The Housing Resource Center of Benton and Franklin Counties screens households that are experiencing homeless or facing an eviction for housing programs in our community.

Screening Times:
Tuesday, Wednesday, Thursday
8am – 11:30am & 1pm-4:30pm (closed 12-1pm)

If you have these documents please bring them with you:

☐ Homeless Status Verification: Letter from the shelter/service provider or self-declaration
☐ Eviction Notice and Lease Agreement
☐ Picture ID
☐ Social Security Cards & birth certificates for children
☐ Proof of income for all adults in household
Requerido para evaluar

2. Verificación del estado de la persona. Se solicita: carta de referencia del proveedor de vivienda/servicio;

3. Verificación del registro, si se ha registrado.

Asistencia

Si usted ha estado viviendo en las calles, o un refugio, O tiene un aviso de desalojo para su

Los días de evaluación son: Martes, Miércoles y Jueves: 8am a 11:30am y 1:00pm-4:30pm
<table>
<thead>
<tr>
<th>Phone #</th>
<th>Last Known Permanent Address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Length of stay at above address</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 1 night</td>
</tr>
<tr>
<td>□ 90 days-1 year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th># of People in household</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Medicaid</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gross Monthly Income</th>
<th>Do you receive:</th>
<th>Source of Income:</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td></td>
<td></td>
<td>Hispanic</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(H) or Non-Hispanic (N)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Social Security Number</td>
</tr>
</tbody>
</table>

Please check the box that reflects your current housing situation.

**A) Homeless Situations**

- □ Place not meant for habitation
- □ Emergency Shelter (including hotel/motel paid for with an emergency voucher)
- □ Staying in a family member’s room, apartment or house
- □ Staying in a friend’s room, apartment or house

**Length of stay in living situation:**

- □ 1 night
- □ 2-6 nights
- □ 1 week or less
- □ less than month
- □ 30-90 days
- □ 90 days-1 year
- □ 1 year or longer

**B) Date you became homeless:**

- How many times homeless in the last 3 years?
  - □ One time
  - □ Two times
  - □ Three times
  - □ Four times or more

- Total number of months homeless:
  - □ One month or less
  - □ 2-12 months
  - □ More than 12 months

**C) Institutional Situations**

- □ Foster care home or 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

**D) Do you have an eviction notice?**

- □ 20-day
- □ 14-day

**E) Transitional & Permanent Housing**

- □ Hotel/motel paid for without emergency voucher
- □ Owned by client, no ongoing subsidy
- □ Owned by client, with ongoing subsidy
- □ Permanent housing (other than Rapid Re-Housing) for formally homeless persons
- □ Rental by client, no ongoing subsidy
- □ Rental by client, with VASH subsidy
- □ Rental by client, with other ongoing housing subsidy
- □ Residential project or halfway house with no homeless criteria
- □ Transitional housing for homeless persons (including homeless youth)
<table>
<thead>
<tr>
<th>(F)</th>
<th>Yes</th>
<th>No</th>
<th>Explanation/notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children 12 and under in the home?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persons over 55 in the home?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anyone in the household have a <strong>Physical Disability</strong>? Are they receiving SSI or ABD? If yes, explain.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anyone in the household have a <strong>Developmental Disability</strong>? If yes, explain.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anyone in the household have a <strong>Chronic Health Condition</strong>. Are they receiving SSI or ABD? If yes, explain.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anyone in the household have a diagnosed <strong>Mental Health Condition</strong> that they are receiving treatment for? Are they engaged in mental health services? If yes, explain.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anyone in the household have a □ drug problem? □ alcohol problem? □ both alcohol and drug problem? Are they engaged in treatment?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fleeing violence, sexual assault, stalking, etc.</td>
<td></td>
<td></td>
<td>Last occurrence:</td>
</tr>
<tr>
<td>Has anyone in your household served in the US armed forces?</td>
<td></td>
<td></td>
<td>Branch: Dates of Service:</td>
</tr>
</tbody>
</table>

Notes: Use this space to add any additional information that may be relevant to your current housing situation.

