EMERGENCY FLEXIBLE FINANCIAL FUND POLICY

Subject: Emergency Flexible Financial Fund

Date: **January 15, 2019**

PURPOSE:

To set minimum eligibility criteria and standardize the process for distribution of Emergency Flexible Financial Fund dollars to clients participating in the AIDS Foundation of Chicago Service Provider System.

POLICY:

The AIDS Foundation of Chicago receives funding through All Chicago that provides emergency flexible financial assistance to low income people in crisis and transition in the Chicago area (only).The funds are last resort, one time payments for items such as bus passes, ID's, work clothing, beds, medicine, eye exams or glasses, food, child care, rent, utilities etc. The cap for this assistance is $300 per household, once per year *(In the cases of extreme need the Service Provider may request approval of expenditures beyond the cap from AFC Staff, approval is not guaranteed and based on funding availability).*

PROCEDURE: Eligible Expenditures:

Expenditures must remove the threat of crisis in a cost-efficient manner:

1. Special items needed for a medical condition but not covered by any medical plan, such as humidifiers, bath chairs, handrails, air conditioners, syringes, orthopedic shoes, medical alert necklaces, lubricants and bandages
2. Important documentation, such as ID's, testing fees etc.
3. Essential home items, such as beds, refrigerators, blankets and linens for fire and flood victims or relocating families or for maintenance of good health (related to sleeping or eating).
4. Special clothing items for work or school, such as uniforms, coats and steel-toe boots
5. CTA / RTA passes to school, work, medical appointments & public aid appointments
6. Child care and child items
7. Gift cards for special dietary items not found at food pantries & personal hygiene items
8. Eye glasses and eye exams required for work or school
9. Phone bills when a medical condition requires phone service to the home
10. Medications prescribed by a physician.
11. Special items for families affected by violence and/or abuse, such as replacement locks, bus tickets out of state and child items
12. Other expenditures that prevent or avert crisis, must be approved by AFC staff before they are made.

Process to obtain assistance:

All Service Providers must complete the Emergency Fund application with clients who are requesting assistance. Staff will complete the application for the client requesting assistance and provide a detailed explanation of the emergency/crisis situation and provide the appropriate documentation. ***The client narrative must be specific in terms of the request for assistance and amount needed to resolve the crisis,*** which is an emergency situation that cannot be resolved by any other agency or means. The

items are to be reasonably priced and not have upgrades or luxury features. The cap amount is $300 but actual payment amounts will be determined by the documentation submitted and situation described in the narrative.

AFC will accept applications from Service Providers based on the designated calendar dates that will be provided at the start of the year. Applications received on those dates will be reviewed for eligibility. Service Providers will be notified within 2 business days if the request has been determined eligible.

Responsibilities of Client/Applicant

1. Clients may request Emergency Flexible Financial assistance from AFC Service Providers.

2. Applicants must provide Service Providers with adequate documentation that there is an emergency situation that cannot be resolved by any other means.

3. Applicants must provide documentation that their household income is less than 50% of the median household income in the Chicago area for their household size (per the official determination of the U.S. Department of Housing and Urban Development).

Responsibilities of Service Provider

1. The Service Provider will meet with clients to obtain necessary documentation including invoices for desired items and review for eligibility. The payment amount should reflect a tax exempt amount. The case manager must show their agencies tax exempt letter when requesting an invoice.

2. The Service Provider will indicate in the application and inform AFC Staff of desired payee/vendor. The Service Provider must confirm that the desired payee/vendor is willing to accept the check from AFC prior to submitting the application.

3. Service Provider will make arrangements to obtain check from AFC or have it mailed to Service Provider agency.

4. Service Provider will use check to pay the third party/vendor (purchase gift card, transit card)

5. The agency must have documentation on file (such as a receipt) that assistance was used for the purpose intended and these receipts must be sent to AFC Staff within **5 business days** of receipt.

Responsibilities of AFC:

1. AFC will cut a check to the appropriate third party/vendor and inform the Service Provider when it is available. No payments will be made directly to the applicant/client; all payments will be made directly to a third party/vendor (store gift card, transit card).

