EXHIBIT E

NorCal HMIS Intake Form – Adult

1. Intake Summary

Agency Case No: **Service Point Client No:**

Intake Date	Month	Day	Year		Intake Staff Name
Case Manager					Staff Direct Phone Line
Agency Name					Notice of Privacy Practices Acknowledgement signed ☐ Yes ☐ No
Program Name					Release of Information (ROI) Signed ☐ Yes ☐ No

2. Household Information

Household Type	☐ Couple (parent & friend) & child(ren)	☐ Foster Parent(s) with child(ren)	☐ Other
	☐ Couple with no child(ren)	☐ Grandparent(s) with child(ren)	☐ Single Adult
	☐ Extended family unit	☐ Male Single Parent	☐ Two Parents with child(ren)
	☐ Female Single Parent	☐ Non-custodial Caregiver(s) w/child(ren)	

3. Client Information

First	Middle	Last	Suffix

Alias	Email Address

Address	Telephone

SSN	- -	**U.S. Military Veteran** *(adults only)*	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
SSN Data Quality	☐ Full Reported ☐ Partial/Approx. Reported ☐ Client doesn't know ☐ Client refused		
Date of Birth	Month / Day / Year	**Gender**	☐ Woman (Girl, if child) ☐ Man (Boy, if child) ☐ Culturally Specific Identity (e.g., Two-Spirit) ☐ Transgender ☐ Questioning ☐ Different Identity
DOB Data Quality	☐ Full DOB Reported ☐ Approximate or Partial DOB Reported ☐ Client doesn't know ☐ Client refused		
Race and Ethnicity	☐ American Indian, Alaska Native, or indigenous ☐ Asian, or Asian American ☐ Black, African American, or African ☐ Hispanic/Latina/e/o ☐ Middle Eastern or North African ☐ Native Hawaiin or Pacific Islander ☐ White		
Relationship to Head of Household (HoH)	☐ Self (Head of Household) ☐ Head of Household's child ☐ Head of Household's spouse or partner ☐ Head of Household's other relation member ☐ Other (non-relation member)	**Disabling Condition?**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Zip Code of Last Permanent Address		**Client Location (CoC) & Current County of Service**	☐ CA-516 ☐ Del Norte ☐ Lassen ☐ Modoc ☐ Plumas ☐ Shasta ☐ Sierra ☐ Siskiyou
Zip Data Quality	☐ Full Reported ☐ Partial/Approx. Reported ☐ Client doesn't know ☐ Client refused		

NOTES:

NorCal HMIS Intake Form – Adult

4. Homeless Determination

Prior Living Situation

--HOMELESS SITUATION--
☐ Place not meant for human habitation (car, abandoned building, bus or train station, etc.)
☐ Emergency shelter (incl. hotel/motel or campground paid for w/ES voucher, or RHY-funded Host Home Shelter) (ES)
☐ Safe Haven (SH)

--INSTITUTIONAL SITUATIONS--
☐ Foster care home or foster care group home
☐ Hospital or other residential non-psychiatric medical facility
☐ Jail, prison, or juvenile detention facility
☐ Long-term care facility or nursing home
☐ Psychiatric hospital or other psychiatric facility
☐ Substance abuse treatment facility/detox

--TEMPORARY AND PERMANENT HOUSING SITUATIONS

Where did you spend last night? *(all adults & unaccompanied youth)*
☐ Residential project or halfway house w/no homeless criteria
☐ Hotel or motel paid for without emergency shelter voucher
☐ Transitional housing for homeless persons (including homeless youth)
☐ Host Home (non-crisis)
☐ Staying or living in a friend's room, apartment or house
☐ Staying or living in a family member's room, apartment or house
☐ Rental by client, with GPD TIP housing subsidy
☐ Rental by client, with VASH subsidy
☐ Permanent housing (other than RRH) for formerly homeless persons
☐ Rental by client, with RRH or equivalent subsidy
☐ Rental by client, with HCV voucher (tenant or project based)
☐ Rental by client in a public housing unit
☐ Rental by client, no ongoing housing subsidy
☐ Rental by client, with other ongoing housing subsidy
☐ Owned by client, with ongoing housing subsidy
☐ Owned by client, no ongoing housing subsidy

