COMMUNITY RESPONSE/CONNECTED YOUTH INITIATIVE INFORMATION FORM

Community IMPACT Network of Adams, Clay, Nuckolls & Webster Counties

United Way Of South Central Nebraska

For office use only:
*NMIS#:*_____ *Entered into Clarity:* ☐

TODAY'S DATE: _____

If you are needing emergency assistance, please contact 911. If you are interested in non-emergency assistance please text "HELP" to 402-226-5842 to be connected with someone in your local area.

SECTION I-a: Participant/Client Information

Full Legal Name (first, middle, last)*:		
Maiden/Alias:	Suffix (Jr, III):	Preferred Name:
Street Address:		
City:	State:	Zip:
County*:	Email:	
Home or Cell Phone #:	Date of Birth*:	

Last 4 digits of Social Security Number: ☐ Prefer Not to Answer

What is your Gender?:*
- ☐ Women (Female)
- ☐ Man (Male)
- ☐ I don't know
- ☐ Prefer not to answer
- ☐ Another Gender:
- ☐ Trans Female (MTF or Male to Female)
- ☐ Trans Male (FTM or Female to Male)
- ☐ Gender Non-Conforming (not exclusively male or female)

Race (Select up to 2):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ White
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ I don't know
- ☐ Prefer not to answer

Ethnicity:
- ☐ Non-Hispanic/Non-Latino
- ☐ Hispanic/Latino
- ☐ I don't know
- ☐ Prefer not to answer

U.S. Military Veteran ☐ Yes ☐ No ☐ I don't know ☐ Prefer not to answer

Do you have a disabling condition? ☐ Yes ☐ No ☐ I don't know ☐ Prefer not to answer

Answer 'Yes' or 'No' for each disability type (in white).
If the client selects 'Yes' for any disability type, you must also complete the shaded sections below.

Disability Type	Yes	No	Is your disability expected to be long-term and indefinite duration or substantially impairs your ability to live independently?
Alcohol Abuse	☐	☐	☐ Yes ☐ No ☐ I don't know ☐ Prefer not to answer
Drug Abuse	☐	☐	☐ Yes ☐ No ☐ I don't know ☐ Prefer not to answer
Developmental Disability	☐	☐	☐ Yes ☐ No ☐ I don't know ☐ Prefer not to answer
HIV/AIDS	☐	☐	☐ Yes ☐ No ☐ I don't know ☐ Prefer not to answer
Mental Health Problem	☐	☐	☐ Yes ☐ No ☐ I don't know ☐ Prefer not to answer
Physical Disability	☐	☐	☐ Yes ☐ No ☐ I don't know ☐ Prefer not to answer
Chronic Health Condition	☐	☐	☐ Yes ☐ No ☐ I don't know ☐ Prefer not to answer

Are you currently covered by Health Insurance?
- ☐ Yes
- ☐ No
- ☐ I don't know
- ☐ Prefer not to answer

Answer 'Yes' or 'No' for each health insurance source. Answer 'Yes' for any source that is currently received. Answer 'No' for sources that have been terminated, even if they were received in the past. If the client selects 'Yes' for any insurance type, complete the shaded section below.

Health Insurance Type	Yes	No	Health Insurance Type	Yes	No
Medicaid	☐	☐	Health Insurance obtained through COBRA	☐	☐
Medicare	☐	☐	Private Pay Health Insurance	☐	☐
State Children's Health Insurance Program	☐	☐	State Health Insurance for Adults	☐	☐
Veteran's Administration (VA) Medical Services	☐	☐	Indian Health Services Program	☐	☐
Employer-Provided Health Insurance	☐	☐	Other (specify):	☐	☐

As a child were you ever in Foster Care or are you now?	☐ Yes ☐ No	☐ I don't know ☐ Prefer not to answer

If YES, number of years:

☐ Less than 1 year – Enter number of months:___ ☐ 1 – 2 years ☐ 3 – 5 or more years ☐ Prefer not to answer

If YES, how long ago did you exit Foster Care?

