KITSAP COMMUNITY RESOURCES
Creating Hope | Restoring Lives

Dear applicant,

Attached to this letter are forms for you to apply for Energy Assistance and a list of all of the documentation that we will need in order to process your application. **Please print out the forms, fill in your information on the highlighted areas, and sign them.**

Once you have signed the forms and obtained all of the required documents, you may scan and email them to energy@kcr.org or fax it to us at (360) 525-6191.

If you prefer to mail in photocopies of your documents, please send it to:

Kitsap Community Resources – Attn: Energy Department
845 8th St
Bremerton, WA 98337

All forms and documents must be submitted to us within two weeks of scheduling your appointment.

If you are unable to submit your documents by the deadline given, please contact us at energy@kcr.org or (360) 479-1507 to discuss your situation and/or request additional time. We will try to accommodate you as best as we can, but please keep in mind that we may request additional documentation from you if we have to extend your deadline.

When your application has been processed you will be notified by mail of the amount of assistance you qualifed for. Please continue to make whatever payments you can on your bill until you have seen the credit noted on your account.

If there are any questions or concerns, please contact the Energy Department at energy@kcr.org or (360) 479-1507.

Sincerely,
Energy Department
Kitsap Community Resources

KITSAP COMMUNITY RESOURCES
Creating Hope | Restoring Lives

YOU MUST SUBMIT THE FOLLOWING DOCUMENTS THAT PERTAIN TO YOUR HOUSEHOLD.

Current heat bill: ☐ Puget Sound Energy ☐ Cascade Natural Gas ☐ Water

Annual billing history: ☐ Oil ☐ Propane ☐ Wood/Pellets

☐ **Renter:** Up-to-date Section 8 / Subsidized Lease / Rental Agreement / Mobile Home Lot Rental Agreement
(If you are on a month-to month lease or your rental agreement states that your rental period will end before the date of your appointment, your agreement is considered outdated and your landlord will need to fill out our Landlord Statement.)

☐ **Homeowner:** Current Mortgage Statement or Loan Modification / Title / Release Deed / Canceled Note
(If you are in foreclosure, please also provide current foreclosure information.)

☑ **Social Security cards for EVERYONE** residing in the home.

☑ **Picture IDs** for everyone **18 years old** or older residing in the home.

☑ **Address verification:** Any mailed document for everyone **18 years old** or older residing in the home.

Due to the pandemic, our programs allowed us flexibility on income requirements. Please provide income documentation for all household members for only the last month: _____ .
This includes, but is not limited to the following list. Additional documentation may be requested for clarification. Example: If you schedule an appointment in January you would provide December income.

☐ **Employment:** All check stubs or payroll print out showing **gross pay** for everyone 18 years old or older.

☐ **Unemployment:** You must obtain a wage report **and** unemployment report from the Employment Security website: https://secure.esd.wa.gov/home/

☐ **Anyone 18 years old or older in the home with NO income** must verify no income status by providing a bank statement, and obtaining a wage report and unemployment report from the Employment Security website: https://secure.esd.wa.gov/home/

☐ **Current School Enrollment Paperwork** for anyone who is **18 years old and still in high school**.

☐ **Enrolled in College:** Printouts of all Educational Assistance (i.e. grants, loans, and/or work-study) and bank statement showing any financial aid deposits and/or refunds.

☐ **Self-Employment: Business License required. KCR Self-employment form must be completed.** Please provide all checking and savings bank statements from personal and business accounts.

☐ **Rental Income:** Current rental agreement(s) and rental receipts for tenant(s).

☐ **Public assistance** (TANF / ABD / HEN / etc.)**:** Current award letter or printout showing grant amount.

☐ **Social Security, Veterans Benefits, Pension or Retirement:** Current award letter.