--**OTHER**--
☐ Client doesn't know
☐ Client refused
☐ Data Not Collected

*If yes to Temporary/Permanent Housing or Institutional Situations:

On the night before, did you stay on the streets, ES, or SH?
☐ Yes ☐ No

Length of stay in previous place	☐ One night or less ☐ Two to six nights ☐ One week or more, but less than one month ☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer ☐ Client doesn't know ☐ Client refused	**Number of times client has been homeless (on the streets, in ES, or SH) in past three years including today**	☐ 1 time ☐ 2 times ☐ 3 times ☐ Four or more times ☐ Client doesn't know ☐ Client refused
Approximate date homelessness started	Month Day Year	**Total number of months homeless on the street in the past three years**	☐ 1 month (this time is the first month) ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ More than 12 months ☐ Client doesn't know ☐ Client refused

5. Monthly Income

Income from any source: ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

Source of Income:	Receiving Income Source	Amount Received	Additional Household Members	Notes
Alimony or Other Spousal Support	☐ Yes ☐ No	$	$	
Child Support	☐ Yes ☐ No	$	$	
Earned Income (wages)	☐ Yes ☐ No	$	$	
General Assistance (GA)	☐ Yes ☐ No	$	$	
Other	☐ Yes ☐ No	$	$	
Pension or retirement income from another job	☐ Yes ☐ No	$	$	
Private Disability Insurance	☐ Yes ☐ No	$	$	
Retirement Income from Social Security	☐ Yes ☐ No	$	$	
SSDI	☐ Yes ☐ No	$	$	
SSI	☐ Yes ☐ No	$	$	
TANF (including CalWORKs)	☐ Yes ☐ No	$	$	
Unemployment Insurance	☐ Yes ☐ No	$	$	

NorCal HMIS Intake Form – Adult

VA Non-Service-Connected Disability Pension	☐ Yes ☐ No	$	$	
VA Service-Connected Disability Compensation	☐ Yes ☐ No	$	$	
Worker's Compensation	☐ Yes ☐ No	$	$	

6. Non-Cash Benefits

Non-cash benefit from any source: ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

Source of Non-cash benefit:	Receiving Benefit	Type Received	Additional Household Members	Notes
SNAP including CalFresh (Food Stamps)	☐ Yes ☐ No			
Special Supplemental Nutrition Program (WIC)	☐ Yes ☐ No			
TANF Child Care Services	☐ Yes ☐ No			
TANF Transportation Services	☐ Yes ☐ No			
Other TANF Funded Services (Sec.8/Public Housing/Rent Assist)	☐ Yes ☐ No			
Other Source	☐ Yes ☐ No			

7. Health Insurance

Covered by Health Insurance: ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

Health Insurance type:	Covered?	Start date	Insurance Notes
MEDICAID/MEDI-CAL	☐ Yes ☐ No		
MEDICARE	☐ Yes ☐ No		
State Children's Health Insurance Program	☐ Yes ☐ No		
Veteran's Administration (VA) Medical Services	☐ Yes ☐ No		
Employer – Provided Health Insurance	☐ Yes ☐ No		
Health Insurance obtained through COBRA	☐ Yes ☐ No		
Private Pay Health Insurance	☐ Yes ☐ No		
State Health Insurance for Adults	☐ Yes ☐ No		
Indian Health Services Program	☐ Yes ☐ No		
Other	☐ Yes ☐ No		

8. Disabilities

Disability Type:	Disability Determination	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	Start date	Disability Notes
Alcohol Use Disorder	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ Client doesn't know ☐ No ☐ Client refused		
Both Alcohol and Drug Use Disorder	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ Client doesn't know ☐ No ☐ Client refused		
Chronic Health Condition	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ Client doesn't know ☐ No ☐ Client refused		
Developmental	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ Client doesn't know ☐ No ☐ Client refused		
Drug Use Disorder	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ Client doesn't know ☐ No ☐ Client refused		
HIV/AIDS	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ Client doesn't know ☐ No ☐ Client refused		
Mental Health Problem	☐ Yes ☐ No ☐ Client doesn't know	☐ Yes ☐ Client doesn't know ☐ No ☐ Client refused		
Physical	☐ Yes ☐ No ☐ Client doesn't know	☐ Yes ☐ Client doesn't know ☐ No ☐ Client refused		