☐ 90 days ☐ 6 months ☐ 9 months ☐ 12 months ☐ More than 12 months

As of today's date are you between the ages of 14 to 25 (have not yet had your 26th birthday)?* ONLY if you are between the ages of 14 and 25, have you experienced any of the following?	☐ In-home services for your family (from DHHS) ☐ Guardianship or Adoption ☐ Probation or Incarceration	☐ Homelessness ☐ Human Trafficking ☐ Prefer not to answer ☐ N/A, no experience with any of these
Are you a domestic violence victim/survivor?	☐ Yes ☐ No	☐ I don't know ☐ Prefer not to answer

If YES, when did the experience occur?

☐ Within the past three months ☐ Three to six months ago ☐ From seven to twelve months ago
☐ More than a year ago ☐ Client does not know ☐ Prefer not to answer

→If YES, Is the client currently fleeing?

☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused ☐ Data not collected

Sexual Orientation	☐ Heterosexual	☐ Gay	☐ Lesbian	☐ Bisexual
	☐ Other	☐ Questioning/Unsure	☐ I don't know	☐ Prefer not to answer

Are you currently pregnant or expecting a child? (Mother or Father)* ☐ Yes ☐ No ☐ I don't know ☐ Prefer not to answer

If pregnant, projected date of birth? ____ ____ / ____ ____ / ____ ____ ____ ____
Month Date Year

What is your Highest level of education attained?	☐ No schooling completed	☐ 9th grade	☐ High School diploma	☐ Post-Secondary School
	☐ Nursery School - 4th grade	☐ 10th grade	☐ I don't know	☐ Prefer not to answer
	☐ 5th grade or 6th grade	☐ 11th grade		
	☐ 7th grade or 8th grade	☐ 12th grade, no diploma		

SECTION I-b: Adult #2 in Household

First Name:	Middle Name:	Last Name:
Maiden/Alias:	Suffix (Jr, III):	Preferred Name:
Email:	Phone #:	Date of Birth:

Last 4 digits of Social Security Number:	☐ Prefer Not to Answer
What is your Gender?:*	☐ Women (Female) ☐ Man (Male) ☐ I don't know ☐ Prefer not to answer ☐ Another Gender: ☐ Trans Female (MTF or Male to Female) ☐ Trans Male (FTM or Female to Male) ☐ Gender Non-Conforming (not exclusively male or female)
Race (Select up to 2):	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ I don't know ☐ Prefer not to answer
Ethnicity:	☐ Non-Hispanic/Non-Latino ☐ Hispanic/Latino ☐ I don't know ☐ Prefer not to answer
U.S. Military Veteran	☐ Yes ☐ No ☐ I don't know ☐ Prefer not to answer
Do you have a disabling condition?	☐ Yes ☐ No ☐ I don't know ☐ Prefer not to answer

Answer 'Yes' or 'No' for each disability type (in white).
If the client selects 'Yes' for any disability type, you must also complete the shaded sections below.

Disability Type	Yes	No	Is your disability expected to be long-term and indefinite duration or substantially impairs your ability to live independently?
Alcohol Abuse	☐	☐	☐ Yes ☐ No ☐ I don't know ☐ Prefer not to answer
Drug Abuse	☐	☐	☐ Yes ☐ No ☐ I don't know ☐ Prefer not to answer
Developmental Disability	☐	☐	☐ Yes ☐ No ☐ I don't know ☐ Prefer not to answer
HIV/AIDS	☐	☐	☐ Yes ☐ No ☐ I don't know ☐ Prefer not to answer

Mental Health Problem	☐	☐	☐ Yes	☐ No	☐ I don't know	☐ Prefer not to answer
Physical Disability	☐	☐	☐ Yes	☐ No	☐ I don't know	☐ Prefer not to answer
Chronic Health Condition	☐	☐	☐ Yes	☐ No	☐ I don't know	☐ Prefer not to answer

Are you currently covered by Health Insurance? ☐ Yes ☐ No ☐ I don't know ☐ Prefer not to answer

Answer 'Yes' or 'No' for each health insurance source. Answer 'Yes' for any source that is currently received. Answer 'No' for sources that have been terminated, even if they were received in the past. If the client selects 'Yes' for any insurance type, complete the shaded section below.

