HOPE for the Inner City

Changing Lives, Transforming Communities

HOPE FOR THE INNER CITY WHERE WE: ENGAGE, INVEST & EMPOWERS.

(PLEASE CIRCLE SERVICE NEED)

Community Development **Dental Clinic** **Grow Hope**
Mercy Ministry **Workforce Development**

Application Information:

Name: Last _____ First _____ MI_____

Address:_____

City:_____ State_____ Zip Code_____

Phone:_____ ALT# _____

Email:_____ Date of Birth _____

Emergency Contact_____ Phone:_____

Please state below what assistance you are needing and why?

_____

_____

How did you hear about Hope?_____

Signature_____ **Date**_____

Hope for the Inner City Release and Waiver

I, the undersigned agree to follow all rules and regulations of Hope for the Inner City while in, upon or about the premises or while using or observing the premises or any facilities or equipment, and understand and agree that I may be expelled at any time, for failure to abide by such rules and regulations.

I, the undersigned, agree to ensure that I, my child(ren), dependent(s), and/or other minors for whom I am responsible or for whose presence at Hope for the Inner City I am responsible follow all rules and regulations of Hope for the Inner City while in, upon or about the premises or while using or observing the premises or any facilities or equipment, and understand and agree that I, my child(ren), dependent(s) and/or other minors for whom I am responsible or for whose presence at Hope for the Inner City I am responsible may be expelled at any time, with no refund of any monies paid, for failure to abide by such rules and regulations.

IN FURTHER CONSIDERATION OF BEING PERMITTED TO ENTER HOPE FOR THE INNER CITY FOR ANY PURPOSE INCLUDING, BUT NOT LIMITED TO OBSERVING OR USING ANY FACILITIES OR EQUIPMENT, OR PARTICIPATING IN ANY ON-SITE OR OFF-SITE PROGRAM, ACTIVITY OR CLASS AFFILIATED WITH HOPE FOR THE INNER CITY, INCLUDING USE OF HOPE FOR THE INNER CITY FACILITIES, THE UNDERSIGNED HEREBY AGREE TO THE FOLLOWING:

1. THE UNDERSIGNED, ON HIS OR HER BEHALF AND BEHALF OF HIS OR HER CHILDREN, HEREBY RELEASES, WAIVES, DISCHARGES AND COVENANTS NOT TO SUE HOPE FOR THE INNER CITY, its directors, officers, employees, and agents (hereinafter referred to as "releasees") from all liability to the undersigned or his or her children and all their respective personal representatives, assigns, heirs, and next of kin for any loss or damage, and any claim or demands therefor on account of injury to the person or property (includes physical property, intellectual property, or identity related property) or resulting in death of the undersigned or his or her children, whether or not caused by the negligence of any person, the releasees or otherwise while the undersigned or his or her children is in, upon, or about Hope for the Inner City premises or any facilities or equipment therein or participating in any program, class or activity affiliated with Hope for the Inner City without respect as to location.

2. THE UNDERSIGNED, ON HIS OR HER BEHALF AND BEHALF OF HIS OR HER CHILDREN, HEREBY AGREES TO INDEMNIFY AND SAVE AND HOLD HARMLESS the releasees and each of them from any loss, liability, damage or cost they may incur due to the presence of the undersigned or his or her children in, upon or about Hope for the Inner City premises or in any way observing the use of or using any facilities or equipment of Hope for the Inner City or participating in any program, class or activity affiliated with Hope for the Inner City without respect as to location whether or not caused by the negligence of any person, the releasees or otherwise.

3. THE UNDERSIGNED, ON HIS OR HER BEHALF AND BEHALF OF HIS OR HER CHILDREN, HEREBY ASSUMES FULL RESPONSIBILITY FOR AND RISK OF BODILY INJURY, DEATH OR PROPERTY LOSS/DAMAGE (includes physical property, intellectual property, or identity related property) to the undersigned or his or her children whether or not caused by the negligence of any person, the releasees or otherwise while in, about or upon the premises of Hope for the Inner City and/or while observing the use of using the premises or any facilities or equipment thereon or participating in any program, class or activity affiliated with Hope for the Inner City without respect as to location. The Undersigned, on his or her behalf and behalf of such children, specifically assumes all risks of personal injury, property loss/damage (includes physical property, intellectual property, or identity related property), or damages whatsoever including risks associated with any and all sporting activities, exercise, locker room, parking, or in any program, class or activity affiliated with Hope for the Inner City without respect as to location. This assumption of risk also includes environmental, theft (includes physical property, intellectual property, or identity related property), and contagion risks in addition to risk associated with use of the Hope for the Inner City's referral and advisory services.

Office Only: Mercy UMT Housing CM DC JEL Time:

HOPE FOR THE INNER CITY

Intake Form

Applicant Information

Please complete ALL boxes.