Clients who are dissatisfied with the process or results of their application for Emergency Fund will be provided the name and number of the Housing Stabilization Director, Alma Arroyo, 312-334-0966

Documentation Overview

Subject: Emergency Flexible Financial Fund
Date: **January 15th, 2018**

PURPOSE:

The Emergency Fund Program application requires the following forms be submitted in order for an application to be reviewed for eligibility. This document will provide a brief overview of each form, assisting the Service Provider in helping their clients gather and complete all needed forms when submitting an Emergency Fund Program application.

AFC Forms & Supporting Documentation Needed:

- AFC Vendor Request Form
- Vendor Invoice
- Documentation of Current Income
- AFC Consent to Enroll in Central Database Form
- AFC Consent to Release Information Form (2 pages)

All Chicago Forms Needed:

- Emergency Flexible Financial Fund- Client Service Form 2019 (2 pages)
- Chicago Homeless Management Information System-Client Consent for Data Sharing (3 pages)
- Homeless Management Information System (HMIS)-Supplemental Client Consent for Sharing of Certain Disability Data and Health Information (2 pages)

Emergency Flexible Financial Fund - Client Service Form (2019)

Date: ____/____/_____ Partner Agency: *AFC*

Client Information

First Name	Last Name	DOB	SSN (Last 4 digits only) DK REF DNC	Hispanic Y or N DK REF DNC	Race (circle all that apply) AI/AN A BL/AA NH/OP W Other DK REF DNC	Sex M F TF TM DK REF DNC GNC

Street Address _____ Zip Code _____

Phone # 1 _____ Phone # 2 _____

Monthly Household Income $_____ Referral Source: HPCC External Internal Self

Does the client have a disability? Yes No Is the client a Veteran? Yes No

2. Household Information (include everyone else *besides* the client who lives in the household)

First Name	Last Name	AGE	Hispanic Y or N DK REF DNC	Race (list all that apply in the spaces below) AI/AN A BL/AA NH/OP W Other DK REF DNC	Sex M F TF TM DK REF DNC GNC

CODE:
DK = Client Doesn't Know
REF = Client Refused
DNC = Data Not Collected
GNC = Gender Non-Conforming
AI/AN = American Indian/Alaskan Native
A = Asian
BL/AA = Black/African American
NH/OP = Native Hawaiian/Other Pacific Islander
W = White
M = Male
F = Female
TF = Trans Female
TM = Trans Male

3. Program Eligibility: Have you received these funds in the last 12 months? Y N

4. Homeless Prevention Services

Reason for assistance	Security Deposit/ Rental Application Fee	Rent	Mortgage	Utility
1. To maintain current residence.	$	$	$	$
2. To move from residence to other permanent housing.	$	$	$	$
3. To move from a shelter to permanent housing.	$	$	$	$

Revised: November 2018

5. Additional Financial Crisis Assistance

Type and Amount of assistance:	Amount
☐ Moving costs	$_____
☐ Storage costs	$_____
☐ Medical items	$_____
☐ Documents	$_____
☐ Child items	$_____
☐ Home items	$_____
☐ Transportation	$_____
☐ Child care	$_____
☐ Adult clothing	$_____
☐ Car repair	$_____
☐ Food	$_____
☐ Hygiene	$_____
☐ Training Cost	$_____
☐ Other: _____	$_____
Case Total:	$_____

6. Case Information

Reason for assistance (Select only one):

- ☐ Natural disaster
- ☐ Victimization by criminal activity
- ☐ Eviction
- ☐ Medical disability or emergency
- ☐ Homelessness
- ☐ Work hours decreased/Lost job/Laid off
- ☐ Moving
- ☐ Domestic Violence
- ☐ Displacement by private or government action
- ☐ Illegal landlord action
- ☐ Maintain/Enter subsidized housing
- ☐ Car Repair
- ☐ Death in family
- ☐ New baby
- ☐ Loss or delay of public benefits
- ☐ New job
- ☐ Household increase/decrease
- ☐ Imprisonment
- ☐ Displacement due to foreclosure
- ☐ Impoverished
- ☐ Other:_____

Please write a brief narrative detailing the crisis that caused the client's situation and the impact of the assistance. Be sure to include any case management or referrals you provided to the client. (Note: This information will be shared with staff of the Emergency Fund)

Upon approval, I understand that payment will be made on my behalf for the financial assistance described in Sections 4 & 5.

