abc
ARIZONA BEHAVIORAL HEALTH CORPORATION

Housing Application
AHCCCS Housing Programs

APPLICANT INFORMATION (ALL FIELDS MUST BE COMPLETED)

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)? Yes No SSN: Name(s):			Date of Birth (MM/DD/YY):	
Are you a citizen of the U.S? Yes No	AHCCCS ID Number:	Application Type: New Transfer	Designation: SMI GMH/SU & T19	
Are you a veteran? Yes No	Please write in your Health Plan name (No Acronyms):			

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 region in AZ you would like to live:	Please check one or both Housing Types you wish to apply to:
Northern Arizona Central Arizona Southern Arizona	Scattered Sites (SS) Community Living Program (CLP) **(SMI Only)** *(check all that apply)* Shared Housing Independent Housing ACT Housing With Service Supports Specialty Location (Central AZ Only), if so list type:
Will family members be living in the household Yes No # of adults: # of children:	
List AZ county preference:	

REFERRING AGENCY

BH Clinic/Health Home Agency Name:	BH Clinic/Health Home Site:	BH Clinic/Health Home Address:
Case Manager Name:	Phone Number:	Email Address:
Clinical Coordinator or Housing Specialist:	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:

> **<u>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.</u>**

This Authorization applies to the following information

> **<u>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.</u>**

EXPIRATION

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

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.