Required Documents for Housing Counseling Program

The following documents are to be obtained and brought with you to your first appointment with your assigned case manager. They are NOT to be brought with you to the budgeting class.

- Copy of one full month of income for everyone in the household
  - Pay stubs from the most recent month of employment
  - Letter from employer verifying current employment, rate, and hours
  - Award letter from Social Security for _____ (year) verifying amount received
  - Statement from Domestic Relations verifying child support amount received
  - Letter (written or typed) from person paying voluntary child support verifying amount and frequency
  - Statement from the County Assistance Office (welfare office) verifying TANF or cash assistance amount received
  - Statement from the County Assistance Office (welfare office) verifying Supplemental Social Security amount (typically $22.10)
  - Statement from the County Assistance Office (welfare office) verifying current SNAP benefit amount (food stamps)
- Copy of most recent bank statement
- Photo ID or driver's license for the head of household
- Social security cards for everyone in the household
- Copy of proof of current or imminent homelessness
  - Eviction notice (written or typed) from landlord
  - Eviction notice (written or typed) from current residence
  - Eviction notice from magistrate court
  - Letter from a homeless shelter verifying dates of stay
- Lease/Verification of residency
  - Copy of the lease/rental agreement from where you are planning on living
  - Copy of the lease/rental agreement from current residence
  - Copy of most recent re-examination letter from subsidized housing
  - Completed landlord agreement letter
- Hardship letter and/or supporting documents

Enrollment in the Housing Counseling Program is NOT a guarantee of financial assistance

_____ _____

(Participant) (Date)

_____ _____

(Intake Worker) (Date)

HAP Rental Assistance Checklist

Eligibility Requirements

- ☐ Low Income – at or below 200% of the Federal Poverty Guideline
- ☐ Client must be homeless or at risk of becoming homeless (through eviction)
- ☐ Client must have income and the ability to pay rent going forward
- ☐ Apartment must meet Fair Market Rent guideline

Required Documents for File

- ☐ Copy of most recent month of income for everyone in the household
- ☐ Copy of photo ID or driver's license for head of household
- ☐ Copy of social security cards for everyone in the household
- ☐ Copy of proof of homelessness OR eviction notice (landlord or magistrate)
- ☐ Copy of lease from the client's current residence or where they are planning on living
- ☐ Hardship letter: written by client in their own words stating what caused the rental delinquency or homelessness. Should be specific, include dates, and any other supporting documents available (illness = letter from the doctor or hospital)

Required Documents from RX Office and Intake for File

- ☐ Printed action plan from RX (needs to be signed by counselor + client on date of intake)
- ☐ Printed budget from RX (including all updated budgets completed in counseling)
- ☐ Printed case notes from all sessions
- ☐ All releases of information signed by both the client and the counselor

Client Consent – Release of Information

The Scranton/Lackawanna County Continuum of Care (CoC) is a group of partner agencies working together to provide services to homeless and low-income individuals and families in Scranton/Lackawanna County. In accordance with US Federal Law, a sub-group of agencies have joined together to build a Homeless Management Information System (HMIS) to report to the Department of Housing and Urban Development on the services we provide to our clients.

We collect information directly from you for reasons described in our Privacy Policy. We may be required to collect some personal information by law or by organization that give us money to operate programs. Other personal information that we collect is important to run our programs, to improve services and to understand your needs. We only collect information we consider to be appropriate. The collection and use of all personal information is guided by strict standards of confidentiality.

The information you give may also be used by other helping agencies in the system, but first you must agree to share the information before any sharing can occur.

BY SIGNING THIS FORM, I AUTHORIZE THE FOLLOWING:

I authorize the partner agencies and their representatives to share the following information regarding my family and me. I understand that this information is for the purpose of assessing our needs for housing, utility assistance, food, counseling, and/or other services. The information may consist of the following:

- Identifying information (name, birthdate, gender, race, social security number, residential information, education level, household information)
- Medical records (except HIV/AIDS diagnosis and drug and alcohol treatment), psychological records and evaluations, vocational assessments, case manager's recommendations and direct observations, employment status, etc.
- Financial information (income verification, public assistance payments and allowances, food stamp allotments, disability payments, etc.)
- HIV/AIDS diagnosis
- Substance abuse diagnoses, treatment plan, progress in treatment, discharge, etc.