May we look up your benefits with DSHS and enter your information into our database? □Yes  □No

Client Signature  
Date
Client Release of Information and Informed Consent

IMPORTANT: Do not enter personally identifying information into HMIS for clients who are: 1) In DV agencies or; 2) currently fleeing or in danger from a domestic violence, dating violence, sexual assault or stalking situation; 3) are being served in a program that requires disclosure of HIV/AIDS status (i.e.: HOPWA); or 4) under 18 with no parent or guardian available to consent to sharing the minor’s information on HMIS. If this applies to you, STOP. Do not sign this form.

This agency participates in the Washington State Homeless Management Information System (HMIS) by collecting information, over time, about the characteristics and service needs of men, women, and children experiencing homelessness. RCW 43.185C.180

To provide the most effective services in moving people from homelessness to permanent housing, we need an accurate count of all people experiencing homelessness in Washington State. In order to insure that clients are not counted twice, we need to collect four pieces of personal information. Specifically, we need: name, birth date, race/ethnicity, and last permanent address. You may also choose to provide your social security number. However, signing this form does not require you to do so. Your information will be stored in our database for 7 years. If you have questions about collection of data or your rights regarding your personally identifying information, contact the HMIS System Administrator at: (360) 725-3028

We use strict security policies designed to protect your privacy. Our computer system is highly secure and uses up-to-date protection features such as data encryption, passwords, and identity checks required for each system user. There is a small risk of a security breach, and someone might obtain and use your information inappropriately. If you ever suspect the data in HMIS has been misused, immediately contact the HMIS System Administrator at: (360) 725-3028

The data you provide will be combined with data from the Department of Social and Health Services (DSHS) for the purpose of further analysis. Your name and other identifying information will not be included in any reports or publications. Only a limited number of staff members, who have signed confidentiality agreements, will be able to see this information. Your information will not be used to determine eligibility for DSHS programs. Washington State HMIS system administrators have full access to all information in HMIS. This includes the Department of Commerce staff, designated HMIS system administrators, and the software vendor.

By signing this form, you acknowledge and allow Department of Commerce staff to obtain additional records of information from other state agencies with which there is a data sharing agreement on file between Commerce and the other agency. Our data share agreement guides data transfer and storage security protocols. If data share agreements are in place, Commerce is authorized by you to obtain, add to HMIS, and use for evaluation purposes any other data you have provided to other Washington state agencies.

Your decision to participate in the HMIS will not affect the quality or quantity of services you are eligible to receive from this agency, and will not be used to deny outreach, assistance, shelter or housing. However, if you do choose to participate, services in the region may improve if we have accurate information about homeless individuals and the services they need. Furthermore, some funders MAY require that you consent to your information be supplied in HMIS in order for you to receive services from that funding source.

I understand the above statements and consent to the inclusion of personal information in HMIS about me and any dependents listed below, and authorize information collected to be shared with partner agencies. I understand that my personal information will not be made public and will only be used with strict confidentiality. I also understand that I may withdraw my consent at any time by filing a ‘Client Revocation of Consent’ form with this agency.

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

________________________

________________________

________________________

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Client Signature (Parent/Guardian)

________________________

________________________

________________________

________________________

________________________

________________________

Client Name (Print clearly) Date of Birth

Date

Agency Staff Name (Print clearly) Initials

Client refused consent (Agency Staff Initials)

Client Release of Information and Informed Consent

This form may not be amended except by approval of the Washington State Department of Commerce

Approved as to form by Sandra Adix, Assistant Attorney General, 3/22/2016

Revised 5/2017
Termination and Grievance Policy and Procedure

The BFDHS in their sole discretion can terminate program participants for violations of Family/Client Responsibilities, Program Occupancy Agreement or these policies and procedures. Termination of such services is the decision of BFDHS, respectively.

Repeated violation of program rules or obligations undermines the functioning of the program and constitutes abuse of the program by the client. The client's assistance may be terminated after they do not take corrective action after one documented incident of program violation. Prior to termination of the participant, BFDHS will give written notice to the program participant. This notice will include the reason(s) for termination. The client has a right to appeal this decision utilizing the grievance procedure below; a signed copy is provided to client and kept in client file. BFDHS will send a Notice of Termination of Tenancy to the participant with the effective date of the termination.

Step 1:
If you have a grievance, please bring it to the attention of the staff. An attempt will be made to immediately resolve the issue.