☐ **L&I:** You must obtain a history report from L&I located at **10049 Kitsap Mall Blvd. #100 – Silverdale**. Phone: (360) 308-2800

☐ **Receiving/Paying Child support or Spousal Maintenance:** Monthly statement from Child Support Enforcement or bank statement showing deposits.

Washington State Department of Commerce, Low Income Home Energy Assistance Program (LIHEAP)

HOUSEHOLD INFORMATION FORM (HIF) (7/2016)

***Agency:** 65	**Assistance Provided:** ❑ *Energy Assistance **OR** ❑ *Crisis - Imminent **OR** ❑ *Crisis - No Heat ❑ Other Emergency Services ☑ Conservation Education	❑ Interested in Weatherization ❑ Tribal Member ❑ Received Food Assistance ❑ Heat with rent ❑ Received EAP last program year	**File Number:**
***County:** 18			**Certification Date:**

SECTION A: Household Contact & Eligibility Information

***Primary Applicant:** _____
(Last Name) (First Name) (Middle Initial)

***Residence Address:** _____

City, State, Zip: _____

Mailing Address: _____
(*If different*)
City, State, Zip: _____

Phone Number:	**Message Phone:**	**Lived at Residence:**
( ) -	( ) -	**Years:** **Months:**

***Housing Status:**	***Housing Type:**	***Income/Benefits:**	***Total Number of People in the Household:**
1 ❑ Own/buy 2 ❑ Subsidized 3 ❑ Rental 4 ❑ Roomer/Boarder 5 ❑ Temp Housing **Cost per Month:** **$**	1 ❑ 1-3 Family 2 ❑ 4+ Family 3 ❑ Hi-Rise 4 ❑ Mobile 5 ❑ RV **Number of Bedrooms:**	❑ SSI ❑ Earned Income ❑ TANF ❑ Pension ❑ GA ❑ Self Employed ❑ VA ❑ Child Support ❑ Soc. Sec. ❑ Unemployment ❑ Military ❑ Other	***Household's Monthly Income:** **$**

Target Group #1:	***Primary Heat Source:**	***Annual Heat Cost:** $_____ ❑ Back Up Heat Cost
❑ Yes ❑ No	1 ❑ Electric 4 ❑ Oil	**Total Energy Cost:** $_____ ❑ Used Surrogate Data
Target Group #2:	2 ❑ Natural Gas 5 ❑ Wood	***Total Annual Electric Costs:** $_____
❑ Yes ❑ No	3 ❑ Propane 6 ❑ Coal	

SECTION B: Energy Assistance (EAP)

Staff: _____ **P.O.#:** _____

HOUSEHOLD ELIGIBILITY AMOUNT: $_____

Payment to Vendor(s): **Direct Pay to Applicant:** $_____

#1 _____ Acct. #: _____ $_____

#2 _____ Acct. #: _____ $_____

TOTAL EAP PAID TO DATE: $_____

SECTION C: Other Emergency Services (OES)

Staff: _____ **P.O.#:** _____

Heat System: Repairs ❑ Vendor #: _____ $_____

Replacement ❑ Vendor #: _____ $_____

Other Repairs & Services: Vendor #: _____ $_____

Vendor #: _____ $_____

Shelter Assistance: Vendor #: _____ $_____

TOTAL OES PAID TO DATE: $_____

I certify that I have provided and reviewed all information on each page of this document and it is accurate to the best of my knowledge. I understand that I may be subject to criminal prosecution if I have knowingly provided false information. I further understand that I may request a Fair Hearing if the provision of the above information is not acted on to determine my eligibility within a reasonable time or if I do not receive benefits for which I feel I am eligible. I give my permission for this agency and Washington State Department of Commerce (COMMERCE) to request/release necessary information that may result in my receiving benefits from this assistance request and from similar and related programs administered by the State of Washington, including food assistance. I also give the above listed heating vendor(s) permission to establish a line of credit, and/or to release my account information to this agency or COMMERCE for current and future data analysis and eligibility determination. I understand that provision of my social security number is necessary to avoid duplicate energy assistance benefit payments to the same applicant household. I hereby authorize energy program staff to also use my social security number for income verification purposes (including Employment Security Unemployment Insurance and DSHS Food Assistance). I further authorize this agency and COMMERCE to use my personal information within their organizations for the purpose of identifying and reporting unduplicated non-personal applicant data.