If approved, I understand that as part of receiving assistance I will be contacted and asked about the impact of this assistance. I agree to participate in the follow-up when contacted by the service provider.

I attest that all the information I have provided above and all the documentation I submit to complete this application for homeless prevention and/or crisis assistance is accurate and true to the best of my knowledge.

By signing my name below, I am confirming and agreeing to all the above statements.

Client Signature _____ Date _____

Case Manager Signature _____ Date _____

Revised: November 2018

AFC VENDOR REQUEST FORM

Vendor Name:

Address:

City State Zip:

Requested Amount:

I understand that any assistance provided must only be used for the above vendor and that I must obtain a receipt.
(Client Initials) _____

I understand that the Emergency Flexible Financial Fund program is a last resort, one-time, crisis solution payment and that I am not guaranteed to receive assistance.
(Client Initials) _____

I verify that the above information is accurate to the best of my knowledge.

Client Signature _____

Printed Name _____

Date _____

Service Provider Signature _____

Printed Name _____

Date _____

VENDOR INVOICE MUST BE ATTACHED

AFC CONSENT TO ENROLL IN CENTRAL DATABASE

I, *(enter client's name)* _____, consent to enroll in the centralized client database established by the AIDS Foundation of Chicago (the "Database") to assist and monitor the enrollment of persons receiving financial assistance through the AFC Emergency Fund Program application.

In connection with my enrollment in the Database, I hereby allow the following information to be furnished to the AIDS Foundation of Chicago for entry into the Database: my name (where applicable), date of birth, any positive or negative HIV status and other demographic data. In addition depending on funding source; services or financial assistance received may be reported. I understand that this information will be grouped together with that of other clients for the purpose of generating statistical reports, avoiding duplication of services and coordinating a system for service delivery to persons with or at risk of HIV, their family members, and/or significant others and specifically authorize the use of such information for that purpose.

_____
Signature of Client or Client's Legal Representative

_____
Print Name

_____
Date

_____
Relationship (if signed by person other than Client)

AFC CONSENT TO RELEASE INFORMATION

Subject to the limitations and conditions set forth below, I, _____ hereby consent to _____ ("Provider/Housing Advocate"), acting through its employees or agents, to use and/or disclose my health information and medical records to the AIDS Foundation of Chicago, the Emergency Fund and/or any sub-contracted agencies that provide services through them, as follows: (i) in connection with my participation in the centralized client database established by the AIDS Foundation of Chicago (the "Database") and the operation of the client database; (ii) to allow sharing of my case management agency with my housing advocate. (iii) to allow sharing of my rent mortgage or utility assistance enrollments with my case management agency. (iv) to enable the AIDS Foundation of Chicago and the Cooperative to conduct quality assurance programs for individuals receiving case management services through the Cooperative; (iiv) to avoid duplication of services by case management agencies; and (vi) in connection with the submission of reports and other data to funding sources.

In connection with my enrollment in the Database, I hereby give my consent for the following information to be furnished to the AIDS Foundation of Chicago for entry into the Database: my name (when applicable), date of birth, and other demographic data. In addition, verification of HIV positive status (if applicable) and dates of medical and case management service will be released to the AIDS Foundation. I understand that this information will be grouped together with that of other clients for the purpose of generating statistical reports, avoiding duplication of services and coordinating a system for service delivery to persons with HIV, their family members, and/or significant others and specifically authorize the use of such information for that purpose.