Health Insurance Type	Yes	No	Health Insurance Type	Yes	No
Medicaid	☐	☐	Health Insurance obtained through COBRA	☐	☐
Medicare	☐	☐	Private Pay Health Insurance	☐	☐
State Children's Health Insurance Program	☐	☐	State Health Insurance for Adults	☐	☐
Veteran's Administration (VA) Medical Services	☐	☐	Indian Health Services Program	☐	☐
Employer-Provided Health Insurance	☐	☐	Other (specify):	☐	☐

As a child were you ever in Foster Care or are you now? ☐ Yes ☐ No ☐ I don't know ☐ Prefer not to answer

If YES, number of years:

☐ Less than 1 year –Enter number of months:__ ☐ 1 – 2 years ☐ 3 – 5 or more years ☐ Prefer not to answer

If YES, how long ago did you exit Foster Care?

☐ 90 days ☐ 6 months ☐ 9 months ☐ 12 months ☐ More than 12 months

As of today's date are you between the ages of 14 to 25 (have not yet had your 26th birthday)?* ONLY if you are between the ages of 14 and 25, have you experienced any of the following?

☐ In-home services for your family (from DHHS)
☐ Guardianship or Adoption
☐ Probation or Incarceration
☐ Homelessness
☐ Human Trafficking
☐ Prefer not to answer
☐ N/A, no experience with any of these

Are you a domestic violence victim/survivor? ☐ Yes ☐ No ☐ I don't know ☐ Prefer not to answer

If YES, when did the experience occur?

☐ Within the past three months ☐ Three to six months ago ☐ From seven to twelve months ago
☐ More than a year ago ☐ Client does not know ☐ Prefer not to answer

If YES, Is the client currently fleeing?

☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused ☐ Data not collected

Sexual Orientation ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Other ☐ Questioning/Unsure ☐ I don't know ☐ Prefer not to answer

Are you currently pregnant or expecting a child? (Mother or Father)* ☐ Yes ☐ No ☐ I don't know ☐ Prefer not to answer

If pregnant, projected date of birth? ____ ____ / ____ ____ / ____ ____ ____ ____
Month Date Year

What is your Highest level of education attained?

☐ No schooling completed
☐ Nursery School - 4th grade
☐ 5th grade or 6th grade
☐ 7th grade or 8th grade
☐ 9th grade
☐ 10th grade
☐ 11th grade
☐ 12th grade, no diploma
☐ High School diploma
☐ I don't know
☐ Post-Secondary School
☐ Prefer not to answer

SECTION II: Household Information

Household Relationship Information

☐ Blended
☐ Couple with No Children
☐ Couple (Parent & Friend) w/ child(ren)
☐ Non-Custodial Caregiver(s)
☐ Foster Parent(s)
☐ Grandparent(s) and Child(ren)
☐ Single Female Parent
☐ Single Male Parent
☐ Single Person
☐ Two Parent Family
☐ Other

Housing Status

☐ Category 1 – Homeless
☐ Category 2 – At imminent risk of losing housing
☐ Category 3 – Homeless under other Federal Statues
☐ Category 4 – Fleeing violence
☐ At-risk of homelessness
☐ Stably housed
☐ I do not know
☐ Prefer not to answer