***Applicant Signature:** _____ **Date:** _____

(**Note:** All fields designated with an (*) are required information.)

Washington State Department of Commerce, Low Income Home Energy Assistance Program (LIHEAP)

Household Member Information Form (7/2016)

*Last Name	*First Name	MI	*SSN (required if primary) X X X-X X-X X X X	*DOB __ __/__ __/__ __ __ __

*Relation to Primary	*Gender / Ethnicity	Race	Education (24 Years or Older)	Disabled / Military Veteran / Health Insurance
☑ Self ❑ Spouse ❑ Partner ❑ Child ❑ Other Relative ❑ Other Non-Relative	***Gender** ❑ Male ❑ Female **Ethnicity** ❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Multi-Race ❑ Other	❑ 0-8 ❑ 9-12 Non-Graduate ❑ High School Graduate/GED ❑ 12+ Some Post-Secondary ❑ 2 or 4 Year College Graduate **Included in Calculation** ☑ Yes ❑ No	**Disabled** ❑ Yes ❑ No **Military Veteran** ❑ Yes ❑ No **Health Insurance** ❑ Yes ❑ No

* Last Name	* First Name	MI	*SSN (required if secondary) X X X-X X-X X X X	*DOB __ __/__ __/__ __ __ __

*Relation to Primary	*Gender / Ethnicity	Race	Education (24 Years or Older)	Disabled / Military Veteran / Health Insurance
❑ Spouse ❑ Partner ❑ Child ❑ Other Relative ❑ Other Non-Relative **Secondary Applicant** ❑ Yes ❑ No	***Gender** ❑ Male ❑ Female **Ethnicity** ❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Multi-Race ❑ Other	❑ 0-8 ❑ 9-12 Non-Graduate ❑ High School Graduate/GED ❑ 12+ Some Post-Secondary ❑ 2 or 4 Year College Graduate **Included in Calculation** ☑ Yes ❑ No	**Disabled** ❑ Yes ❑ No **Military Veteran** ❑ Yes ❑ No **Health Insurance** ❑ Yes ❑ No

* Last Name	* First Name	MI	SSN X X X-X X-X X X X	*DOB __ __/__ __/__ __ __ __

*Relation to Primary	*Gender / Ethnicity	Race	Education (24 Years or Older)	Disabled / Military Veteran / Health Insurance
❑ Spouse ❑ Partner ❑ Child ❑ Other Relative ❑ Other Non-Relative	***Gender** ❑ Male ❑ Female **Ethnicity** ❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Multi-Race ❑ Other	❑ 0-8 ❑ 9-12 Non-Graduate ❑ High School Graduate/GED ❑ 12+ Some Post-Secondary ❑ 2 or 4 Year College Graduate **Included in Calculation** ☑ Yes ❑ No	**Disabled** ❑ Yes ❑ No **Military Veteran** ❑ Yes ❑ No **Health Insurance** ❑ Yes ❑ No

* Last Name	* First Name	MI	SSN X X X-X X-X X X X	*DOB __ __/__ __/__ __ __ __

*Relation to Primary	*Gender / Ethnicity	Race	Education (24 Years or Older)	Disabled / Military Veteran / Health Insurance
❑ Spouse ❑ Partner ❑ Child ❑ Other Relative ❑ Other Non-Relative	***Gender** ❑ Male ❑ Female **Ethnicity** ❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Multi-Race ❑ Other	❑ 0-8 ❑ 9-12 Non-Graduate ❑ High School Graduate/GED ❑ 12+ Some Post-Secondary ❑ 2 or 4 Year College Graduate **Included in Calculation** ☑ Yes ❑ No	**Disabled** ❑ Yes ❑ No **Military Veteran** ❑ Yes ❑ No **Health Insurance** ❑ Yes ❑ No