NorCal HMIS Intake Form – Adult

9. Domestic Violence Questions

Are you a Domestic Violence Victim/Survivor?	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
IF YES – When did the Domestic Violence experience occur?	☐ Within past 3 months ☐ 3-6 mo. Ago ☐ 6-12 mo. Ago ☐ More than a year ago ☐ Client doesn't know ☐ Client refused
	IF YES – Are you currently fleeing? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

10. Coordinated Entry Questions

Do you have a felony conviction?	☐ Yes ☐ No	**Registered sex offender?**	☐ Yes ☐ No
Have you ever been denied housing because of criminal convictions?	☐ Yes ☐ No	**Do you have any pets?**	☐ Yes ☐ No

11. Residential Move-In Date

If Yes, Date of Move-In	Month	Day	Year

12. Street Outreach Only

Date of Engagement:

NOTES:

Homeless Management Information System (HMIS)
Authorization to Use or Disclose Confidential Information

I hereby authorize use or disclosure of the named individuals' confidential information (CI) collected in the Vulnerability Index, as described below. I understand this authorization may include the disclosure or exchange of information in written, verbal, electronic and/or other forms. The named individuals' CI will not be made public and will only be used with strict confidentiality.

Client:
Last Name:_____ First Name:_____
Address:_____
City:_____State:_____Zip:_____
Telephone Number:_____
Date of Birth:_____

I understand that _____(Service Provider) collected information about me and/or my dependents listed below to enter it into a database system called Homeless Management Information System (HMIS). This database helps the Continuum of Care (CoC) members and HUD to better understand homelessness, to improve service delivery to the homeless, and to evaluate the effectiveness of services provided to the homeless in the CoC. Participation in data collection and release, although optional, is a critical component of our community's ability to provide the most effective services and housing. The information that is collected in the HMIS database is protected by limiting access to the database and by limiting with whom the information may be shared, in compliance with the standards set forth by federal, state, and local regulations governing confidentiality of client records. Every person and agency that is authorized to read or enter information into the database has signed an agreement to maintain the security and confidentiality of the information.

The CI gathered and prepared will be included in a HMIS database of participating agencies who have entered into a Data Sharing Agreement and shall be used to:

a. Produce a client profile at intake that will be shared by collaborating agencies
b. Produce anonymous, aggregate-level reports regarding use of services
c. Track individual program-level outcomes
d. Identify unfilled service needs and plan for the provision of new services
e. Allocate resources among agencies engaged in the provision of new services
f. Disclose if required by court order or as required by law
g. Assess needs for housing, utility assistance, food, counseling and/or other services.

The information may include, but is not limited to the following CI:

- Full Name
- Date of Birth
- Social Security Number
- Gender
- Ethnicity & Race
- Veteran Status
- Program entry date
- Program exit date
- CIN/insurance
- Residence prior to project entry
- HIV/AIDS status
- Homeless history
- Zip Codes of last permanent address
- Family composition
- Employment status
- Housing information
- Income and benefits information
- Domestic Violence
- Mental Health
- Disabling condition
- Alcohol & drug
- Legal history
- Photo (if applicable)

- The release of my information listed above does not guarantee that I will receive assistance, and my refusal to authorize the use of my information does not disqualify me from receiving assistance.
- I may revoke this authorization at any time by signing a "Revocation of Consent to Release Information form".
- I understand the revocation will not apply to information already released based on this authorization, and all information about me already in the database will remain but will become invisible to all of the participating agencies.
- My records are protected by federal, state, and local regulations governing confidentiality of client records and cannot be disclosed without my written consent unless otherwise provided for in the regulations, law, or court order.
- Auditors or funders who have legal rights to review the work of this agency, including the U.S. Department of Housing & Urban Development and Department of Healthcare Services may see my information.
- People using HMIS information to write reports may see my information. Researchers must sign an agreement to protect and deidentify CI before seeing HMIS data.
- I understand I may inspect or obtain a copy of the CI to be used or disclosed. I have the right to receive a copy of this authorization.
- This authorization is valid for three (3) years from the date of my signature below or the 18th birthday of the minor dependent, whichever occurs first.