Zip Code of last permanent address

Including yourself, how many adults (people 18+) are in your household?*		
How many CHILDREN (people 17 and younger) are in your household? Enter 0 if no children live with you.*		
Do any of your children have a disability?*	☐ Yes, how many _____ ☐ No	☐ I don't know ☐ Prefer not to answer
Do you have full custody of your child/children?	☐ Yes ☐ No	☐ I don't know ☐ Prefer not to answer
Do you have an open or voluntary case with the Child Protective Services/ DHHS?	☐ Yes ☐ No	☐ I don't know ☐ Prefer not to answer

SECTION III: Assistance Request

You will be asked to provide documentation for certain needs such as rent support or unpaid bills, so please bring them with you if you can. Examples include: Shut off notices from utility companies, eviction notices, unpaid medical bills, estimate of health services, childcare assistance, etc.

What is your most urgent need? About how much does it cost? Please include as much detail as possible.

Check all that apply:

- ☐ Child Care Assistance
- ☐ Daily living (tel., clothes, hygiene)
- ☐ Dentist
- ☐ Education
- ☐ Employment
- ☐ Finances
- ☐ General Life Skills
- ☐ Housing
- ☐ Legal Help
- ☐ Mental Health
- ☐ Parenting Assistance
- ☐ Physical Health
- ☐ Substance Use
- ☐ Supportive Relationships
- ☐ Transportation
- ☐ Utilities
- ☐ Other:_____

Explain your need in as much detail as possible with cost information:

Where should we send payment?

Business Name:	Contact Name:	Phone #:	
Street Address:	City:	State:	Zip:

Have you been financially impacted by COVID-19?

☐ Yes	☐ No	☐ Unsure	☐ Prefer not to say

If yes, please explain:

Do you or your children QUALIFY for Medicaid, Title XX, and/or free and reduced lunch, even if you don't receive any of them? *

☐ Yes	☐ No	☐ Unsure	☐ Prefer not to say

Is there someone who doesn't live with you we can contact if we can't reach you?

☐ Yes, please list below:	☐ No	☐ Unsure	☐ Prefer not to say
Name:		Phone:	
Relationship to you (ex. friend, foster parent, etc):			

Do you have enough people to count on when you need someone to give you good advice?*

☐ Yes, how many? (write in number)	☐ No	☐ Unsure	☐ Prefer not to say

SECTION IV: Child/Children Intake Form					
	CHILD #1	**CHILD #2**	**CHILD #3**	**CHILD #4**	**CHILD #5**
Last Name					
First Name					
Last 4 Digits of SSN					
Date of Birth					
Gender	☐ Female ☐ Male ☐ Trans Female (MTF or Male to Female) ☐ Trans Male (FTM or Female to Male) ☐ Gender Non-Conforming (not exclusively male or female) ☐ I don't know ☐ Prefer not to answer	☐ Female ☐ Male ☐ Trans Female (MTF or Male to Female) ☐ Trans Male (FTM or Female to Male) ☐ Gender Non-Conforming (not exclusively male or female) ☐ I don't know ☐ Prefer not to answer	☐ Female ☐ Male ☐ Trans Female (MTF or Male to Female) ☐ Trans Male (FTM or Female to Male) ☐ Gender Non-Conforming (not exclusively male or female) ☐ I don't know ☐ Prefer not to answer	☐ Female ☐ Male ☐ Trans Female (MTF or Male to Female) ☐ Trans Male (FTM or Female to Male) ☐ Gender Non-Conforming (not exclusively male or female) ☐ I don't know ☐ Prefer not to answer	☐ Female ☐ Male ☐ Trans Female (MTF or Male to Female) ☐ Trans Male (FTM or Female to Male) ☐ Gender Non-Conforming (not exclusively male or female) ☐ I don't know ☐ Prefer not to answer
Race	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ I don't know ☐ Prefer not to answer	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ I don't know ☐ Prefer not to answer	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ I don't know ☐ Prefer not to answer	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ I don't know ☐ Prefer not to answer	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ I don't know ☐ Prefer not to answer
Ethnicity	☐ Non-Hispanic / Non-Latino ☐ Hispanic / Latino ☐ I don't know ☐ Prefer not to answer	☐ Non-Hispanic / Non-Latino ☐ Hispanic / Latino ☐ I don't know ☐ Prefer not to answer	☐ Non-Hispanic / Non-Latino ☐ Hispanic / Latino ☐ I don't know ☐ Prefer not to answer	☐ Non-Hispanic / Non-Latino ☐ Hispanic / Latino ☐ I don't know ☐ Prefer not to answer	☐ Non-Hispanic / Non-Latino ☐ Hispanic / Latino ☐ I don't know ☐ Prefer not to answer
Disabling Condition	☐ Yes ☐ No ☐ I don't know ☐ Prefer not to answer	☐ Yes ☐ No ☐ I don't know ☐ Prefer not to answer	☐ Yes ☐ No ☐ I don't know ☐ Prefer not to answer	☐ Yes ☐ No ☐ I don't know ☐ Prefer not to answer	☐ Yes ☐ No ☐ I don't know ☐ Prefer not to answer

