Foundational Community Supports Enrollee Release of HMIS Information and Informed Consent

This agency participates in the Foundational Community Supports (FCS) program, providing supportive housing services to eligible individuals. The purpose of this form is to authorize the one-time release of personal information, including information about your housing history, collected from HMIS to the FCS Third Party Administrator (TPA), Wellpoint, for the purposes of confirming FCS program eligibility.

- We need to confirm your eligibility for this program. Specifically, we need information about your housing history from HMIS as part of verifying your Chronic Homelessness status. Your information will be stored in our database for seven years. If you have questions about the collection of data or your rights regarding your personally identifying information, contact Wellpoint at 844-451-2828.

- 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. As with any system, there is a risk of security breach, but we believe it is small. If there is a security breach, someone might obtain and use your information inappropriately. If you ever suspect the data has been misused, immediately contact Wellpoint at 844-451-2828.

- Your decision to release this information to the TPA does not guarantee eligibility for FCS services, nor does your refusal guarantee that you will not receive FCS services from this agency.

- Signing this form only authorizes a one-time release of information for the purpose of confirming eligibility for FCS services. Any additional release of HMIS information to the TPA will require an additional signed release.

I understand the above statements and consent to the sharing of personal information in HMIS listed above with the TPA. I understand that my personal information will not be made public and will only be used with strict confidentiality.

_____ _____

Enrollee Signature Date

_____ _____ _____

Enrollee Name (Print clearly) Date of Birth Agency Staff Name (Print clearly) Initials

Enrollee refused consent _____(Agency Staff Initials)

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, 12/20/2017