Participating agencies: Agencies within the NorCal Continuum of Care HMIS are authorized to use, disclose, and obtain information from the HMIS database are listed below. These agencies may update periodically and can have retroactive effectiveness:

Del Norte:
County of Del Norte

Del Norte Mission Possible
Crescent City

Lassen:

Lassen County HSS
Susanville Indian Rancheria

Modoc County:

TEACH
Modoc County

Plumas:

Plumas Crisis Intervention Resource Center
Plumas County Behavioral Health

Sierra County:

Sierra County

Shasta:

Faithworks
No Boundaries
Good News Rescue Mission
Nation's Finest
Pathways to Housing
Ready for Life
Hill Country Community Clinic
Shasta Community Health Center
Access Homes
Shasta County HHSA
Shasta County Housing Authority
City of Redding
Lutheran Social Services
North Valley catholic Social Services
Northern California Youth and Family Programs
Shasta County Office of Education
United Way

Siskiyou County:

Siskiyou County HHSA
Karuk Tribe
Youth Empowerment Siskiyou

Partnership Health Plan of California

Please initial one of the following levels of consent:

_____ I give authorization for confidential information **to be entered into HMIS and shared between participating agencies.**

OR

_____ I do not consent to the inclusion of confidential information in HMIS.

_____ I, _____(name of parent or legal guardian), am the parent or legal guardian of child(ren) listed below) and have legal authority to execute this Release.
My signature on this document is intended to bind myself, my child or any child whom I have legal custody and control of and for whom I have the authority to execute this release. The undersigned expressly agrees that this Release is intended to be as broad and inclusive as permitted by California law.

List all Dependent children under 18 in household, if any (first and last names):

1.	2.
3.	4.
5.	6.
7.	8.

_____ _____
Printed name Date

_____ _____
Signature Relationship to Client

1. Exit Summary	
Agency Name	Staff Name
Program Name	Staff Phone Line
Date of entry into program	Date of exit from program
2. Client Information	
Client Name	Today's Date
SSN	Street Address
Date of Birth	City, State, Zip
Email	Phone

3. Reason For Leaving		
	☐ Completed program ☐ Criminal activity/violence ☐ Death ☐ Disagreement with rules/persons ☐ Left for housing opportunity before completing program ☐ Needs could not be met	☐ Non-compliance with program ☐ Non-payment of rent ☐ Other ☐ Reached maximum time allowed ☐ Unknown/Disappeared
If other, specify:		

4. Destination	
	☐ Place not meant for habitation ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher ☐ Safe Haven ☐ Foster care home or foster care group home ☐ Hospital or other residential non-psychiatric medical facility ☐ Jail, prison, or juvenile detention facility ☐ Long-term care facility or nursing home ☐ Psychiatric hospital or other psychiatric facility ☐ Substance abuse treatment facility or detox center ☐ Residential project or halfway house w/no homeless criteria ☐ Hotel or motel paid for without emergency shelter voucher ☐ Transitional housing for homeless persons (including homeless youth)* ☐ Host Home (non-crisis) ☐ Staying or living in a friend's room, apartment or house, temporary tenure ☐ Staying or living in a family member's room, apartment or house, temporary tenure ☐ Staying or living in a friend's room, apartment or house, permanent tenure ☐ Staying or living in a family member's room, apartment or house, permanent tenure ☐ Moved from one HOPWA funded project to HOPWA PH ☐ Moved from one HOPWA funded project to HOPWA TH ☐ Rental by client, with GPD TIP housing subsidy ☐ Rental by client, with VASH housing subsidy ☐ Permanent housing (other than RRH) for formerly homeless persons ☐ Rental by client, with RRH or equivalent subsidy ☐ Rental by client, with HCV voucher (tenant or project based) ☐ Rental by client in a public housing unit ☐ Rental by client, no ongoing housing subsidy ☐ Rental by client, with other ongoing housing subsidy ☐ Owned by client, with ongoing housing subsidy ☐ Owned by client, no ongoing housing subsidy ☐ No exit interview completed ☐ Other ☐ Deceased ☐ Client doesn't know ☐ Client refused ☐ Data Not Collected
If other, specify:	