Type of Disabling Condition (check all the apply if YES is marked on the previous question *Disabling Condition*)	☐ Alcohol Abuse ☐ Drug Abuse ☐ Developmental Disability ☐ HIV/AIDS ☐ Mental Health Problem ☐ Physical Disability ☐ Chronic Health Condition	☐ Alcohol Abuse ☐ Drug Abuse ☐ Developmental Disability ☐ HIV/AIDS ☐ Mental Health Problem ☐ Physical Disability ☐ Chronic Health Condition	☐ Alcohol Abuse ☐ Drug Abuse ☐ Developmental Disability ☐ HIV/AIDS ☐ Mental Health Problem ☐ Physical Disability ☐ Chronic Health Condition	☐ Alcohol Abuse ☐ Drug Abuse ☐ Developmental Disability ☐ HIV/AIDS ☐ Mental Health Problem ☐ Physical Disability ☐ Chronic Health Condition	☐ Alcohol Abuse ☐ Drug Abuse ☐ Developmental Disability ☐ HIV/AIDS ☐ Mental Health Problem ☐ Physical Disability ☐ Chronic Health Condition
Relationship to Participant/ Client	☐ Head of household's child ☐ Head of household's spouse or partner ☐ Head of household's other relation member ☐ (other relation to head of household) ☐ Other: non-relation member ☐ Prefer not to answer	☐ Head of household's child ☐ Head of household's spouse or partner ☐ Head of household's other relation member ☐ (other relation to head of household) ☐ Other: non-relation member ☐ Prefer not to answer	☐ Head of household's child ☐ Head of household's spouse or partner ☐ Head of household's other relation member ☐ (other relation to head of household) ☐ Other: non-relation member ☐ Prefer not to answer	☐ Head of household's child ☐ Head of household's spouse or partner ☐ Head of household's other relation member ☐ (other relation to head of household) ☐ Other: non-relation member ☐ Prefer not to answer	☐ Head of household's child ☐ Head of household's spouse or partner ☐ Head of household's other relation member ☐ (other relation to head of household) ☐ Other: non-relation member ☐ Prefer not to answer
Covered by Insurance	☐ Yes (check all that apply below) ☐ No ☐ I don't know ☐ Prefer not to answer	☐ Yes (check all that apply below) ☐ No ☐ I don't know ☐ Prefer not to answer	☐ Yes (check all that apply below) ☐ No ☐ I don't know ☐ Prefer not to answer	☐ Yes (check all that apply below) ☐ No ☐ I don't know ☐ Prefer not to answer	☐ Yes (check all that apply below) ☐ No ☐ I don't know ☐ Prefer not to answer
Health Insurance (check all the apply if YES is marked on the question "Covered by Insurance")	☐ Medicaid ☐ Medicare ☐ CHIP ☐ Veteran's Affairs ☐ Head of household's employer ☐ Head of household's COBRA ☐ Private Pay ☐ Indian Health Services ☐ Other:_____	☐ Medicaid ☐ Medicare ☐ CHIP ☐ Veteran's Affairs ☐ Head of household's employer ☐ Head of household's COBRA ☐ Private Pay ☐ Indian Health Services ☐ Other: _____	☐ Medicaid ☐ Medicare ☐ CHIP ☐ Veteran's Affairs ☐ Head of household's employer ☐ Head of household's COBRA ☐ Private Pay ☐ Indian Health Services ☐ Other:_____	☐ Medicaid ☐ Medicare ☐ CHIP ☐ Veteran's Affairs ☐ Head of household's employer ☐ Head of household's COBRA ☐ Private Pay ☐ Indian Health Services ☐ Other:_____	☐ Medicaid ☐ Medicare ☐ CHIP ☐ Veteran's Affairs ☐ Head of household's employer ☐ Head of household's COBRA ☐ Private Pay ☐ Indian Health Services ☐ Other:_____