Step 2:
If the issue cannot be resolved with the staff directly, please promptly submit your complaint in writing to: BFDHS Grievance Coordinator, 7102 W. Okanogan Place, Ste. 201, Kennewick, WA 99336. You will receive a response to your written complaint within 30 (thirty) business days.

Step 3:
If you are still not satisfied with the results, please submit a written request for a hearing to: BFDHS Administrator, 7102 W. Okanogan Place, Ste. 201, Kennewick, WA 99336.
A hearing will be scheduled within 10 (ten) business days upon receipt of your written request. After your hearing, you will be notified in writing within 5 (five) business days of the hearing results.

By signing below, I acknowledge that I have been informed of the Benton and Franklin Counties Department of Human Services Grievance Policy and Procedure; a signed copy will be provided to me for my records.

Client Signature  Date  Staff Initials
## Client Information

**Household Information**
Please enter each household member below.

<table>
<thead>
<tr>
<th>Relation to Head of Household (if applicable)</th>
<th>First Name</th>
<th>Last Name</th>
<th>Birth Date</th>
<th>Gender</th>
<th>Race (enter all that apply)</th>
<th>Ethnicity</th>
<th>Veteran (served in Armed Forces)</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse/Child/Etc</td>
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<tr>
<td>Self</td>
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<td>7.</td>
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<td></td>
</tr>
</tbody>
</table>

Client Phone Number: ___________________________  Message Phone: ___________________________

**Current Living Situation**: Please check the best one that fits your current living situation.

- [ ] Place not meant for habitation
- [ ] Emergency Shelter, including motel paid for with Voucher
- [ ] Safe Haven
- [ ] Interim Housing/Couch Surfing
- [ ] Foster Care/Group Home
- [ ] Hospital or other residential non-psychiatric medical facility
- [ ] Jail, prison or juvenile detention
- [ ] Long term care facility or nursing home
- [ ] Psychiatric hospital or other psychiatric facility
- [ ] Substance abuse treatment facility
- [ ] Hotel or motel paid for without voucher
- [ ] Living in house/apartment you own with no other housing subsidy
- [ ] Living in house/apartment you own with housing subsidy______ (what type of subsidy)
- [ ] Renting with housing subsidy______ (what type of subsidy)
- [ ] Renting without housing subsidy
- [ ] Staying or living in a family member's home
- [ ] Staying or living in a friend's home
- [ ] Transitional housing for homeless persons
- [ ] Fleeing Violence or Sex-Trafficking

**Homeless**:  
Approximate Date Homelessness Started: __________________________
How many times have you been on the streets or in shelters in the past three years? __________________________
Total number of months homeless on the streets or shelters: __________________________

**At Risk of Homelessness**:  
When will you lose your primary nighttime residence? __________________________
### Length of Prior Living Situations:
- □ 1 night or less
- □ 2-6 nights
- □ 1 week or more, but less than 1 month
- □ 1 month or more, but less than 90 days
- □ 90 days or more, but less than 1 year
- □ 1 year or longer

### Length of Stay Less Than 7 Nights?
- □ Yes
- □ No

### Household Wellbeing Questions:

#### Self (1):

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have a physical disability?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Is this long-term?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Do you have a developmental disability?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Does this impair daily living?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Do you have a chronic health condition?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Is this long-term?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Do you have a mental health problem?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Is this long-term?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Do you have a mental health provider?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>If yes, please list provider here:</td>
<td>__________________________</td>
<td></td>
</tr>
<tr>
<td>Do you have a drug or alcohol problem?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Please circle: Alcohol, Drug, Both</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Is this being treated?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Have you been a victim of violence or sex trafficking?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>When was the last time?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Have you ever been arrested?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>If yes, Please list date and charge:</td>
<td>__________________________</td>
<td></td>
</tr>
</tbody>
</table>

#### Household Member Adult (2):

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have a physical disability?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Is this long-term?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Do you have a developmental disability?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Does this impair daily living?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Do you have a chronic health condition?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Is this long-term?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Do you have a mental health problem?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Is this long-term?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Do you have a mental health provider?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>If yes, please list provider here:</td>
<td>__________________________</td>
<td></td>
</tr>
<tr>
<td>Do you have a drug or alcohol problem?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Please circle: Alcohol, Drug, Both</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Is this being treated?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Have you been a victim of domestic or intimate partner violence?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>When was the last time?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Have you ever been arrested?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>If yes, Please list date and charge:</td>
<td>__________________________</td>
<td></td>
</tr>
</tbody>
</table>