5. Residential Move-In Date *(RRH Only)*

If Yes, Date of Move-In	Month	Day	Year

6. Updates

Monthly Income	Amount	Non-Cash Benefits	Amount
☐ *NO CHANGE AT EXIT*		☐ *NO CHANGE AT EXIT*	
☐ Alimony or Other Spousal Support	$	☐ SNAP including CalFresh (Food Stamps)	$
☐ Child Support	$	☐ Special Supplemental Nutrition Program (WIC)	$
☐ Earned Income (wages)	$	☐ TANF Child Care Services	$
☐ General Assistance (GA)	$	☐ TANF Transportation Services	$
☐ Other	$	☐ Other TANF Funded Services (Sec.8/Public Housing/Rent Assist)	$
☐ Pension or retirement income from another job	$	☐ Other Source	$
☐ Private Disability Insurance	$		
☐ Retirement Income from Social Security	$		
☐ SSDI	$		
☐ SSI	$		
☐ TANF (including CalWORKs)	$		
☐ Unemployment Insurance	$		
☐ VA Non-Service Connected Disability Pension	$		
☐ VA Service Connected Disability Compensation	$		
☐ Worker's Compensation	$		

Health Insurance:	Notes	Disabilities	Notes
☐ *NO CHANGE AT EXIT*		☐ *NO CHANGE AT EXIT*	
☐ MEDICAID/MEDI-CAL		☐ Alcohol Abuse	
☐ MEDICARE		☐ Both Alcohol and Drug Abuse	
☐ State Children's Health Insurance Program		☐ Chronic Health Condition	
☐ Veteran's Administration (VA) Medical Services		☐ Developmental	
☐ Employer – Provided Health Insurance		☐ Drug Abuse	
☐ Health Insurance obtained through COBRA		☐ HIV/AIDS	
☐ Private Pay Health Insurance		☐ Mental Health Problem	
☐ State Health Insurance for Adults		☐ Physical	
☐ Indian Health Services Program			
☐ Other			

OPTIONAL EXIT QUESTIONS

What supportive services did the client receive while in the program?

☐ Outreach	☐ Education
☐ Drug or Alcohol abuse services	☐ Child care
☐ Employment assistance	☐ Domestic Violence services
☐ Legal Services	☐ Life skills (outside of case management)
☐ Credit repair	☐ Housing placement and search
☐ Medi-Cal related services	☐ Transportation
☐ Case management	☐ Financial Assistance
☐ Mental Health services	☐ Other
☐ Landlord engagement	

NorCal CA 516 Continuum of Care
Homeless Management Information System (HMIS)
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, you may contact either your service provider, or:
United Way of Northern California
3300 Churn Creek Rd, Redding, CA 96002
(530) 241-7521

Your information is personal, and the NorCal CA 516 Continuum of Care is committed to protecting it. Your information is also very important to our ability to provide you with quality services, and to comply with certain laws. This notice describes the privacy practices our employees and other personnel are required to follow in handling your information.

We are legally required to: Keep your information confidential, give you this notice of our legal duties and privacy practices with respect to your information, and comply with this notice.

CHANGES TO THIS NOTICE
We reserve the right to revise or change the terms of this Notice, and to apply those changes to our policies and procedures regarding your information. To obtain a copy of this notice, you can either ask any member of staff, or go to the Nor Cal Continuum of Care website at: https://www.cityofredding.gov/government/departments/housing/housing___community_development/norcal_continuum_of_care/index.php

HOW WE MAY USE AND DISCLOSE YOUR INFORMATION

For Housing: We create a record of your information, including housing services you receive at our partner agencies. We need this record to provide you with quality services and to comply with certain legal requirements.

Participating agencies may use or disclose your information to other personnel who are involved in providing services for you. For example, a housing navigator may need to know disability information to provide appropriate housing resources. Your service team may share your information in order to coordinate the different things you need, such as referrals and services.

Participating agencies may use and disclose your information to other participating HMIS agencies.