OPTIONAL - Section V: Childcare Information			
This section needs to ONLY be completed if you are in need of childcare assistance.			
Name of Childcare Provider:		**Average Weekly Childcare Cost:**	
Childcare Provider Phone #:		**Average number of hours per week your child/children attend childcare:**	
Childcare Provider Address:			

SECTION VI: Household Income and Expenses Information		
	Participant/Client	**Adult #2**
Employer		
Hourly Wage		
Hours of Work per Week		
Are you out of work because of COVID-19?	☐ Yes ☐ I don't know ☐ No ☐ Prefer not to answer	☐ Yes ☐ I don't know ☐ No ☐ Prefer not to answer
Have you applied for Unemployment?	☐ Yes ☐ I don't know ☐ No ☐ Prefer not to answer	☐ Yes ☐ I don't know ☐ No ☐ Prefer not to answer

Source of Income	Yes	No	If yes, monthly amount from source:
Earned Income (from job/jobs)			$
Unemployment			$
SSI - Supplemental Security Income			$
SSDI - Social Security Disability Income			$
VA Service Connected Disability Compensation			$
VA Non-Service Connected Disability Pension			$
Private Disability Insurance			$
Worker's Compensation			$
TANF - Temporary Assistance for Needy Families			$
General Assistance (GA)			$
SSA - Social Security			$
Pension/Retirement Income from Former Job			$
Child Support			$
Alimony or Other Spousal Support			$
Contributions from Other People			$
Aid to Dependent Care (ADC)			$
Other (specify):			$
TOTAL MONTHLY INCOME FROM ALL SOURCES:			$0

PUBLIC BENEFITS – Do you have any non-cash benefits from any source?			
Source of Public Benefit	**Yes**	**No**	**If yes, monthly amount from source**
Housing Voucher/Section 8			$
LIHEAP - *Low Income Home Energy Program*			$
SNAP - *Supplemental Nutrition Assistance Program*			$
WIC - *Special Supplemental Nutrition Program for Women, Infants, and Children*			$
TANF Child Care Services			$
TANF Transportation Services			$
Other TANF-funded Services			$
Other (specify):			$
TOTAL NON-CASH BENEFIT:			**$**0

