



Client Needs Assessment

*We use this to assess your current needs
and ensure you have needed support to address any concerns.
Project Place will develop a plan to address needed resources and options.*

		Notes
Do you have access to shelter?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have access to food and clean water?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have access to personal protective gear to avoid illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Soap or hand sanitizer to clean hands	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Disinfectants to clean surfaces	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mask to wear in public	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Gloves	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have enough clean clothing and/or access to laundry machines?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is your physical health currently stable?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you experiencing any symptoms?		
Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Temperature	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Muscle Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No	
New loss of taste or smell	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If you are in recovery, is this a current concern for you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you been using today?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Within the past week?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is it possible you are detoxing from any substances that may be dangerous for your health?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Narcotics?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Benzodiazepine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Stimulants?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you currently experiencing a mental health crisis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have supports?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you familiar with the BEST team?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you concerned about your safety or the safety of another person or group of people?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you currently fleeing domestic violence?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Other Notes:



RELEASE OF INFORMATION

Client Name: _____

Date of Birth: _____ **S.S. #:** _____

I hereby give permission to **Project Place** to exchange information in order to collaborate with community partners to assist me in meeting personal goals while I am a Project Place client.

Furthermore, I give permission to Project Place staff to have two-way communication with the following individuals or service providers in order to collaborate and assist me in meeting my employment, housing and personal goals while I am a Project Place client.

Name/Title	Agency	Email	Phone/Fax

The information exchanged between Project Place staff and service providers is related to: *mark an X next to all that apply*

Housing	___	Recovery supports	___	Legal Obligations	___
Physical Health	___	Mental Health	___	Other	___

Project Place staff and I have discussed this release of information, and I fully understand its purpose. I voluntarily consent to the disclosure of the above information.

I further release Project Place, their programs and employees from any liability arising from said release of information if done substantially in accordance with applicable law.

I, _____, affirm that I have reviewed with client, _____, the above information and have recorded their answers accurate and honestly.

Signature of Intake Coordinator

Date

Federal regulations prohibit any further disclosure of information obtained without the specific written consent of the person to whom it pertains.



**COVID-19 Boston Homeless Assistance Network (HAN) Release:
Client Authorization for Coordinating Services**

_____ (Client name), hereby verbally authorizes each *Homeless Assistance Network (the "Network")* member (see below) to share any and all personal information with any other member of the Network as may be necessary to provide and coordinate services requested or may from time to time request. The client specifically consents to the release to any other member of the Network of case notes, substance use records, mental health records, domestic violence records, HIV status, and criminal records information. They also authorize each member of the Network to share this information electronically, orally or otherwise. They understand that a photocopy or digital copy of this authorization is as valid as the original.

**If this person is not 18 years of age, a parent or guardian verbally accept on their behalf.*

Date Case Manager Signature

Case Manager Name/Agency Printed

- COVID-19 HAN release allows for client to give verbal authorization to a case manager in person, by phone, or virtually. Client must be aware that this authorizes their information to be shared. For clients who do not wish to share their information to be shared, a Limited CAS release (boston.gov/limited-cas-release) should be used.
- COVID-19 HAN release is to be used to limit in person contact between clients and case managers per CDC instructions during the COVID-19 crisis.
- COVID-19 HAN release is only valid during the COVID-19 crisis. The Department of Neighborhood Development for the City of Boston will announce when this document should cease to be used.
- COVID-19 HAN releases signed, dated, and submitted during the crisis will be valid until the Department of Neighborhood Development announces cessation of use of the release at which point standard HAN releases signed by the clients will need to be obtained for clients who have used the COVID-19 HAN release.
- This authorization will expire after 24 months since last contact with any member of the Network.
- Client may withdraw this authorization at any time by informing any member of the Network in writing or verbally that they no longer want my information shared among them.
- Client understand that members of the Network will not deny service provision or payments based on whether they sign this authorization. However, the client understands coordination among the members of the Network for services that they have requested may be impacted by not doing so.
- By signing this form, the client allows Member organizations to share their information as may be necessary to provide services requested or may from time to time request. However, the client understands that their information may be redisclosed by the recipient and may no longer be protected by the Member’s privacy policies or by applicable state or federal law or regulation.
- Additional agencies may join the Network and will have access and permission to share their information. The list of agencies in the Network is attached. An updated list of agencies is posted online at boston.gov/han-providers. The list may also be requested at any time from any member agency.

Boston Homeless Assistance Network (HAN) Providers

Below is a list of the member agencies of the Boston Homeless Assistance Network. Additional agencies may join the network at any time. An updated list of agencies is posted online at boston.gov/han-providers and may also be requested from any of the participating agencies.