We also may use and disclose your information to recommend service options or alternatives that may be of interest to you. Additionally, we may use and disclose your information to tell you about health-related benefits or services that may be of interest to you for example, Medi-Cal eligibility or Social Security benefits. You have the right to refuse this information.

For Service Collaboration: We also may use and disclose your information about you so that you do not have provide information more than once. This sharing, only when you access one of the participating agencies, can help avoid duplication of services and referrals that you are already receiving.

USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR AUTHORIZATION

Research: Under certain circumstances, we may use and disclose information about you for research purposes. For example, a research project may involve comparing your service level and of all clients who received similar services. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of information, trying to balance the research needs with clients' need for privacy of their information. Before the use or disclosure of information for research purposes, any such research project must be

approved through an approval process. Aggregate information about you may be disclosed to people conducting a research project to help them identify data for clients with specific needs.

As Required By Law: We will use and disclose information when required by federal or state law or regulation.

To Avert a Serious Threat to Health or Safety: We may use and disclose your information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Public Health Activities: We may disclose your information for public health activities such as to report the abuse or neglect of children, elders, and dependent adults.

Abuse, Neglect, or Domestic Violence: We may disclose your information when notifying the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Oversight Activities: We may disclose your information to an oversight agency, such as the Department of Housing and Urban Development (HUD) or the State of California, for activities authorized by law. These oversight activities are necessary for the government to monitor government service programs, and compliance with civil rights laws.

OTHER USES OF YOUR INFORMATION

Other uses and disclosures of your information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to disclose your information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your information for the reasons covered by the authorization, except that, we are unable to take back any disclosures we have already made when the authorization was in effect, and we are required to retain our records of the services that we provided to you.

YOUR RIGHTS REGARDING INFORMATION ABOUT YOU

Right to Inspect and Obtain Copies:
With certain exceptions, you have the right to inspect and obtain copies of your information from our records. To inspect and obtain copies of your information, you must submit a request in writing to your service provider where you received services. The request will be reviewed and responded to within three (3) business days. We reserve the right to deny your right to inspect and obtain copies of your information. If your request is denied, you may appeal this decision and request that another services professional by the United Way of Northern California, who was not involved in your provision of services, review the denial.

Right to Request an Amendment:
If you feel that your information in our records is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment, you must submit a request in writing to your service provider. Your request will become part of your record.

Right to Request Restrictions:
You have the right to request that we follow additional, special restrictions when disclosing your information. To request restrictions, you must make your request in writing to your service provider. In your request, you must tell us what information you want to limit, the type of limitation, and to whom you want the limitation to apply.

Right to Request Confidential Communications:
You have the right to request that we communicate with you about appointments or other matters related to your service in a specific way or at a specific location. For example, you can ask that we only contact you at work, or by mail at a post office box. To request confidential communications, you must make your request in writing to your Agency case manager or the person in charge of your services. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice:
You may ask us for a paper copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are entitled to receive a paper copy of this Notice. To obtain a paper copy of this Notice, ask any member of staff..

You have the right to file a complaint if you believe that staff has not complied with the practices outlined in this Notice. All complaints must be submitted in writing. You will not be penalized in any way for filing a complaint.

If you believe your privacy rights have been violated, you may file a complaint with the NorCal CA 516 Continuum of Care System Administrator.

To file a complaint with the Administrative Entity, contact:
City of Redding, 777 Cypress Ave. Redding, CA 96001

Email: norcalcoc@cityofredding.org

To file a complaint with the State of California, contact:
www.privacy.ca.gov
866-785-9663
800-952-5210

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the HMIS Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our web site, https://www.norcalunitedway.org/hmis or by contacting any staff person involved in your services.

If you have any questions about our Notice of Privacy Practices, please contact:

United Way of Northern California
3300 Churn Creek Rd, Redding, CA 96002
(530) 241-7521

I acknowledge receipt of the HMIS Notice of Privacy Practices.

_____ _____ _____
Client Signature Client Name Printed Date

Inability to Obtain Acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the client's acknowledgement, describe the good faith efforts made to obtain the client's acknowledgement, and the reasons why the acknowledgement was not obtained:

_____ _____ _____
Staff Member's Signature Staff Name and Title Printed Date