I UNDERSTAND THAT:

- Information I give concerning physical or mental health will be shared with other partner agencies (see attached list of current participating agencies) to help identify needs.
- The partner agencies have signed agreements to treat my information in a professional and confidential manner. I have the right to view the CoC's HMIS privacy policy.
- Staff members of the partner agencies who will see my information have signed agreements to maintain confidentiality regarding my information.
- The partner agencies may share non-identifying information about the people they serve with other parties working to end homelessness.
- The release of my information does not guarantee that I will receive assistance.
- My refusal to authorize the use of my information does not disqualify me from receiving assistance.

- This authorization will remain in effect unless I revoke it in writing, and I may revoke authorization at any time by signing a written statement available at any partner agency.
- If I revoke my authorization, all information about me already in the database will remain, but will become invisible to all of the partner agencies except for the agency that entered the data.
- I have the right to request information about the information maintained in the system for me.

The information that I 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. 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. Any person or agency that is found to violate their agreement may have their access rights terminated and may be subject to further penalties.

[ ] I agree that information regarding myself, my family, and my housing situation can be shared among the Lackawanna County Continuum of Care HMIS providers.

[ ] I have given verbal permission to the intake worker to share my information among the Lackawanna County Continuum of Care HMIS providers.

[ ] I agree that information regarding myself, my family, and my housing situation can be shared among the Lackawanna County Housing and Homeless Continuum of Care HMIS providers except for the following:

_____

_____

Client Name (*please print*)	Client Signature	Date
Agency Personnel Name (*please print*)	Agency Personnel Signature	Date

ARE YOU SAFE?

If you are trying to get away from an abusive person and need to keep your information confidential, you do not have to sign this form.

If you are being abused by someone at home or have left an abusive relationship and are trying to get safe, someone can help you contact the Women's Resource Center by calling 570-346-4671.

This form was amended January 2016

Authorization, Disclosure, Privacy Statement (3-in-1)

COUNSELING SERVICES AUTHORIZATION

My personal information and counseling services

By signing this form I agree to share my personal financial and other private information. Signing this form also allows lenders and the Counseling Agency to discuss my accounts, credit, and finances, and to share my nonpublic personal information, described in the Privacy Policy provided with this authorization.

I understand that funders provide grants to make the counseling services possible, and that the Counseling Agency shares my information with these funders. These funders review Counseling Agency files, including my file, and may contact me to evaluate the counseling services that I receive.

I authorize my Counselor and the Counseling Agency to negotiate for me. The counseling services are offered free of charge, and neither the Counselor, nor the Counseling Agency, guarantees any result or outcome. I may be referred to other housing agencies for their services. I am not obligated to accept services or products from the Counseling Agency, its partners, or any organization I am referred to.

I understand that my Counselor cannot offer me legal or other professional advice or representation. If I need legal or other professional services I can ask my Counselor for information about referral services.

Counseling Services Checklist
Client must **initial** all items that are applicable

___ I have been verbally advised of the fee schedule, if any, prior to services being provided
___ I understand that the counselor will discuss my budget with me and I will receive a copy of my Budget
___ I understand that the counselor will discuss my Action Plan with me and I will receive a copy of my Action Plan
___ I understand the counselor will explain the next steps needed to reach my financial goal to my satisfaction

___ Homebuyer Counseling	___ Homebuyer Education
___ Homeowner Counseling	___ Homeowner Education
___ Delinquency and Default Counseling	___ Delinquency and Default Education
___ Reverse Mortgage Counseling	___ Fair Housing Education
___ Tenant Counseling	___ Homelessness and Displacement Counseling