* Last Name	* First Name	MI	SSN X X X-X X-X X X X	*DOB __ __/__ __/__ __ __ __

*Relation to Primary	*Gender / Ethnicity	Race	Education (24 Years or Older)	Disabled / Military Veteran / Health Insurance
❑ Spouse ❑ Partner ❑ Child ❑ Other Relative ❑ Other Non-Relative	***Gender** ❑ Male ❑ Female **Ethnicity** ❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Multi-Race ❑ Other	❑ 0-8 ❑ 9-12 Non-Graduate ❑ High School Graduate/GED ❑ 12+ Some Post-Secondary ❑ 2 or 4 Year College Graduate **Included in Calculation** ☑ Yes ❑ No	**Disabled** ❑ Yes ❑ No **Military Veteran** ❑ Yes ❑ No **Health Insurance** ❑ Yes ❑ No

* Last Name	* First Name	MI	SSN X X X-X X-X X X X	*DOB __ __/__ __/__ __ __ __

*Relation to Primary	*Gender / Ethnicity	Race	Education (24 Years or Older)	Disabled / Military Veteran / Health Insurance
❑ Spouse ❑ Partner ❑ Child ❑ Other Relative ❑ Other Non-Relative	***Gender** ❑ Male ❑ Female **Ethnicity** ❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Multi-Race ❑ Other	❑ 0-8 ❑ 9-12 Non-Graduate ❑ High School Graduate/GED ❑ 12+ Some Post-Secondary ❑ 2 or 4 Year College Graduate **Included in Calculation** ☑ Yes ❑ No	**Disabled** ❑ Yes ❑ No **Military Veteran** ❑ Yes ❑ No **Health Insurance** ❑ Yes ❑ No

Note: All fields designated with an (*) are required information. SSN's for the primary and secondary applicants are also required.

PUGET SOUND ENERGY

PSE HELP APPLICATION

AGENCY # *(Required)*	COUNTY	CERTIFICATION DATE	FILE # *(Optional)*
65	18		

SECTION A: HOUSEHOLD INFORMATION *(Required)*

APPLICANT'S NAME (LAST)	(FIRST)	(MIDDLE INITIAL)	LAST FOUR OF SSN	DATE OF BIRTH (MM/DD/YY)
SECOND ADULT IN HOUSEHOLD (LAST)	(FIRST)	(MIDDLE INITIAL)	LAST FOUR OF SSN	DATE OF BIRTH (MM/DD/YY)

EMAIL ADDRESS

RESIDENCE ADDRESS	CITY	STATE	ZIP
MAILING ADDRESS (IF DIFFERENT THAN RESIDENCE)	CITY	STATE	ZIP

PHONE ( )	MESSAGE PHONE ( )	DATE MOVED INTO RESIDENCE (MM/DD/YY)

SECTION B: BILLING INFORMATION *(Required)*

HOW DOES APPLICANT'S NAME APPEAR ON PSE BILL?

☐ **PRIMARY** ☐ **CO-CUSTOMER** ☐ **NOT LISTED***

*Note: PSE will sign you up for service as co-customer, or primary dependent on Section B questions 1-4.

If the Applicant is the Primary on the PSE bill please skip to Section C.

PRIMARY NAME ON PSE BILL (LAST)	(FIRST)	(MIDDLE INITIAL)	LAST FOUR OF SSN	DATE OF BIRTH (MM/DD/YY)

Is the Primary name listed on the PSE bill:

1. At least 18 years of age or emancipated*? No ___ Yes ___
2. Still living at residence*? No ___ Yes ___
3. Spouse of applicant? No ___ Yes ___
4. Deceased spouse of applicant No ___ Yes ___

(If you answer "yes" to #4, the Applicant's name will appear as primary. Their account number will be changed.)

