or transitional housing
- Ongoing monthly help paying your rent

What is this form for?

The OHOP Client Referral Form lets you tell us about your current housing situation so that we can start helping you. It's important that you know that all of the information on this form is confidential. We can't share it with anyone unless you tell us we can.

Nothing you tell us will keep you from getting help with housing. At the end of the form, we'll ask you to sign it to tell us that the information on the form is true. By answering all of the questions with the truth, we will be able to get you better help with your housing more quickly.

After your case manager sends us the form, your OHOP housing coordinator will contact you to tell you more about OHOP and will work with you to make a plan for how we can start to help.

Submitting this form does not guarantee that you will qualify for or receive financial services from the OHOP program.

Oregon Health Authority

Part 1: How can we contact you?

1. Your full legal name *(first, MI, last)*: ______
2. What language do you speak best? ☐ English ☐ Spanish ☐ Other: ______
3. Where can we send you mail? ______
   Street address or PO Box City State ZIP

   What is your address? ______
   (if different from mailing) Street address City State ZIP
4. At what phone number can we call you? ______
   Can we leave messages at that phone number? ☐ Yes ☐ No
   This phone number is? ☐ Home ☐ My cell ☐ Friend/family ☐ Case manager
   ☐ Other: ______

Part 2: Where do you live right now?

☐ Apartment ☐ House ☐ Duplex/multiplex
☐ Manufactured home ☐ Homeless

Tell us about your current housing situation? *(who lives with you, what kind of house do you live in, how long have you been living there, how are you paying your rent)*

Part 3: Sign this statement.

I verify that all statements on this form are true. I understand that by submitting this form the OHOP housing coordinator will contact me to gather more information.

Your signature: ______ Date: ______

Authorization for Use and Disclosure of Information

This form is available in alternative formats including Braille, computer disk and oral presentation.

Legal last name of client/applicant:	First:	MI:	Date of birth:
Other names used by client/applicant:			Case ID number:

By signing this form, I authorize the following record holder to disclose the following specific confidential information about me:

Section A

Release from one record holder – *(individual, school, employer, agency, medical or other provider)*	Specific information to be disclosed	Mutual exchange: Yes / No
Ryan White case manager serving Enter county name County	Program eligibility, housing status and housing stability information.	Yes

If the information contains any of the types of records or information listed below, additional laws relating to use and disclosure may apply. I understand that this information will not be disclosed unless I place my initials in the space next to the information:

HIV/AIDS: _________ **Mental health:** _________ (These must be initialed)

Alcohol/drug diagnoses, treatment, referral: _________ **Genetic testing:** _________

Section B

Release to *(address required if mailed)*. If releasing to a team, list members.	Purpose	Expiration date or event*
Oregon Health Authority: Oregon Housing Opportunities in Partnership Program (OHOP) Housing Coordinator.	Housing coordination	

*** This authorization is valid for one year from the date of signing unless otherwise specified.**

I can cancel this authorization at any time. The cancellation will not affect any information that was already disclosed. I understand that state and federal law protects information about my case. I understand what this agreement means and I approve of the disclosures listed. I am signing this authorization of my own free will.

I understand that the information used and disclosed as stated in this authorization may be subject to re-disclosure and no longer protected under federal or state law. I also understand that federal or state law prohibits re-disclosure of HIV/AIDS, mental health and drug/alcohol diagnosis, treatment, vocational rehabilitation records or referral information without specific authorization.

Section C

Full legal signature of individual or authorized personal representative:	Relationship to client:	Date:
Name of staff person *(print)*:	Initiating agency name/location:	Date:

Full legal signature of agency staff person making copies:	**This is a true copy of the original authorization document.**
Print staff person name:	

Do not disclose this authorization outside OHOP/HIV CM programs

See "Required Information" on following page of this form.
(not valid without page)

Required information for the client

To provide or pay for health services: If the Department of Human Services (DHS) is acting as a **provider** of your health care services, or paying for those services under the Oregon Health Plan or Medicaid Program, you may choose not to sign this form. That choice **will not** adversely affect your ability to receive health services, *unless* the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. *(Examples of this would be assessments, tests or evaluations.)* Your choice not to sign **may affect** payment for your services if this authorization is necessary for reimbursement by private insurers or other non-governmental agencies.

This authorization for use and disclosure of information **may also be necessary** under the following situations:

- To determine if you are eligible to enroll in some medical programs that pay for your health care
- To determine if you qualify for another DHS program or service not acting as a health care provider

This is a voluntary form. DHS cannot condition the provision of treatment, payment or enrollment in publicly funded health care programs on signing this authorization, except as described above. However, you should be given accurate information on how refusal to authorize the release of information may adversely affect eligibility determination or coordination of services. If you decide not to sign, you may be referred to a single service that may be able to help you and your family without an exchange of information.

Using this form

1. **Terms used: Mutual exchange:** A "yes" allows information to go back and forth between the record holder and the people or programs listed on the authorization. **Team:** A number of individuals or agencies working together regularly. The members of the team must be identified on this form.
2. **Assistance:** Whenever possible, a DHS staff person should fill out this form with you. **Be sure you understand the form before signing.** Feel free to ask questions about the form and what it allows. You may substitute a signature with making a mark or by asking an **authorized** person to sign on your behalf.
3. **Guardianship/custody:** If the person signing this form is a personal representative, such as a guardian, a copy of the legal documents that verify the representative's authority to sign the authorization must be attached to this form. Similarly, if an agency has custody and their representative signs, their custody authority must be attached to this form.
4. **Cancel:** If you later want to cancel this authorization, contact your DHS staff person. You can remove a team member from the form. You will be asked to put the cancellation request in writing.
   Exception: Federal regulations do not require that the cancellation be in writing for the Drug and Alcohol Programs. No more information can be disclosed or requested after authorization is cancelled. DHS can continue to use information obtained prior to cancellation.
5. **Minors:** If you are a minor, you may authorize the disclosure of mental health or substance abuse information if you are age 14 or older; for the disclosure of any information about sexually transmitted diseases or birth control regardless of your age; for the disclosure of general medical information if you are age 15 or older.
6. **Special attention:** For information about **HIV/AIDS, mental health, genetic testing or alcohol/drug abuse treatment**, the authorization must clearly identify the specific information that may be disclosed and the purpose.

Re-disclosure: Federal regulations (42 CFR part 2) prohibit making any further disclosure of alcohol and drug information; state law prohibits further disclosure of HIV/AIDS information (ORS 433.045, OAR 333-12-0270); and state law prohibits further disclosure of mental health, substance abuse treatment, vocational rehabilitation and developmental disability treatment information from publicly funded programs (ORS 179.505, ORS 344.600) without specific written authorization.

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Section A

Release from one record holder – *(individual, school, employer, agency, medical or other provider)*	**Specific information to be disclosed**	**Mutual exchange: Yes / No**
Oregon Department of Human Services: Seniors and People with Disabilities, case worker assigned to individual client listed in section C.	Housing status	Yes

Section B

Release to ***(address required if mailed).*** **If releasing to a team, list members.**	**Purpose**	**Expiration date or event***
Department of Human Services: Oregon housing Opportunities in Partnership Program including local housing coordinator and program support and administrative staff.	To verify OHOP and/or LIHEAP program eligibility and to obtain and maintain housing assistance *(including energy assistance).*	

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Full legal signature of individual or authorized personal representative:	**Relationship to client:**	**Date:**
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