___ I want to buy a home in the next six (6) months
___ I want to buy a home, but not in the next six (6) months
___ Other programs, services, or products:

_____

For Pre-Purchase Clients only:

___ I have received the HUD forms:
"Ten Important Questions to Ask Your Home Inspector" & "For Your Protection: Get a Home Inspection"

Counseling Agency Information

Counselor Name: _____ Phone: _____
Counseling Agency: _____ Email: _____
HCO Client Number: _____ Fax: _____

Authorization, Disclosure, Privacy Statement (3-in-1)

PRIVACY POLICY

This Counseling Agency respects the privacy of the people that come to us for assistance. We understand that the matters you discuss with us are very personal. All spoken and written information shared with us will be managed with our legal and ethical obligations to you taken into consideration. We will not sell your personal information and we only share it to provide you with counseling services.

Your "nonpublic personal information" (including total debt information, income, living expenses, and personal information concerning your financial circumstances) will be shared with creditors, funders, and others only after you sign the Counseling Services Authorization. We may also collect, use, and share anonymous aggregated case file information to evaluate our services, to gather valuable research information, and to design future programs.

Types of Information That We Gather About You:

- Spoken or written information on applications and other documents, such as your name, address, social security number, assets, and income;
- Information about your transactions with us, your creditors, or others, such as your account balance, payment history, parties to transactions and credit card usage; and
- Information we receive from a credit reporting agency, such as your credit history.

You May Opt-Out If You Do Not Want Us to Share Your Information:

- You may "opt-out" to prevent the disclosure of your nonpublic personal information to third parties (such as your creditors).
- If you opt-out we cannot share your nonpublic information and we cannot answer questions from your creditors. We need to share your information to provide you with most services.
- You may opt-out at any time by calling the Counseling Agency at the phone number listed on the Counseling Services Authorization provided with this Privacy Policy.

How We Use Your Information:

- If you do not opt-out we may share information that we collect about you with your creditors or others if we think it would be helpful to you, would help us counsel you, or when required by funders that make our services possible.
- We may share information about you to anyone as permitted or as required by law (*e.g.*, if a Court requires us to provide it with documents).
- Within our organization, we restrict access to your information to those employees who need to know that information to provide services to you. We maintain physical, electronic, and procedural safeguards to protect your information as required by federal and state law.

Client Authorization

By signing below I authorize my employers, lenders, creditors, servicers, and others to share personal and financial information with my Counselor and the Counseling Agency. I authorize my Counselor and the Counseling Agency to collect information about my accounts and to share this information with others, including funders, as needed to provide counseling services, to seek assistance from programs, or for related products and services. I authorize funders to contact me to evaluate programs that I participate in.

CLIENT NAME(S):	CLIENT SIGNATURE(S):	DATE:
1. _____	_____	_____
2. _____	_____	_____

United Neighborhood Centers Of Northeastern Pennsylvania

Acknowledgement of Receipt of Privacy Notice & SMS Texting Release

I acknowledge that I have received a copy of UNC's Notice of Privacy Practices.

_____ _____

Client/Patient or Legally Authorized Signature Date

_____ _____

Printed Name if Signed on Behalf of Client/ Patient Date

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications: Clients in our community health department may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with your appointment, healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ **(Client initials)** I consent to receive text messages from the UNC at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____. 000 - 0000. The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____. The community health department does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Documentation of Good Faith Efforts to Obtain Acknowledgement of Receipt of Privacy Notice:

_____ _____

Client/Patient Name Date of Encounter

The client/patient presented at UNC and was provided with a copy of the Notice of Privacy Practices. A good faith effort was made to obtain from the client/patient or the client/patient's representative, if applicable, written acknowledgements of his/her receipt of the notice; however, such acknowledgement was not obtained because:

	Client/Patient refused to sign.
	Client/Patient's representative refused to sign.
	Client/Patient was sent home with a copy to be signed and returned. Client/Patient is a minor. *Returned Date:*_____
	Client/Patient was unable to sign because:_____
	Other reason (please describe):_____