***Note:** If you answered No to questions 1 or 2, PSE will automatically sign you up for service as the primary and contact agency with your new account number. PSE may contact landlord to avoid discrepancies. A Deposit may be requested. Payment arrangements may be made on the deposit by contacting customer service prior to the due date @ 1-888-225-5773 M - F 7:30 am - 6:30 pm.*

SECTION C: HELP

TOTAL # PEOPLE IN HOUSEHOLD

HOUSEHOLD MEMBERS (VOLUNTARY) *# of people in household who are:*

___ 0-2 yrs ___ 3-5 yrs ___ 6-17 yrs ___ 60+ yrs ___ Disabled ___

HOUSING STATUS	HOUSING TYPE	ENERGY TYPE	ANNUAL USAGE COST	INCOME SOURCE(S)	INCOME
1 ☐ Own/buy	1 ☐ 1-3 Family	1 ☐ All Electric	☐ Back Up Energy Cost	1 ☐ SSI 7 ☐ PEN	Household's Monthly Income
2 ☐ Subsidized	2 ☐ 4+ Family	2 ☐ Gas + Electric	☐ Used Surrogate Data	2 ☐ TANF 8 ☐ MIL	
3 ☐ Rental	3 ☐ Hi-Rise	3 ☐ Gas only	Gas $_____	3 ☐ GA 9 ☐ CS	
	4 ☐ Mobile	4 ☐ Electric Base	Electric $_____	4 ☐ VA 10 ☐ UI	$_____ . _____
$_____ per month	5 ☐ RV		LIHEAP Heat Cost $_____ (If applicable)	5 ☐ SSA 11 ☐ Self Employ	
			Total $_____	6 ☐ EI 12 ☐ Other	

RECEIVED LIHEAP THIS PROGRAM YEAR?: ☐ YES ☐ NO

$_____

STAFF NAME

INTERESTED IN HOME WEATHERIZATION?: ☐ YES ☐ NO

PURCHASE ORDER #

2-Year Certification

Certify eligibility for two years after demonstrating a steady household income.

Not Applicable: _____
1st Year Qualified: _____
2nd Year Qualified: _____
No Steady Income Source(s) & Occupant(s): _____

#1 Gas Acct. # _____ vendor # _____ $_____

vendor # _____ $_____

#2 Electric Acct. # _____ vendor # _____ $_____

vendor # _____ $_____

APPLICANT'S TOTAL ELIGIBILITY AMOUNT: $_____

I certify that I have provided and reviewed the above information, which is accurate to the best of my knowledge. I understand that I may be subject to criminal prosecution if I have knowingly provided false information. Additionally, I hereby authorize Puget Sound Energy, Inc. ("PSE"), this Agency, and Washington State Department of Commerce (COMMERCE) to exchange and release, disclose and make available to each other, information about me, my use of PSE products and services and/or my application for or participation in the PSE HELP program. This includes any information furnished or disclosed by me to this Agency herein or otherwise and any other information necessary or useful in assessing, documenting or confirming my eligibility or ineligibility to receive PSE HELP benefits (including Employment Security, Unemployment Insurance and DSHS Food Stamp benefits) or for current or future data analysis related to the provision of these or similar benefits. I do so with full knowledge that this information is or may be confidential and as such will be protected as outlined in PSE, COMMERCE, or this Agency's privacy policy, as those policies are updated from time to time (see, e.g., PSE's Privacy Policy). I understand that this authorization may be revoked at any time by written notice to PSE and or this Agency. Until such time as I do so revoke this authorization in writing, however, this authorization shall remain in full force and effect and PSE, this Agency, and COMMERCE may rely on this authorization in exchanging, releasing, disclosing and making available to each other all such information.