#### Household Member Child (3):

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have a physical disability?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Is this long-term?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Do you have a developmental disability?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Does this impair daily living?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Do you have a chronic health condition?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Is this long-term?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Do you have a mental health problem?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Is this long-term?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Do you have a mental health provider?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>If yes, please list provider here:</td>
<td>__________________________</td>
<td></td>
</tr>
</tbody>
</table>

#### Household Member Child (4):

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have a physical disability?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Is this long-term?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Do you have a developmental disability?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Does this impair daily living?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Do you have a chronic health condition?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Is this long-term?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Do you have a mental health problem?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Is this long-term?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Do you have a mental health provider?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>If yes, please list provider here:</td>
<td>__________________________</td>
<td></td>
</tr>
</tbody>
</table>
Non-Cash Benefits: Check all that apply
☐ Food Stamps/Benefits Card
☐ State Children’s Health Insurance
☐ TANF Child Care
☐ Temporary Rental Assistance
☐ Employer provided health insurance
☐ Medicaid
☐ VA Medical Services
☐ TANF Transportation
☐ Section 8 or Rental Assistance
☐ COBRA health insurance
☐ Medicare
☐ WIC
☐ Other TANF
☐ Private health insurance
☐ State Adult health insurance

Household Income:
Total Monthly Gross (before taxes) Income: ________________

Income Source: ____________________________

I do hereby swear and attest that all of the information in this application is true and correct.

Client Signature ____________________________ Date __________

BFDHS Case Manager Signature ____________________________ Date __________

ZERO INCOME AFFIDAVIT: Complete this only if you have no income.

I have applied for housing assistance. Program regulations require verification of all income from participating households.

Income includes but is not limited to:
• Gross wages, salaries, overtime pay, commissions, fees, tips and bonuses
• Net income from operation of a business or from rental or real personal property
• Interest, dividends and other net income of any kind for real personal property
• Periodic payments received from Social Security, annuities, insurance policies, retirement funds, pensions, disability or death benefits and other similar types of period receipts
• Lump sum payment(s) for the delayed start of a periodic payment (except as provided in 24 CFR 5.609 (b)(5))
• Payments in lieu of earnings, such as unemployment and disability compensation, worker’s compensation, and severance pay
• Public assistance
• Alimony and child support payments (whether through the court system or not)
• Regular pay, special pay and allowances of a head of household or spouse who is a member of the Armed Forces (whether or not living in the dwelling)
• Regular monetary gifts from family and/or friends

I have stated during the last 30 days that I have no income at this time. I have not received any income since ________________, I do not expect to receive any income until ________________, I applied for ________________ (other financial assistance) on ________________.

I understand that any misrepresentation of information or failure to disclose information requested on this form may disqualify me from participation in the program, and may be grounds for termination of assistance.
WARNING: It is unlawful to provide false information to the government when applying for federal public benefit programs per the Program Fraud Civil Remedies Act of 1986, 31 U.S.C. §§ 3801-3812.

I certify that the above information is true and correct.

Client Signature ____________________________ Date __________
PLEASE READ THE FOLLOWING CAREFULLY

The Housing Resource Center (HRC) administered by Benton and Franklin Counties Department of Human Services Housing Division, is requesting your permission to share your confidential information and records in order to provide you with outreach and program services that are provided by other programs and agencies.

The sole purpose of revealing this information will be to enable the HRC staff, under the administration of Benton and Franklin Counties Department of Human Services, to provide you with appropriate external and internal services.

You are not required to give your consent to share this confidential and personal information.

Your eligibility to participate in HRC programs does not depend on your agreement to share your confidential information and personal records with outside agencies.

If you choose not to share your confidential information and personal records, including your Social Security Number, you may not be eligible for further services that require inter-agency cooperation.

Information may be shared with any or all of the following agencies: Community Action Connections, Lourdes Counseling Center, Department of Social and Health Services, Domestic Violence Services, Elijah Family Homes, My Friend's Place, Veterans Opportunity Center, Communities in Schools of Benton and Franklin Counties, Salvation Army, Kennewick Housing Authority, and Oxford House.

