Universal Release Form  
Consent to Release Confidential Information

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ISSUING AGENCY | | |  | | | | | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | | | | |  | | | |
|  | | |  | | | | |  | | | |
| Client’s Name | | | DOB | | | | | SS# | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Please indicate “ALL Of the Following” or initial the individual agencies you wish to share information. | | | | | | | | | | | |
| I, hereby authorize:\_\_\_ All of the Organizations Below | | | | | | | | | | | |
| \_\_\_O.S.U. Extension | | \_\_\_ Mental Health | | | | | | | | | \_\_\_ One-Stop |
| \_\_\_ Early Start | | \_\_\_Probate Juvenile Court | | | | | | | | | \_\_\_ Red Cross |
| \_\_\_ School Districts | | \_\_\_Miami Trace Schools | | | | | | | | | \_\_\_ Sheriff |
| \_\_\_ Board of MRDD | | \_\_\_Community Action | | | | | | | | | \_\_\_ Police Department |
| \_\_\_ Head Start | | \_\_\_ Bureau of Support | | | | | | | | | \_\_\_ Prosecutor |
| \_\_\_ Job & Family Services | | \_\_\_ Recovery Centers | | | | | | | | | \_\_\_ Victim/Witness |
| \_\_\_ Children’s Services | | \_\_\_ Hospital | | | | | | | | | \_\_\_Adult Probation |
| \_\_\_ Health Department | | \_\_\_Hopewell SERRC | | | | | | | | | \_\_\_Adult Parole |
| \_\_\_Rehabilitation Services Commission | | \_\_\_ Veteran’s Services | | | | | | | | | \_\_\_VA Chillicothe |
| \_\_\_Great Oaks Even Start | | \_\_\_Goodwill Industries | | | | | | | | | \_\_\_ Commission on Aging |
| \_\_\_ Early Intervention | | \_\_\_Great Oaks Employment Services Program | | | | | | | | | \_\_\_Alternative School |
| \_\_\_Service Plan Coordinator | | \_\_\_ Metropolitan Housing Authority | | | | | | | | | \_\_\_Nursing Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_Legal Services | | \_\_\_My Sister’s House | | | | | | | | | \_\_\_Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_Family & Children First | | \_\_\_L.I.F.E. Pregnancy Center | | | | | | | | | \_\_\_Landlord\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_Continuum of Care | | \_\_\_Food Pantry \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | \_\_\_CLUSTER |
| \_\_\_Potential Housing Providers | | \_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | \_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_Region 16 Coordinated Intake Partners | | | | | | | | | | |  |
| To share such information and/or papers with one another as may be necessary to develop an effective service plan, avoid duplication of services to, and better assess the needs of individuals and families. | | | | | | | | | | | |
| Such information and/or papers may include: | | | | | \_\_\_All of the following | | | | \_\_\_Medical Records | | |
| \_\_\_Psychotherapy Reports | | | | | \_\_\_Psychological Reports | | | | \_\_\_Service Records | | |
| \_\_\_Scholastic/Attendance Reports | | | | | \_\_\_Court Records | | | | \_\_\_Employment Information | | |
| \_\_\_Individual/Family Service Plans | | | | | \_\_\_Individual/Family Case/Goal Plans | | | | \_\_\_Individual/Family Referrals | | |
| \_\_\_Housing Information | | | | | \_\_\_Arrearages | | | | \_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| \_\_\_Only\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| Specify where required by confidentiality laws and regulations.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
|  | | | | | | | | | | | |
| By signing this form, I understand that papers may contain private information about me and my children and that I am allowing this information to be shared by those indicated above. I also understand that the information released is protected by State and Federal confidentiality regulations and cannot be disclosed without my written consent. I further understand that I may revoke this consent at any time. This consent expires automatically one year after the day of the signature. | | | | | | | | | | | |
| Date: \_\_\_\_-\_\_\_\_-\_\_\_\_\_ | Signature: | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
|  |  | | |  | | | | | | | |
| Please Indicate: | \_\_\_Father | | | \_\_\_Mother | | \_\_\_Legal Guardian | \_\_\_Self | | | \_\_\_Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  |  | | |  | |  |  | | |  | |
| Revoked date: \_\_\_\_-\_\_\_\_-\_\_\_\_\_ | Signature: | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
|  |  | | |  | | | | | | | |
| Please Indicate: | \_\_\_Father | | | \_\_\_Mother | | \_\_\_Legal Guardian | \_\_\_Self | | | \_\_\_Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  |  | | |  | |  |  | | |  | |
|  |  | | |  | |  |  | | |  | |
| Renewal Date: \_\_\_\_-\_\_\_\_-\_\_\_\_\_ | Signature: | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
|  |  | | |  | | | | | | | |
| Please Indicate: | \_\_\_Father | | | \_\_\_Mother | | \_\_\_Legal Guardian | \_\_\_Self | | | \_\_\_Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