Bay Cove	Eliot Community Human Services	Middlesex Human Services
Boston Housing Authority	Ecumenical Social Action Committee	New England Center and Home for Veterans
Boston Healthcare for the Homeless	HEARTH	Pine Street Inn
Boston Medical Center	Home for Little Wanderers	Project Place
Boston EMS	Home Start	St. Francis House
Boston Public Health Commission	Justice Resource Institute	US Department of Veteran Affairs
Boston Rescue Mission	Metro Housing Boston	Volunteers of America
Bridge Over Troubled Waters	Massachusetts Housing and Shelter Alliance	Women's Lunch Place

A Division of BOSTON PLANNING & DEVELOPMENT AGENCY **BENEFICIARY INCOME VERIFICATION FORM**

DATE	LAST NAME	FIRST NAME	Middle Initial	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ADDRESS		CITY	ZIP CODE	
TELEPHONE NUMBER		DATE OF BIRTH	I.D. # (If applicable)	

NEIGHBORHOODS (Check zip code you live in)

<input type="checkbox"/> ALLSTON/BRIGHTON - 02134, 02135, 02146 <input type="checkbox"/> CHARLESTOWN - 02129 <input type="checkbox"/> CHINATOWN / DOWNTOWN - 02109, 02110, 02111, 02114 <input type="checkbox"/> EAST BOSTON - 02128 <input type="checkbox"/> FENWAY - 02115, 02215 <input type="checkbox"/> HYDE PARK - 02136 <input type="checkbox"/> JAMAICA PLAIN - 02130 <input type="checkbox"/> MATTAPAN - 02126	<input type="checkbox"/> NORTH or SOUTH DORCHESTER - 02122, 02124, 02125 <input type="checkbox"/> NORTH END - 02113 <input type="checkbox"/> ROSLINDALE - 02131 <input type="checkbox"/> ROXBURY - 02119, 02120, 02121 <input type="checkbox"/> SOUTH BOSTON - 02127 <input type="checkbox"/> SOUTH END / BACKBAY - 02118, 02108, 02116 <input type="checkbox"/> WEST ROXBURY - 02132, 02167
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<p>RACE/ETHNICITY/ MULTI-RACE</p> <table style="width:100%;"> <tr> <td style="width:50%; vertical-align: top;"> <input type="checkbox"/> WHITE (Non-Latino) <input type="checkbox"/> BLACK (Non- Latino) <input type="checkbox"/> HISPANIC <input type="checkbox"/> AMER. INDIAN / ALASK. NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> HAITIAN <input type="checkbox"/> CAPE VERDEAN <input type="checkbox"/> OTHER: _____ </td> <td style="width:50%; vertical-align: top;"> <input type="checkbox"/> HAWAIIAN/PACIFIC ISLANDER <input type="checkbox"/> AFRICAN AMER & WHITE <input type="checkbox"/> ASIAN & WHITE <input type="checkbox"/> AMER. INDIAN & WHITE <input type="checkbox"/> AMER. INDIAN/ALASKAN & WHITE <input type="checkbox"/> AMER. INDIAN/ALASKAN & BLACK </td> </tr> </table>	<input type="checkbox"/> WHITE (Non-Latino) <input type="checkbox"/> BLACK (Non- Latino) <input type="checkbox"/> HISPANIC <input type="checkbox"/> AMER. INDIAN / ALASK. NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> HAITIAN <input type="checkbox"/> CAPE VERDEAN <input type="checkbox"/> OTHER: _____	<input type="checkbox"/> HAWAIIAN/PACIFIC ISLANDER <input type="checkbox"/> AFRICAN AMER & WHITE <input type="checkbox"/> ASIAN & WHITE <input type="checkbox"/> AMER. INDIAN & WHITE <input type="checkbox"/> AMER. INDIAN/ALASKAN & WHITE <input type="checkbox"/> AMER. INDIAN/ALASKAN & BLACK	<p>PARTICIPANT CHARACTERISTICS (Check off all that apply)</p> <input type="checkbox"/> TAFDC RECIPIENT <input type="checkbox"/> VETERAN STATUS <input type="checkbox"/> DISABLED <input type="checkbox"/> REFUGEE/ENTRANT <input type="checkbox"/> FEMALE-HEADED HOUSEHOLD <input type="checkbox"/> BHA RESIDENT
<input type="checkbox"/> WHITE (Non-Latino) <input type="checkbox"/> BLACK (Non- Latino) <input type="checkbox"/> HISPANIC <input type="checkbox"/> AMER. INDIAN / ALASK. NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> HAITIAN <input type="checkbox"/> CAPE VERDEAN <input type="checkbox"/> OTHER: _____	<input type="checkbox"/> HAWAIIAN/PACIFIC ISLANDER <input type="checkbox"/> AFRICAN AMER & WHITE <input type="checkbox"/> ASIAN & WHITE <input type="checkbox"/> AMER. INDIAN & WHITE <input type="checkbox"/> AMER. INDIAN/ALASKAN & WHITE <input type="checkbox"/> AMER. INDIAN/ALASKAN & BLACK		

***Mark the HOUSEHOLD SIZE box and select ONE of the three income options going across ON THE SAME LINE.**
 Example: a 3-person household with an annual income of \$17,000 would be marked on the third row, as **Extremely-Low Income**.