I further allow the program staff of the AIDS Foundation of Chicago and its designated Oversight Committee to review my individual service records as part of the funders quality assurance program. For the purposes of this consent, I acknowledge and agree that my service records include any and all records generated by any of the Provider agencies that participate in the Ryan White Northeastern Illinois Cooperative, AFC Supportive Housing Programs or Financial Assistance Programs.

Any information I provide for the purposes of receiving services will not be disclosed to any government agency or health department for purposes of surveillance, contact tracing, or any other purpose other than obtaining health care, housing, financial assistance or social services, except (1) with my consent, (2) as required by law, or (3) if necessary, to prevent a serious attempt to inflict harm on myself or others. Security precautions will be maintained to prevent unauthorized access to the Database by anyone other than the program staff of the AIDS Foundation of Chicago.

I give further consent to allow the AIDS Foundation of Chicago to report information that I provide in connection with my enrollment in the Database and in connection with my receipt of services to the federal grant programs that support the AIDS Foundation of Chicago. I understand that such information may be provided either in the aggregate or on an individualized basis. I understand that, in order to protect my privacy, any information that is provided on an individualized basis, with the exception of Title II funded service utilization, will be furnished using unique client codes, without names or other information that identifies me.

I further understand that should I receive service funded under Part A and B of the Ryan White CARE Act or IDPH HOPWA, certain information will be reported to the Direct Services Unit of the Illinois Department of Public Health and the Chicago Department of Public Health, including:

- demographic information, including but not limited to name, gender, race, ethnicity, and birth date; service utilization information; HIV/AIDS diagnosis and treatment information, if any; and mental health and/or substance use diagnosis, treatment, and service information, if any.

I understand that this information will be shared for the purposes of evaluating Part A and B and IDPH HOPWA service utilization patterns, on-site service reviews, and when necessary to coordinate services.

I can terminate this consent by submitting a written request to any of the Recipients (agencies in the Cooperative) indicating that I no longer desire to receive services through the Cooperative, or my written revocation of this authorization, whichever occurs first.

I understand that I have the right to receive a copy of this consent. I further understand that I may revoke this consent at any time by providing written notice of my intent to revoke this consent to Provider. This consent cannot be revoked to the extent that action has already been taken based on this consent.

This consent is valid for a period of two years from the date of the actual client signature below.

Provider will not use or disclose personal health information beyond the scope of this authorization without your written consent or authorization. Please note that, subject to applicable law, disclosed information may be subject to re-disclosure by the recipient, and may no longer be considered to be protected health information pursuant to the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

_____
Signature of Client or Client's Legal Representative

_____
Print Name

_____
Date

_____
Relationship (if signed by person other than client)

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Chicago Homeless Management Information System
Client Consent for Data Sharing

Agency Name: _____

This Agency is part of a group of stakeholders that coordinate their efforts to end homelessness in Chicago. This group is referred to in this document as the Chicago Homeless Management Information System (HMIS) Collaborative ("Collaborative", "we", or "us"). The Agency and members of the Collaborative collect your information and enter it into HMIS)*.

A representative of this Agency is going to ask you for information about you and your dependents. (The word "dependent" is used in this document to refer to any person under the age of 18 for whom you consider yourself to be responsible.) Once your information is entered into HMIS it will be shared as described below.

The purpose of this form is to allow you to decide how much of the information that you provide to this Agency can be shared with third parties and how it might be shared within the Collaborative. You may decline to allow this Agency to share any of your information other than to the system administrator of HMIS, which may disclose such information in accordance with the Standard Agency Privacy Practices Notice. If you decline, the ability of this Agency and the Collaborative to provide housing to you may be reduced, but this Agency will still provide emergency services to you.

PART I – BRIEF ANSWERS TO QUESTIONS YOU MAY HAVE

What Are the Reasons for Sharing Information about Me?

- Help service providers offer suitable housing and care options to you.
- Assist the Collaborative in documenting the need and obtaining funding for its housing and services.
- As described in the Standard Agency Privacy Practices Notice, as may be amended from time to time.

How Is My Data Protected?