CURRENT MONTHLY LIVING EXPENSES

Expense Category	Amount of Expense	Expense Category	Amount of Expense
SAVINGS		**FAMILY**	
Emergency Plan		Life Insurance	
HOUSING		Childcare	
Rent/Mortgage		Allowance/Spending Money	
2nd Mortgage/Mobile Home Space		Alimony/Child Support	
Property Tax		**EDUCATION**	
Renters/Homeowners Ins		Tuition/School Expense	
Home Furnishings (ex. rent to own)		Music or Other Lessons	
Repairs & Improvements		Student Loans	
UTILITIES		**ENTERTAINMENT**	
Electricity/Water		Movie Rentals/Netflix	
Gas		Dining Out	
Trash		Sports/Hobbies	
FOOD		Vacations	
Groceries		Lottery/Gambling	
Food Bought at Work			
School Lunches		**PERSONAL**	
TRANSPORTATION		Hair Cut/Nails	
Car Payment #1		Toiletries/Cosmetics	
Car Payment #2		Tobacco/Alcohol/Drugs	
Gasoline		**BUNDLED SERVICES**	
Auto Insurance		Phone	
Maintenance/Tires		Cable/Satellite	
Parking/Carpool		Internet	
CLOTHING		**MISC**	
For Family		Pet Care	
Laundry		Other Debts/Garnishments	
HEALTH CARE			
Health Insurance**		**TOTAL EXPENSES**	0
Doctor/Dentist/Eye Care		**TOTAL INCOME**	
Prescriptions			
Other		**NET MONTHLY INCOME**	

SECTION VII: CR/CYI Participant Information Survey

INSTRUCTIONS: All parts of the Participant Information Survey should be completed at the start of participation in Community Response or the Connected Youth Initiative. The form may be completed with the assistance of a Central Navigator or other service provider, if needed.

I agree to have my information shared for the Evaluation below:	☐ **Yes**	☐ **No**
As part of the evaluation of Community Response and the Connected Youth Initiative, your data will be shared with Nebraska Children and their evaluators from Munroe-Meyer Institute. Your name will not be included in any of the information that is provided to the evaluation team. All data is summarized as a group. You can choose not to participate in the evaluation. If you have questions please call Dr. Barbara Jackson at 402-559-5765		
Participant Signature:	**Date:**	
Required if young person is 18 or younger - Signature of parent or legal guardian	**Date:**	

For each of the following, mark the response that most closely matches how you feel.

SOCIAL CONNECTIONS	**A. NOT AT ALL LIKE MY LIFE**	**B. NOT MUCH LIKE MY LIFE**	**C. SOMEWHAT LIKE MY LIFE**	**D. QUITE A LOT LIKE MY LIFE**	**E. JUST LIKE MY LIFE**	**N/A I DO NOT HAVE KIDS**
I have people who believe in me.	☐	☐	☐	☐	☐	
I have someone in my life who gives me advice, even when it's hard to hear.	☐	☐	☐	☐	☐	
When I am trying to work on achieving a goal, I have friends who will support me.	☐	☐	☐	☐	☐	
When I need someone to look after my kids on short notice, I can find someone I trust	☐	☐	☐	☐	☐	☐

I have people I trust to ask for advice about (check all that apply)	☐ Money/Bills/Budgeting ☐ Relationships and/or my love life ☐ Food/Nutrition	☐ Stress, Anxiety, and/or Depression ☐ Parenting/My kids (if applicable) ☐ None of the above

CONCRETE SUPPORTS	**A. NOT AT ALL LIKE MY LIFE**	**B. NOT MUCH LIKE MY LIFE**	**C. SOMEWHAT LIKE MY LIFE**	**D. QUITE A LOT LIKE MY LIFE**	**E. JUST LIKE MY LIFE**
I was able to cover all my expenses last month *(expenses include costs like rent, utility bills, food, transportation, child care, and medical expenses)*	☐	☐	☐	☐	☐
The transportation I use is reliable and consistent	☐	☐	☐	☐	☐
My housing situation is affordable, safe, and stable	☐	☐	☐	☐	☐
Over the past three months, my children and I have been able to see a doctor when we needed to. *(If you do not have children, answer for just yourself)*	☐	☐	☐	☐	☐
Over the past three months, I have found a job and/or worked when I needed to	☐	☐	☐	☐	☐

NMIS#:_____

NMIS
Nebraska Management Information System

Community Response and Homeless Management Information System (HMIS) Services Consumers Informed Consent & Release of Information Authorization

I_____understand information about me and/or my dependents listed in this application is entered into a database system called Clarity Human Services. This system helps to better understand homelessness, to improve service delivery, and to evaluate the effectiveness of services provided. Participation in data collection is a critical component of our community's ability to provide the most effective services and housing possible. The information that is collected is protected by limiting access to the database and limiting what information may be shared. Access to the data and sharing of the data is in compliance with the standards set by the federal, state, and local regulations governing confidentiality of client records. Every person and agency that is authorized to read or enter information into the system has signed an agreement to maintain the security and confidentiality of the information.

