ARIZONA BEHAVIORAL HEALTH CORPORATION

Housing Application
AHCCCS Housing Programs

APPLICANT INFORMATION

Last Name	First Name	Middle Initial	Gender	Social Security Number

Phone Number:	Second Phone Number:	Email Address:

Do you use any other Social Security Number or Name(s)? ☐ No ☐ Yes SSN: Name(s):	Date of Birth (MM/DD/YY)

Are you a citizen of the U.S? ☐ Yes ☐ No	AHCCCS ID Number:	Title XIX (AHCCCS) ☐ Yes ☐ No	Designation: ☐ SMI ☐ GMH/SU

Are you a veteran? ☐ Yes ☐ No	Please write in your Health Plan name:

Race – Check All that Apply	Ethnicity
☐ White ☐ Black or African American ☐ American Indian/Native Alaskan ☐ Asian/Pacific Islander ☐ Other	☐ Hispanic ☐ Non-Hispanic

Please check which GSA you would like to live:	Please check one or both Housing Types you wish to apply to:
☐ Central ☐ Northern ☐ Southern	☐ Scattered Sites (SS) ☐ Community Living Program (CLP) **(SMI Only)**

Will family members be living in the household ☐ Yes ☐ No # of adults: # of children:

List any county preferences:

List any special housing type needs:

REFERRING AGENCY

Case Manager Name:	Provider Name:	Clinic/Health Home Site:

Provider Address:	Phone Number:	Email Address:

Identified Housing Need to be completed by approved representative:

☐ Actual Homelessness

☐ Institutional or Hospital Discharge

☐ Other Identified Housing Crisis, please specify:

- ☐ Fleeing domestic violence
- ☐ Frequent hospitalization
- ☐ Housing instability

All applications and questions can be sent to AHPapplications@azabc.org.

Applicant Signature: _____ Date: _____

Agency Rep Signature: _____ Date: _____

Agency Rep Title: _____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosures and/or use of individually identifiable health information, as set forth below, consistent with Arizona and Federal law concerning the privacy of such information. Failure to provide all information requested will invalidate this Authorization.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use and disclosure of my Protected Health Information (PHI) as follows:

Enrolled Member Name:

Persons/Organizations authorized to use or disclose the information:

- **Arizona Behavioral Health Corporation (ABC)**
- **Arizona Health Care Cost Containment System (AHCCCS)**
- **HOM, Inc. (HOM)**
- **The Managed Care Organization with whom the member is enrolled.**
- **The service team, case manager, care coordinator or other designated housing supportive service provider the member may be working with.**

Purpose of the use or disclosure:

> **Information will be used to facilitate, manage and comply with State and Federal requirements related to the Federal and/or State housing subsidy of the individual named above and to assist the member in attaining and maintaining housing placement and subsidy support.**

This Authorization applies to the following information

> **Name, AHCCCS enrollment and enrollment in RBHA or any successor corporation that contracts with the State of Arizona to provide behavioral health services in Arizona, verification of Serious Mental Illness diagnosis and information required to verify eligibility and prioritization for the housing program.**

EXPIRATION

> **This authorization will expire one year from the date this document is signed below.**

RESTRICTIONS

This Authorization may not be used to release Substance Abuse or Confidential Communicable Disease/1-IIV information in combination with any other health care information. Federal law requires a specific Authorization be used for the disclosure of this information.

If we share you PHI with the people or agencies that you name, they may share it with others if allowed under the law.

YOUR RIGHTS

I understand that I may refuse to sign this Authorization. My refusal to sign will not affect my ability to obtain, treatment, payment, or my eligibility of benefits. I may inspect or copy any information used or disclosed under this Authorization, unless the information is contraindicated as determined by my psychiatrist. **I do understand that my refusal to sign may prevent me from participation in any in any housing program administered by ABC.**

I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf by an authorized representative. My revocation will be effective upon receipt but will not be effective to the extent that the Requesting Party or others have acted in reliance upon this Authorization. **I do understand that my revocation may prevent me from continued participation in any housing program administered by ABC.**

I have a right to receive a copy of this Authorization.

MEMBER SIGNATURE

Signature: _____
Enrolled Member/Representative/Guardian

Date: _____

If signed by someone other than the Enrolled Member, state your relationship to the Member:

_____

REFERRING AGENCY SIGNATURE

Name: _____

Title: _____

Date: _____

Note: This form may not be used to release psychotherapy notes in combination with other types of health information (45 CFR § 164.508(b)(ii). If this form is being used to authorize the release of psychotherapy notes, a separate form must be used to authorize release of any other Protected Health Information.