Last Name | First Name | MI | Date

Street Address | Referred by: N/A [ ]

City | State | Zip Code

Phone # 1 | Phone # 2 | Date of Birth:

Race/Ethnicity: AA C H Other Marital Status: Single Married Significant Other Other

Is this housing: Section 8 [ ] Subsidized [ ] Public Housing [ ] Rent [ ] Own [ ]

Dependents/Houshold members/Relationship/Age

#1: #4:

#2: #5:

#3: #6:

Emergency Contact Name: Phone Number:

Type of Assistance Needed/Amount Needed, If Known

Electricity Bill	[ ] $	Rent/Mortgage	[ ] $
Water Bill	[ ] $	Food Stamps	[ ]
Gas Bill	[ ] $	Identification Documents	[ ]
Medication	[ ]	Medical Care	[ ]
Employment	[ ]	Dental Care	[ ]
Learn to Read	[ ]	Food-perishable	[ ]
G.E.D.	[ ]	Food-non-perishable	[ ]
Mental Health Services	[ ]	Housing Repairs	[ ]

Are you a United States citizen? Yes or No If no, are you authorized to work in the U.S.? Yes or No

Have you visited other churches, agencies in the lost three (3) months? No [ ]

Name:

Name:

Employment:	
Company:	Phone:
Start Date:	End Date:
Are you a veteran? Yes No	

Household Income	Household Expenses
Job: $	Mortgage or Rent: $
Families First: $	Child Care/Support: $
Food Stamps: $	Groceries: $
Child Support: $	Utilities: $
Other: $	Other: $

Church Affiliation:

Have you asked your church for help? YES NO If yes, how did they help you?

Prayer Request:

Additional Notes:

Social Security #:	Service Point #:

Applicant Signature

Staff Signature

Required Documents

1. Current Lease & eviction notice if applicable (Mercy & JFL clients only)
2. Photo Identification
3. Proof of Income (two current check stubs, tax return or any government assistance letters)
4. Social Security card
5. For electricity bill payment, bill and disconnect notice, lease, contact with other agencies
6. For water bill payment, bill and disconnect notice, lease, contact with other agencies
7. For rental assistance, lease and connected with other, contact with other agencies
8. For food, need the first four documents listed above
9. Letter stating residence address (JFL only)
10. Birth Certificate (JFL only)

Disposition: No Referrals done Single Service Request Amt. Rcvd:

Referral to:

Dr. William Roy Dental Clinic

HIPAA AUTHORIZATION FOR RELEASE OF MEDICAL/HEALTH INFORMATION

Information will be released for: (print name)		Date:	
Street Address:		Identify Signer: ___Self ___Parent of Minor ___Guardian ___Other Authorized Representative (explain) Proof of legal authorization may be required	
Phone Number: ( )	City	State	Zip
Social Security Number–not required–used by some health care providers for identification:		Date of Birth:	

I give permission for the following records to be sent to the Dr. William Roy Dental Clinic and its authorized agents/contractors. The records may be used to help decide eligibility for services or benefits and to provide services.

- Dr. William Roy Dental Clinic may get any and all medical/health records: Yes_____ No_____ Initials_____
- Dr. William Roy Dental Clinic may get any and all mental health records: Yes_____ No_____ Initials_____
- Dr. William Roy Dental Clinic may get drug or alcohol treatment/referral records: Yes_____ No_____ Initials_____
- Dr. William Roy Dental Clinic may get HIV/AIDS test/treatment records: Yes_____ No_____ Initials_____
- Specific Description of any other medical/health information that may be provided: _____

***The law requires specific identification of the person(s) or class of persons, from whom information can be requested. Choose one of the following below.

1. _____(initials) I choose to identify specific persons/organizations from whom information can be requested. The Dr. William Roy Dental Clinic can get my medical/health information from only the following specified persons/organizations:

_____

_____

2. _____ Dr. William Roy Dental Clinic (initials) Rather than specifically identifying persons/organizations from whom information can be requested, I choose to permit the Dr. William Roy Mercy Dental Clinic to request information from the following class of persons/organizations: doctors, hospitals, clinics, nursing homes, any other private or government health care providers, insurance companies and public or private health plans.

YOU DO NOT HAVE TO SIGN THIS FORM. *If you do not sign this form, or if you take back your permission, the Dr. William Roy Dental Clinic may not be able to decide to assist you or provide services you need.*

>This permission is good for 12 months from the date you sign this form, unless you take back your permission sooner.

>You have the right to withdraw your permission at any time. *You cannot take back information that has been given to us before you take back your permission or that was used to take action on your request for assistance.*

>To take back your permission, you can write to the Dr. William Roy Dental Clinic or write your doctors, hospitals or other health care providers or insurance company or health plan to take back your permission at any time.

>All information provided to the Dr. William Roy Dental Clinic is protected by the Privacy Act of 1979 and federal and state law or regulations. It will not be given to other persons or organizations unless the law or regulations allow or require us to give out that information, or you allow us to give out that information. If we are required or permitted to give out that information, it may not be protected if the person or organization that receives it is not required by law to protect the information.