The information disclosed to the HRC partnering agencies will not be further re-disclosed by those agencies without your specific authorization and further consent.

I agree that a photocopy of this authorization may be used for the purpose stated above.

By signing below, I authorize Benton and Franklin Counties Department of Human Services to obtain information from [initial] and/or disclose information to [initial] share my confidential information and personal records; this information will be shared with partnering agencies in the community and only on a need-to-know basis.

I understand that my records are protected under Washington State Law and cannot be disclosed without my written consent unless otherwise provided for in the regulations. **This consent is good for 365 days unless updated and may be revoked in writing at any time except to the extent that action has already been taken based on this authorization.**

__________________________________________________________________________
Print Name

__________________________________________________________________________
Signature

__________________________________________________________________________
Date
Termination and Grievance Policy and Procedure

The BFDHS in their sole discretion can terminate program participants for violations of Family/Client Responsibilities, Program Occupancy Agreement or these policies and procedures. Termination of such services is the decision of BFDHS, respectively. Repeated violation of program rules or obligations undermines the functioning of the program and constitutes abuse of the program by the client. The client's assistance may be terminated after they do not take corrective action after one documented incident of program violation. Prior to termination of the participant, BFDHS will give written notice to the program participant. This notice will include the reason(s) for termination. The client has a right to appeal this decision utilizing the grievance procedure below; a signed copy is provided to client and kept in client file. BFDHS will send a Notice of Termination of Tenancy to the participant with the effective date of the termination.

Step 1:
If you have a grievance, please bring it to the attention of the staff. An attempt will be made to immediately resolve the issue.

Step 2:
If the issue cannot be resolved with the staff directly, please promptly submit your complaint in writing to: BFDHS Grievance Coordinator, 7102 W. Okanagan Place, Ste. 201, Kennewick, WA 99336. You will receive a response to your written complaint within 30 (thirty) business days.

Step 3:
If you are still not satisfied with the results, please submit a written request for a hearing to: BFDHS Administrator, 7102 W. Okanagan Place, Ste. 201, Kennewick, WA 99336.
A hearing will be scheduled within 10 (ten) business days upon receipt of your written request. After your hearing, you will be notified in writing within 5 (five) business days of the hearing results.

By signing below, I acknowledge that I have been informed of the Benton and Franklin Counties Department of Human Services Grievance Policy and Procedure; a signed copy will be provided to me for my records.

Client Signature ___________________________ Date ___________________________ Staff Initials ___________________________

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NON-COMPLIANCE

EACH OF THE FOLLOWING CONSTITUTES ONE PROGRAM NON-COMPLIANCE for internal programs.

1. Missing scheduled appointments without showing good cause
2. Not following housing stability plan and/or goals and objectives
3. Not providing information concerning changes in household and/or income within 10 (ten) days of the change
4. Violation of rental agreement/lease/contract
5. Non-payment of tenants portion of rent
6. Lack of contact with staff within a 30 day period
7. Unauthorized person(s) living in the subsidized unit.
8. Not reporting increased income

THE FOLLOWING CONSTITUTES AUTOMATIC PROGRAM TERMINATION

1. Eviction from rental unit with "cause"
2. Fraud
3. Abandonment of rental unit
4. Damage to rental or motel unit
5. Refusing housekeeping services at motel/hotel

This list is a guideline only and may not include all non-compliance issues. Each case will be dealt with on an individual basis, and may result in a written warning(s), probationary status or up to and including immediate termination.

Please sign below that you understand the contents of this form.

Applicant Signature ___________________________ Date ___________________________ Staff Signature ___________________________ Date ___________________________
BENTON AND FRANKLIN COUNTIES
DEPARTMENT OF HUMAN SERVICES

AUTHORIZATION TO RELEASE INFORMATION

Applicant’s Last Name  First Name  M.I.  Date of Birth
(please print)

I hereby authorize the Benton and Franklin Counties Dept. of Human Services to provide information to the following agencies:

<table>
<thead>
<tr>
<th>Agency Name</th>
<th>Contact Person</th>
<th>Address</th>
<th>Phone Number</th>
<th>Fax Number</th>
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for the purposes such as the verification of rent, residential placement, property management issues, or housing stability goals directly related to participation in the BFDHS Housing Program.