- Every Agency is required to comply with the Standard Agency Privacy Practices Notice.
- Members of the Collaborative must sign an agreement to protect your privacy and comply with state and federal laws and policies before seeing any information.
- HMIS incorporates industry standard security requirements and is updated to stay current with these security requirements.

What Are My Rights?

- You can obtain an electronic version or paper copy of your information that has been entered HMIS upon request and obtain a list of partner agencies within the Collaborative,
- You can ask to amend or revoke the sharing of your information entered in HMIS at any time, by signing a new Consent form.

Are There Circumstances in Which My Information Might Be Disclosed Without My Consent?

- Yes, there are multiple reasons for which your information will be used or disclosed without your consent, which include but are not limited to for administrative functions, payment or reimbursement of services, when required by law, system maintenance and reporting, and academic research purposes described in the Standard Agency Privacy Practices Notice, as may be amended from time to time.

For more detailed information, ask to see a copy of our Standard Agency Privacy Practice Notice.

PART II – YOUR CONSENT

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Basic Information:

This information will be shared through HMIS and with members of the Collaborative.

- Personal Identifying Information (Name, Social Security Number, Date of Birth, Gender, Veteran Status, photo)
- Personal identifying information about your dependents (if applicable) (*Note*: Anyone 18 years of age or older must sign a separate consent form.)
- Enrollment information (may include your past enrollment information)
- Recipient Identification Number (if you do not know the number we will try to look it up)
- Contact information

Coordination of Care and Housing Information:

This information, along with other information from the HMIS, will be used or disclosed for the purposes of matching you to the appropriate services and possible housing, to conduct referrals and assessments, to determine program eligibility, to otherwise collaborate to address specific needs and circumstances, and to share information in case conference meetings for the purposes of finding and/or coordinating services for you and your dependents.

Information about your military service (if applicable)

- Experience with homelessness and living situation (housing status)
- Household income and source(s)
- Presence of a current disabling condition
    - Illinois law requires us to obtain your explicit consent to share information with respect to mental health, substance use, and/or HIV/AIDS issues. ***A separate consent form will be offered to you before you are asked to share information about these conditions.***
- Services you receive, including your receipt of financial assistance
- Medical insurance/primary care provider information

For purposes of this consent, Basic Information and Coordination of Care and Housing Information shall be referred to herein collectively as the "information".

I,_____(Name) agree to share information as detailed below.

A. **Share my information** to provide housing and/or coordinate services to help me end my homelessness.

B. **Share my information as a locked file** to provide housing and/or coordinate services to help me end my homelessness.

Note: The locked file will be visible to the system administrators and be shared with the agencies overseeing/assigned to providing me with matching of housing and care, and agencies I am currently receiving or received services from. My information will not be used or disclosed at case conference meetings for finding and/or coordinating services for me. ***Information from Survivors of Domestic Violence and/or Human Trafficking will automatically be treated only as locked file.***

C. **Do not agree to share any information:** I do not want any of the information about me shared for the purposes of housing and /or coordination of care; I understand the system administrator will have access and my information may be shared in accordance with the Standard Agency Privacy Practices Notice. I acknowledge that if my information is shared as permitted or required, I may be contacted by agencies to which my information was disclosed.

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When you sign this form, it shows that you:

- Acknowledge that certain information may be shared without your consent in accordance with the Standard Agency Privacy Practices Notice, as may be amended from time to time.
- Read this Client Consent or heard an explanation of its contents.
- Understand this consent does not expire unless you withdraw your consent to share at any time by signing a new copy of this Consent; however, any information already shared with another agency cannot be taken back or revoked.
- Understand that housing providers may record significant incidents in which you are involved in their programs, and that these incidents will be shared with the entities that provide emergency services, housing coordination and outreach services for matching individuals to appropriate programs.