<input checked="" type="checkbox"/> 3 Persons	<input checked="" type="checkbox"/> \$0 to \$27,900	<input type="checkbox"/> \$27,901 to \$46,550	<input type="checkbox"/> \$46,551 to \$70,350
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HOUSEHOLD SIZE (Including You)	Extremely-Low Income (30% of Median)	Very-Low Income	Low Income
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<input type="checkbox"/> 1 Person	<input type="checkbox"/> \$0 to \$21,700	<input type="checkbox"/> \$21,701 to \$36,200	<input type="checkbox"/> \$36,201 to \$54,750
<input type="checkbox"/> 2 Persons	<input type="checkbox"/> \$0 to \$24,800	<input type="checkbox"/> \$24,801 to \$41,400	<input type="checkbox"/> \$41,401 to \$62,550
<input type="checkbox"/> 3 Persons	<input type="checkbox"/> \$0 to \$27,900	<input type="checkbox"/> \$27,901 to \$46,550	<input type="checkbox"/> \$46,551 to \$70,350
<input type="checkbox"/> 4 Persons	<input type="checkbox"/> \$0 to \$31,000	<input type="checkbox"/> \$31,001 to \$51,700	<input type="checkbox"/> \$51,701 to \$78,150
<input type="checkbox"/> 5 Persons	<input type="checkbox"/> \$0 to \$33,500	<input type="checkbox"/> \$33,501 to \$55,850	<input type="checkbox"/> \$55,851 to \$84,450
<input type="checkbox"/> 6 Persons	<input type="checkbox"/> \$0 to \$36,000	<input type="checkbox"/> \$36,001 to \$60,000	<input type="checkbox"/> \$60,001 to \$90,700
<input type="checkbox"/> 7 Persons	<input type="checkbox"/> \$0 to \$38,450	<input type="checkbox"/> \$38,451 to \$64,150	<input type="checkbox"/> \$64,151 to \$96,950
<input type="checkbox"/> 8 Persons or more	<input type="checkbox"/> \$0 to \$40,950	<input type="checkbox"/> \$40,951 to \$68,250	<input type="checkbox"/> \$68,251 to \$103,200

***Mark the source(s) of Income Documentation:**

<input type="checkbox"/> TAFDC	<input type="checkbox"/> CHILD SUPPORT	<input type="checkbox"/> PUBLIC HOUSING: _____ (name of development)
<input type="checkbox"/> SSI/SSDI	<input type="checkbox"/> ALIMONY	
<input type="checkbox"/> FOOD STAMP	<input type="checkbox"/> SECTION 8	
<input type="checkbox"/> REFUGEE ASSISTANCE	<input type="checkbox"/> UNEMPLOYMENT INSURANCE	<input type="checkbox"/> OTHER: _____
<input type="checkbox"/> BPS SCHOOL DATA	<input type="checkbox"/> PAYCHECK / W-2	

I hereby confirm that the information that I have provided on this form is true and accurate to the best of my knowledge.

I, _____, affirm that I have reviewed with client, _____, the above information and have recorded their answers accurate and honestly.

PROGRAM INTERVIEWERS SIGNATURE: _____

DATE: ____

**Information collected in this form is confidential and only used to verify that CDBG funds benefit eligible Boston residents.*



**Department of Transitional Assistance
Permission to Share Information Form (PSI)**

Organizations must keep the signed PSI form on file and make the form available to DTA upon request.

Section 1: DTA Client or Applicant

Client/Applicant Name

DTA Agency ID or Last Four Digits of SSN

Date of Birth

Section 2: Information to be Shared (check one or both)

I allow DTA to share information about my TAFDC, EAEDC and/or SNAP case with the **SNAP Outreach Partner** organization named in Section 3.

I allow DTA and the **SNAP Path to Work Provider** named in Section 3 to share information about my TAFDC, EAEDC and/or SNAP case to determine my eligibility for the SNAP Path to Work program and to share information about my participation and progress in the SNAP Path to Work program.

By signing below, I also give permission for DTA to get records about my employment status from other state agencies, federal agencies and from Equifax Workforce Solutions.

Section 3: SNAP Outreach Partner/SNAP Path to Work Provider

Interseminarian Project Place, Inc.

Name of Organization

617-542-3740

Phone Number

1145 Washington Street Boston, MA 02118

Address of Organization

Organization ID

Section 4: Right to Change Your Mind:

You may change your mind and stop sharing this information. To stop it, you must:

- call 1-877-382-2363 during regular business hours and speak to a DTA Representative; or
- send a written request to: DTA Document Processing Center, P.O. Box 4406, Taunton, MA 02780 or fax to (617) 887-8765

Section 5: Signature

Complete at the time of the remote intake

I, _____, affirm that I have reviewed with client, _____, the above information and have recorded their answers accurate and honestly.

*****WE MUST OBTAIN A SIGNATURE FROM CLIENTS via Postal Mail, Docusign or Adobe Fill and Sign*****

I understand that when I sign below, I am giving permission to DTA and the organization named in Section 3 to share information about my case.

Client/Applicant Signature

Date

This form is **valid for two years** from the date of the applicant/client signature, unless revoked (see Section 4).