This request and authorization applies to (check items):

- [ ] Face sheet
- [ ] Physicians
- [ ] Treatment Plans
- [ ] Psychiatric evaluation
- [ ] Progress notes
- [ ] Initial Intake
- [ ] Discharge Summary
- [ ] Medication use and related information
- [X] Other (Specify): Housing

I understand that my records are protected under Washington State Law and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This release is good for 365 days unless updated and may be revoked in writing at any time except to the extent that action has already been taken based on this authorization.

Applicant’s Signature/Authorized Representative (Relation)  Date

Case Manager/Provider Representative  Date
CONSENT

NOTICE TO CLIENTS: The Department of Social and Health Services (DSHS) can help you better if we are able to work with other agencies and professionals that know you and your family. By signing this form, you are giving permission for DSHS and the agencies and individuals listed below to use and share confidential information about you. DSHS cannot refuse you benefits if you do not sign this form unless your consent is needed to determine your eligibility. If you do not sign this form, DSHS may still share information about you to the extent allowed by law. If you have questions about how DSHS shares client confidential information or your privacy rights, please consult the DSHS Notice of Privacy Practices or ask the person giving you this form.

CLIENT IDENTIFICATION:

<table>
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<tr>
<th>NAME</th>
<th>DATE OF BIRTH</th>
<th>IDENTIFICATION NUMBER</th>
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</thead>
<tbody>
<tr>
<td>ADDRESS</td>
<td>CITY</td>
<td>STATE</td>
</tr>
<tr>
<td>TELEPHONE NUMBER (INCLUDE AREA CODE)</td>
<td>OTHER INFORMATION</td>
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</table>

CONSENT:

I consent to the use of confidential information about me within DSHS to plan, provide, and coordinate services, treatment, payments, and benefits for me or for other purposes authorized by law. I further grant permission to DSHS and the below listed agencies, providers, or persons to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or by computer data transfer, mail, or hand delivery.

Please check all below who are included in this consent in addition to DSHS and identify them by name and address:

- [ ] Health care providers:
- [ ] Mental health care providers:
- [ ] Chemical dependency service providers:
- [ ] Other DSHS contracted providers:
- [X] Housing programs: BFDHS
- [ ] School districts or colleges:
- [ ] Department of Corrections:
- [ ] Employment Security Department and its employment partners:
- [ ] Social Security Administration or other federal agency:
- [ ] See attached list
- [ ] Other:

I authorize and consent to sharing the following records and information (check all that apply):

- [ ] All my client records
- [ ] Records on attached list
- [X] Only the following records
  - [ ] Family, social and employment history
  - [ ] Payment records
  - [X] Other (list): Income for Housing Programs
- [ ] Health care information
- [ ] Individual assessments
- [ ] Treatment or care plans
- [ ] School, education, and training

PLEASE NOTE: If your client records include any of the following information, you must also complete this section to include these records.

I give my permission to disclose the following records (check all that apply):

- [ ] Mental health
- [ ] HIV/AIDS and STD test results, diagnosis, or treatment
- [ ] Chemical Dependency (CD) services

- This consent is valid for [ ] one year [ ] as long as DSHS needs records, or [ ] until __________ (date or event).
- I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared.
- I understand that records shared under this consent may no longer be protected under the laws that apply to DSHS.
- A copy of this form is valid to give my permission to share records.

SIGNATURE | DATE | AGENCY CONTACT/WITNESS SIGNATURE | DATE |
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<tr>
<td>PARENT OR OTHER REPRESENTATIVE’S SIGNATURE (IF APPLICABLE)</td>
<td>TELEPHONE NUMBER (INCLUDE AREA CODE)</td>
<td>DATE</td>
<td></td>
</tr>
</tbody>
</table>

If I am not the subject of the records, I am authorized to sign because I am the: (attach proof of authority)

- [ ] Parent
- [ ] Legal Guardian (attach court order)
- [ ] Personal representative
- [ ] Other:

NOTICE TO RECIPIENTS OF INFORMATION: If these records contain information about HIV, STDs, or AIDS, you may not further disclose that information without the client’s specific permission. If you have received information related to drug or alcohol abuse by the client, you must include the following statement when further disclosing information as required by 42 CFR 2.32:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medial or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.