CSBG INTAKE FORM

|  |  |  |
| --- | --- | --- |
| OCEAN ID: | | |
| SS# | Last Name | First Name |
| DOB | Address | |
| City | Zip Code | Telephone ( ) |

Ethnicity

□ B. Black/African Amer. □ H. Hispanic □ A. Asian

□W. White □ N. Native Amer. □ O. Ohter

Gender

□ Female □ Male

Disabled

□ Yes □ No

Health Insurance

□ A. Medicaid □ D. Self- Ins

□ B. Medicare □ E. None

□ C. Private □ F. Unknown

Famer

□ A. Farmer

□ B. Migrant

□ C. Seasonal

Food Stamps

□ Yes □ No

Education

□ A. 0-8 □ D. 12 +

□ B. 9-12 (non-grad) □ E. Unknown

□ C. HS Grad/GED □ F. College Grad

Client Income

□ A. Weekly □ D. Annual

□ B. Bi-Weekly □ E. 13 weeks

□ C. Monthly □ AMOUNT: \_\_\_\_\_\_

Housing

□ Own

□ Rent

□ Homeless

Family Type

□ F. Single PAR/Female □ S. Single

□ M. Single PAR/Male □ C. Couple

□ T. Two Parent □ O. Other

# in HSHLD

Veteran

□ Yes

□ No

Sources of Income

□ A. Employment □ C. Social Security □ E. DA □ G. Pensions □ I. Other

□ B. Unemployment □ D. AFDC/TANF □ F. SSI/SSD □ H. Disability

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| HOUSEHOLD MEMBERS | | | | | |
| SS# |  |  |  |  |  |
| Last Name |  |  |  |  |  |
| First Name |  |  |  |  |  |
| Date of Birth |  |  |  |  |  |
| Gender |  |  |  |  |  |
| Disabled |  |  |  |  |  |
| Ethnicity |  |  |  |  |  |
| Education |  |  |  |  |  |
| Heath Insurance |  |  |  |  |  |
| Veteran |  |  |  |  |  |
| Income Period |  |  |  |  |  |
| Amount |  |  |  |  |  |
| Source |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| # |  |  |  |  |  |  |  |  |  |  | Name | Date |
| Units |  |  |  |  |  |  |  |  | Intake |  |  |
| Site |  |  |  |  |  |  |  |  | Data Entry |  |  |

I certify that this statement is true and correct to the best of my knowledge, and authorize the release of any or all information necessary for verification purposes.

Signature of Client Date

Comments:

Self-Declaration of Income

HCRP Applicant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This is to certify the income status for the above named individual. Income includes but is not limited to:

* The full amount of gross income earned before taxes and deductions.
* The net income earned from the operation of a business, i.e., total revenue minus business operating expenses. This also includes any withdrawals of cash from the business or profession for your personal use.
* Monthly interest and dividend income credited to an applicant’s bank account and available for use.
* The monthly payment amount received from Social Security, annuities, retirement funds, pensions, disability and other similar types of periodic payments.
* Any monthly payments in lieu of earnings, such as unemployment, disability compensation, SSI, SSDI, and worker's compensation.
* Monthly income from government agencies excluding amounts designated for shelter, and utilities, WIC, food stamps, and childcare.
* Alimony, child support and foster care payments received from organizations or from persons not residing in the dwelling.
* All basic pay, special day and allowances of a member of the Armed Forces excluding special pay for exposure to hostile fire.

Check only one box and complete only that section

I certify, under penalty of perjury, that I currently receive the following income:

Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_  
Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_  
Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify, under penalty of perjury, that I do not have any income from any source at this time.

Applicant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HCRP Staff Verification   
I understand that third-party verification is the preferred method of certifying income for assistance. I understand self declaration is only permitted when I have attempted to but cannot obtain third party verification.   
*Documentation of attempt made for third-party verification:*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HCRP Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_