

Do you have a housing subsidy or voucher (such as CMHA Section 8)?	
Are you enrolled in PIPP?	
Do you have an eviction court date? If yes, when?	
What is your monthly rent or mortgage amount?	
How much rent or mortgage do you owe?	
How much do you owe for gas/electric?	
About how many months of gas/electric are you behind?	
Do you have a Caracole case manager? If yes, who?	

These questions help Caracole decide which applications have the greatest need. **Please include details** about your situation to help us understand your need.

What happened that made you fall behind on your rent, utilities, or mortgage?

Are you currently dealing with any additional health conditions, financial problems, or other special circumstances? Please describe.

How much assistance do you think you will need before paying your rent, mortgage, or utilities on your own again?

We will respond to your application within 1 week via the contact information you provided. Please do not contact our offices to follow up on your application unless it has been more than 7 days since you applied.

This release of information will be used to contact your HIV doctor to verify that you are living with HIV. If your doctor is not listed or you (the person completing this form) are not the person in your household living with HIV, leave this form blank and we will contact you for other verification.

Authorization for Release of Confidential Information

By signing below, I, _____ (print name) authorize _____ (HIV medical provider) to disclose information to **Caracole Inc.;** and/or _____ (print name) authorize **Caracole Inc.** to disclose information to _____ (HIV medical provider) for the purpose of receiving and coordinating services.

- My health information
- My finances
- My legal history
- Services I have requested and/or received
- Mental Health
- Substance Use Disorders and Treatment
- Communicable Disease (including HIV, AIDS or AIDS Related Conditions)

The information cannot be shared except for these purposes.

I know that:

- I do not have to sign this form. I can still receive services if I do not sign this form.
- I have the right to have all of my questions about this form answered before signing.
- Information released may include information concerning testing, diagnosis or treatment of HIV, AIDS, AIDS Related Conditions, mental health and/or drug/alcohol treatment.
- Information about drug and alcohol treatment is protected by federal law and cannot be re-disclosed without your consent. Other information could be disclosed again if the receiving organization is not required by state or federal privacy law to protect it.
- I can end the release of information at any time over the phone, in person or in writing to stop the sharing of information. If I end this release of information the "authorization revoked*" portion of this form will be completed. **Information already shared cannot be taken back.**

This release of information will end in thirteen (13) months, and I will need to sign a new form at that time.

SIGNATURE: _____ DATE: _____

Prohibition on re-disclosure: *Information that has been disclosed to you from records whose confidentiality is protected by federal law (42 CFR Part 2) is prohibited from being further disclosed without specific consent from the person to whom it pertains.*

*AUTHORIZATION REVOKED

In writing

Verbally

COMPLETED BY: _____ DATE: _____