_____ _____

Signature of Employee Completing Form Date

UNITED NEIGHBORHOOD CENTERS

CASE MANAGEMENT SERVICE AGREEMENT

I, _____, agree to abide by the terms of United Neighborhood Centers Housing Counseling Departments' Case Management Service Agreement. As indicated by my signature below, I fully understand that, with my enrollment in the Housing Counseling Program, staff will assist me through assessment of my needs in the following: Budgeting, Physical and Mental Health, Education, Employment, Training, Finances, Housing, Substance Abuse, Legal Aid, Health, Life Skills, and make appropriate referrals to meet those needs; and assist in the application for funds, if funds are available and the application qualifies.

I, _____, understand that receiving these services is contingent upon my full participation and compliance with the case management stipulations.

I, _____, agree to receive case management in the forms of phone calls and/or face to face contact from United Neighborhood Centers' staff and affiliates, until stable and permanent housing is achieved.

Client Name: _____

Client Signature: _____

Date Signed: _____

Case Manager Signature: _____

UNITED NEIGHBORHOOD CENTERS of Northeastern Pennsylvania

425 Alder Street, Scranton, Pennsylvania 18505
Phone: (570) 346-0759
www.uncnepa.org

CHILD CARE
Administrative Office
570-344-9882
Bellevue Center
570-342-5251
Progressive Center
570-207-4950
Green Ridge Center
570-961-2224

COMMUNITY YOUTH
Bellevue Center
570-342-5251
Progressive Center
570-207-4950
Leaders in Training
570-961-1592
Adventure Course
570-961-1592
Project Hope
570-344-9882
Creative Arts
570-961-1592

COMMUNITY SERVICES
Emergency Assistance
570-343-8835
Energy Assistance
570-343-8835
Transitional Housing
570-343-8835
Permanent Supportive Housing
570-343-8835
One Stop Shop
570-343-8835
Rental Assistance
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Angel's Attic
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First Time Homebuyers
570-343-8835
Violence Intervention
570-343-8835
Foreclosure Prevention
570-343-8835
Post Foster Care Housing
570-343-8835
Community Organizing
570-343-8835

SENIOR CENTERS
West Side Center
570-961-1592
South Side Center
570-346-2487
Carbondale Center
570-282-6167
Mid Valley Center
570-489-4415

SCOLA
570-346-6203

COMMUNITY HEALTH
570-346-0759

Release to Obtain and Disclose Information

I authorize United Neighborhood Centers to obtain and disclose pertinent information from my/our records to/from:

Agency: _____

Worker / Department: _____

Phone Number: _____

_____ I authorize the release of information for the duration of my/our counseling (up to one year)

I understand that my records are protected under the Federal Confidentiality Regulations as well as the provisions of HIPAA of 1996 and cannot be disclosed without my written consent unless otherwise provided for within the regulations. I understand that I may revoke this consent at any time, provided that action has not been taken in reliance upon this authorization. Without written notice to withdraw this consent, it expires at the earlier of the listed expiration date or upon release of the information. The nature of this consent form has been explained to me and I understand its contents.

Client Name: _____

Signature: _____

Date: _____

Case Manager Name: _____

Signature: _____

Date: _____

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Client Name: _____

Signature: _____

Date: _____

Case Manager Name: _____

Signature: _____

Date: _____

Hardship Letter

Client Signature: _____ Date: _____

Case Management Service Plan

Client Name: _____ DOB: _____

S.M.A.R.T. Goal Questionnaire

What is your main goal in the housing counseling program?

_____

_____

_____

1. What will reaching this goal accomplish? How and why will it be accomplished?

   _____

   _____

2. How will you know you have reached the goal?

   _____

   _____

3. Is it possible to reach this goal?

   _____

   _____

4. What is the result of reaching your goal?

   _____

   _____

5. When do you want to reach this goal?

   _____

   _____

Client Signature: _____

Case Manager Signature: _____