By signing this form, I authorize the following:
The information collected by this agency will be included in Clarity Human Services and only partner agencies, which have entered into an HMIS Agency Participation Agreement, may use it to:

- Produce a client profile at intake that will be shared with collaborating agencies
- Produce aggregate level reports regarding use of services
- Track individual program-level outcomes
- Identify unfilled service needs and plan for enhancements
- Allocate resources among agencies engaged in services
- Share information from the CR/CYI evaluation

By signing this form, I authorize the following:
I authorize the partner agencies and their representatives to share basic information regarding my family members listed below and/or me. I understand that this information is for the purpose of assessing my/our needs for housing, utility assistance, food, counseling, and/or other services.
Additionally, the United Way of South Central Nebraska Response System, its partners and community assistance organizations to communicate with and disclose to one another in verbal, written, electronic or facsimile in regard to services that are provided to me and my family on an as needed basis only. The purpose of disclosing basic information such as name and type/amount of assistance provided is to better coordinate services for the family and make the best use of limited community resources.

The information may consist of the following PPI (Personal Protected Information):

- Housing information
- Name
- Date of Birth
- Family Composition
- Health Insurance Status
- Income/Non-cash
- VI-SPDAT
- Residence Prior to Project Entry
- Gender
- Social Security Number
- Ethnicity and Race
- Client Location
- Veteran Status
- Services Provided
- Disabling Condition
- Homeless History
- Photo (if applicable)
- Domestic Violence
- Program Entry and Exit
- Assessments

I Understand That:

- ✔ The partner agencies have signed agreements to treat my information in a professional and confidential manner. I have the right to view the client confidentiality polices used by the HMIS partner agencies.
- ✔ Staff members of the partner agencies who will see my information have signed agreements to maintain confidentiality regarding my information.
- ✔ 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.
- ✔ My records are protected by federal, state, and local regulations governing confidentially of client records and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- ✔ This authorization will remain in effect until I revoke it in writing, and I may revoke authorization at any time, if I revoke my authorization, all information about me already in the database will remain.
- ✔ This release is valid for one year from the date of my signature below.
- ✔ I understand I may withdraw my consent at any time.
- ✔ I understand that the United Ways of South Central Nebraska Response System, the Central Navigator, and its partners and community assistance organizations cannot condition decisions about my treatment, payment, enrollment or eligibility for benefits or services on whether or not I sign this authorization. A copy of this authorization shall be as valid as the original.

Partner Agencies: A list of the partner agencies within the Nebraska Homeless Management Information System may be viewed prior to signing this form.

- ✔ Auditors or funders who have legal rights to review the work of this agency, including the U.S. Department of Housing and Urban Development and Nebraska Department of Health and Human Services Homeless Assistance Program may see my complete file in HMIS if services received are funded by their Department/s.

Please initial one of the following levels of consent:

_____ I give authorization to have Protected Personal and relevant Information for me and my dependents entered into the NMIS and shared between Partner Agencies.

OR

_____ I do not consent to the inclusion of personal information in the NMIS about me and any dependents.

_____
Participant Name

_____ _____
Participant/Client Signature Date

_____
Adult #2 Name

_____ _____
Adult #2 Signature Date

_____ _____
Witness Name Witness Position Title

_____ _____
Witness Signature Date

Information to be completed by the referral agency and/or Central Navigator	
Referral agency – please fill in the following before submitting this form to the Central Navigator:	
Referral Agency Name:	
Contact Phone Number:	
Referral Staff Member Name:	
Contact Email Address:	