Names of Dependents (please list ALL dependents):

Name 1: _____ **Name 2:** _____

Name 3: _____ **Name 4:** _____

Name 5: _____ **Name 6:** _____

Data Sharing Selection for Head of Household (check one):

A. Share my information

B. Share my information as a locked file

C. Do not agree to share any information.

Data sharing selection for all dependents, as listed (check one, if applicable):

A. Share my information

B. Share my information as a locked file.

C. Do not agree to share any information.

Client or Representative Signature: _____ **Date:** _____

Agency Witness Signature: _____ **Date:** _____

For Organization Use only: (Initial all that apply)

The Client above received a telephonic explanation of this form, as needed. On behalf of the Client, staff at this agency served as the representative. The Consent was read in its entirety. _____

An authorized representative completed this consent for the Client. A description of the representation as required by the agency is approved and included in the file.

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Homeless Management Information System (HMIS)

Supplemental Client Consent for Sharing of Certain Disability Data and Health Information

Agency Name: _____

This Supplemental Client Consent for Sharing of Certain Disability Data and Health Information should be completed at the time of initial assessment, in addition to the Client Consent for Data Sharing. This supplemental consent is consistent with the policies laid out in the All Chicago Making Homelessness History HMIS Standard Agency Privacy Practice Notice ("Privacy Notice"). The current version of the Privacy Notice and a list of partners in the Collaborative can be viewed at www.allchicago.org. Alternatively, the agency you are working with should also be able to provide you with these documents upon request.

We are required by law to obtain your explicit consent to share information with respect to your experience with mental health issues, HIV/AIDS, and substance abuse. Some agencies within the Collaborative have specific eligibility requirements. Sharing this information allows us to connect you with as many housing and care options as possible for which you might be eligible.

This information will be collected as part of your assessment and will be disclosed by the agency you are working with to the Collaborative to improve the ability of the Collaborative to make an appropriate housing match and coordinate care on your behalf. You may decline to share this information as noted below, but doing so may make it more difficult for the participating agencies in the Collaborative to qualify you for assistance suited to your needs.

Please check the appropriate box below:

_____ I consent to the use and disclosure of my mental health condition, HIV/AIDS status, alcohol and/or drug abuse history, as may be applicable, with the Collaborative. I authorize the agency providing me with services to enter my mental health condition, HIV/AIDS status, alcohol and/or drug abuse history, as may be applicable, into the HMIS and I authorize the Collaborative to use such information to make an appropriate housing match and coordinate care on my behalf. In addition, I authorize the use and disclosure of my mental health condition, HIV/AIDS status, alcohol and/or drug abuse history, as may be applicable, on an aggregate basis so long as my information is de-identified.

____I decline to share any information relating to my mental health condition, HIV/AIDS, alcohol and/or drug abuse for the purposes of matching or other specific services; provided that I understand that the foregoing information will be; (i) shared among a certain cohort of assessors within the Collaborative, only if this information is being collected as part of the Standardized Housing Assessment and (ii) used and disclosed on an aggregate basis so long as my information is de-identified and I expressly authorize the foregoing.

____I do not presently experience the above conditions or have any information to share.

This authorization shall be in force and effect for seven years from the date of signing, at which time this authorization to use or disclose this information expires.

I understand that I have the right to inspect and copy any mental health information included in or made part of the information disclosed in accordance with this consent.

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I understand that the Collaborative will not disclose information about my experience with these conditions without my specific written authorization unless a disclosure is authorized by applicable law including Confidentiality of Alcohol & Drug Abuse Patient Records (42 CFR, Part 2). I also understand that I may revoke my authorization to disclose this information by signing a new copy of this Supplemental Client Consent in which I decline future sharing of the information. I understand that my revocation will not be effective to the extent that my information has been used or disclosed in reliance on this consent. I also understand that the Collaborative will not use or disclose personal health information beyond the scope of this authorization without my written authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act. However, except as provided herein, information regarding mental health, HIV/AIDS, substance abuse and alcoholism may not be disclosed by the person or entity authorized herein to receive said information without my express written consent.

If I am requesting disclosure of psychological test material, I understand that all records related to any psychological testing shall only be disclosed to a psychologist designated by me.

Client Name: _____

Client Signature: _____ Date: _____

Agency Witness: _____ Date: _____

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