>We may also use your information when we compare records by computer. The computer matches our information with other federal, state or local government agencies. Many agencies use matching information to find out if a person gets benefits paid by the federal or state government. The matches also help prove that a person is eligible for help. The law lets us do this even if you do not agree to it.

>Ask the Dr. William Roy Dental Clinic staff to explain if you have any questions about how or why your information is used.

Signature of Person or Person's Authorized Representative: _____ Date: _____

Date: _____

Authorization for Release of Information
Homeless Management Information System (HMIS)

Consumer's Name: _____ Date of Birth: _____

Social Security Number: _____

This agency, as a member of the Chattanooga Homeless Coalition, is participating in a data collection project to improve health and social services to the homeless in our community.

The purpose of the Homeless Management Information System is to improve the quality and integration of services, to increase the productivity of case managers in participating agencies, and to provide a central repository of data for service planning and quality improvement.

Authorization

By signing this document, I authorize this agency to disclose information from my records to other agencies participating in the Homeless Management Information System for the purpose of service coordination.

I understand this authorization may include information concerning my employment, education, health, mental health, drug/alcohol use, family relationships, services, housing, legal status or any other information deemed important in providing me with needed health and social services.

By signing this agreement, I understand that I have a right to inspect the disclosed information at any time by contacting this agency during regular business hours and arranging a meeting with my case manager or a designated agency representative.

I furthermore understand that I may revoke this authorization, in whole or in part, at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to this agency or to the Chattanooga Homeless Coalition.

Client's Printed Name: _____

Signature of Client/Parent/Guardian: _____ Date: _____

Agency Name: _____

Agency Representative Printed Name: _____

Agency Representative Signature: _____ Date: _____

HOPE
for the Inner City

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Transforming communities.

And what does the Lord require of you? To act justly, to love mercy and to walk humbly with your God.

Micah 6:8

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Purpose and Laws: This form, when properly completed, permits the release of confidential information about a person receiving services governed and regulated by Title 33, Tennessee Code Annotated. Any information to be released under this form shall be released in accordance with the following confidentiality laws and regulations: Title 33, Tennessee Code Annotated; the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations at 45 Code of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidentiality of Alcohol and Substance Abuse Patient Records and its regulations at 42 CFR Part2. The records released through this Authorization are protected by the above named confidentiality laws and regulations. A general authorization for the release of medical or other information is NOT sufficient for the purpose of disclosing mental health or alcohol and substance abuse information. Federal rules restrict any use of alcohol and substance abuse information to criminally investigate or prosecute the person to whom the information pertains.

I, _____(print name) am seeking services from Hope for the Inner City/Jobs for Life Program for _____myself, _____my family, _____my child (check all that apply). By signing this form, I am giving Hope for the Inner City/Jobs for Life Program staff permission to communicate regarding services offered to me and/or my family. I understand that all records and information regarding services will be protected by regulations that govern the exchange of confidential information. I further understand that services may include an assessment of our needs and the development of a plan to meet those needs.

I give permission for any of the following records about me and my family to be given to Hope for the Inner City/Jobs for Life for the purposes of determining my eligibility for services and to coordinate services for me and my family unless stated otherwise below:

- Employment records, past or present
- Financial records from banks, credit unions or any other financial services, credit or financial information agencies
- Social Security, insurance companies, retirement or pension funds/departments records
- Social services, housing or public assistance agency records of any type
- Any court or law enforcement agency records
- Any other agency, person or organization records (except persons or organizations that have medical/health information or educational agencies**) that have information about me and my family.

***NOTE: IF MEDICAL/HEALTH INFORMATON IS REQUESTED, THE APPLICANT/RECIPIENT MUST COMPLETE A HIPAA RELEASE FORM. IF EDUCATIONAL RECORDS ARE TO BE RELEASED, THE EDUCATION AGENCY MAINTAINING THE RECORDS MUST BE CONTACTED DIRECTLY BY THE PERSON OR ENTITY SEEKING THE RECORDS.**

YOU DO NOT HAVE TO SIGN THIS FORM. *If you do not sign this form or if you take back your permission, Hope for the Inner City/Jobs for Life may not be able to provide services to you.*

I give permission to Hope for the Inner City/Jobs for Life to use a paper, fax or electronic copy or copies of this to get my information. Hope for the Inner City/Jobs for Life staff may talk to or get copies of my records from any of the persons or organizations I have permitted and can get this information by paper, fax, computer or electronic copies of those records.

This authorization to receive services and to exchange confidential information shall remain in effect for a period of twelve (12) months. I understand that this release may be revoked by me at any time if requested in writing.

_____ _____ _____

Client Signature Date Witness Signature

AUTHORIZATION IS NOT REQUIRED TO COMPLY WITH LAWS REGARDING MANDATORY REPORTING OF SUSPECTED ABUSE OR NEGLECT OR ASSESSMENT THAT THERE IS A DANGER OF SERIOUS HARM TO SELF OR OTHERS.