LA BOSCOC Disability Certification

This form is to be completed when a participant may be eligible for Permanent Supportive Housing through the Continuum of Care (CoC) Program. The U.S. The Department of Housing and Urban Development (HUD) requires housing projects to verify all information that is used to document eligibility, including disability diagnosis. Your local coalition to end homelessness asks for your expertise in ensuring this person is eligible for services. The participant has consented to this release of information.

Homeless services staff shall complete ROI on page 2.

Recipient:	**Date:**
Participant Name:	**Participant DOB:**
Return this document to:	
Return Address:	**Return Fax:**

Verification by a Qualified Licensed Professional
A certified professional with one of the following credentials must complete this form:
MD, DO, LPC, LCSW, APRN-BC, or NP.

I certify that this person has been diagnosed with at least one of the following:

- ❑ A physical, mental or emotional impairment, including an impairment caused by alcohol or drug abuse, post traumatic stress disorder, or brain injury that indefinite in duration and substantially impedes the individual from living independently and could be improved by the provision of more suitable housing conditions;
- ❑ A developmental disability, as defined in Section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002), i.e., a person with a severe chronic disability that is attributable to a mental or physical impairment or combination of mental and physical impairments; Is manifested before the person attains age 22; Is likely to continue indefinitely; Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated. Results in subsational functional limitation in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning mobility, self- direction, capacity for independent living, and economic self-sufficiency;
- ❑ The disease of acquired immunodeficiency syndrome (AIDS) or any condition rising from the etiologic agency for acquired immunodeficiency syndrome (HIV).

Name and Licensure:

Organization:

Signature and Date:

Consent for the Release of Confidential Information
Louisiana Services Network Data Consortium (All Providers)

Authorization to Release or Obtain Information
(including paper, oral and electronic information)

To better address some needs and coordinate services, a request may be made to share sensitive personal information that is protected from public disclosure. Confidential information can include, but is not restricted to, health-related issues (physical and mental impairments, illnesses and conditions, addictions and treatments); domestic violence issues; or issues related to unaccompanied youth.

Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Medicaid ID# or Social Security #

I authorize:
Name: _____
Mailing Address: _____
City, State, Zip Code _____ Phone: _____
□ **To Release Information TO** **OR** □ **To Obtain Information FROM**
(***Place an "X" in the box that indicates if the information is being released OR requested***)

Name: _____
Mailing Address: _____
City, State, Zip Code: _____
Relationship: _____ Telephone Number: _____

The Purpose of this Authorization is indicated in the box(es) below (*Place an "X" in the box(es) that apply.)*
□ Eligibility Determination
□ Other: (Specify) _____

I authorize the release of the following protected health information.
(*Place an "X" in the box(es) that apply to the information you want released or you want to obtain.*)

□ Entire Record □ Medical History, Examination, Reports □ Surgical Reports
□ Treatment of Tests □ Prescriptions □ Immunizations □ Laboratory Reports
□ Hospital Records including Reports □ X-ray Reports □ MR/DD Reports
□ Other: _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records:

□ Alcoholism □ Drug Abuse □ Mental Health □ Vocational Rehabilitation □ HIV (AIDS)
□ Sexually Transmitted Diseases □ Genetics □ Psychotherapy Notes □ Foster Care Records
□ Other _____

This authorization shall expire on _____ (date or event) and is needed for the period beginning _____ and ending _____.
□ I understand that if I do not specify an expiration date, this authorization will expire twelve (12) months from the date signed.
□ I acknowledge that I have fully read this form.
□ The regulations are the Federal Law of Confidentiality for Alcohol and Drug Abuse Patients, (42 CFR, Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CRF, Parts 160 & 164.
□ I understand that there may have been information shared and services provided based on this consent when it was in effect. Ending this consent cannot change that.

_____ _____
Signature of Individual or Personal Representative Authorized by Law Date

_____ _____
Signature of Witness (*If signed with an "X" or mark*) Date

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You do not have to sign this form. If you agree to sign this authorization to release or obtain information, you will be given a signed copy of the form. If you do not agree to release of information required to determine your eligibility for enrollment in our program or to determine your entitlement to benefits we may not be able to make the required eligibility determinations.