APPLICANT'S SIGNATURE	DATE

HOUSEHOLD MEMBER and INCOME INFORMATION

List all household members, their sources of income and the gross amount each member received from each source for the previous three months.

Household Members

Include last names and ages of children, beginning with the PRIMARY applicant)

Total Income For Months:

DEDUCTIONS
10% deduction for retirement (if taxed)
10% deduction for unemployment (if withheld)
20% deduction for earned income (if withheld)

NOTE: No deductions on earned income if not withheld

					N/A	N/A				
Name(s)	**Age(s)**	**Income Source**	**Code**	Month 1	Month 2	Month 3	**Total Gross**	**Applied (%)**	**Amount**	**Adjusted Gross**

Documentation Used (Code)

A.) No Income Statement
B.) Self Declaration
C.) Bank Statement
D.) Pay Stubs
E.) Award Letter
F.) Payroll Printout
G.) Other _____

I certify that the above information I have provided is a complete and accurate list of all household members and their income for the months listed above. I understand that I am signing this form under penalty of criminal prosecution if I knowingly give false information which results in payment to which I am not entitled.

Applicant's Signature **Date** **Staff Initials**

Calculations

Total Adjusted Gross Income _____

Number of Months 1

Average Monthly Income _____

How much is the rent/mortgage?

KITSAP COMMUNITY RESOURCES
Creating Hope | Restoring Lives

For Administrative Use Only:

_____ _____
KCR Staff Signature Date

AUTHORIZATION TO RELEASE & SHARE INFORMATION

KITSAP COMMUNITY RESOURCES (KCR) is requesting your permission to share your confidential information within KCR in order to plan, provide, and coordinate services for your household.

You are not required to give your consent to share your confidential information. If you do not consent to share your confidential information, your confidential information will only be shared to the extent allowed by state and federal law.

I, _____ allow KCR to release my confidential information to
CLIENT NAME

the following KCR departments within the Housing & Community Support Services Division:

Please check the appropriate box(es):

- ☐ **KCR – Weatherization**
- ☐ **KCR – Housing**
- ☐ **KCR – Housing Solutions Center**
- ☐ **KCR – Veterans**

I understand that I have the right to refuse to sign this form and that I may revoke my consent at any time in writing (except to the extent that the information has already been released with my consent prior to my revocation).

_____ _____
CLIENT SIGNATURE DATE

Client Identification			
NAME	DATE OF BIRTH	IDENTIFICATION NUMBER	
ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NUMBER (INCLUDE AREA CODE)	OTHER INFORMATION		

Washington State Department of Social & Health Services
Transforming lives

Consent

Notice to Clients: The Department of Social and Health Services (DSHS) can help you better if we are able to work with other agencies and professionals that know you and your family. By signing this form, you are giving permission for DSHS and the agencies and individuals listed below to use and share confidential information about you. DSHS cannot refuse you benefits if you do not sign this form unless your consent is needed to determine your eligibility. If you do not sign this form, DSHS may still share information about you to the extent allowed by law. If you have questions about how DSHS shares client confidential information or your privacy rights, please consult the DSHS Notice of Privacy Practices or ask the person giving you this form.

Consent

1. I consent to the use of confidential information about me within DSHS to plan, provide, and coordinate services, treatment, payments, and benefits for me or for other purposes authorized by law. I also grant permission to DSHS and the below listed agencies, providers, or persons to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or electronically, by mail, or hand delivery.

   Reason for Disclosure: This information is required before DSHS can share drug and alcohol or mental health records. If you do not fill in this field, DSHS will note the reason for disclosure as being at your request.

   Please check all below who are included in this consent in addition to DSHS and identify them by name and address:

   - ☐ Health care providers: _____
   - ☐ Mental health care providers: _____
   - ☐ Substance use disorder service providers: _____
   - ☐ Other DSHS contracted providers: _____
   - ☐ Housing programs: _____
   - ☐ School districts or colleges: _____
   - ☐ Department of Corrections: _____
   - ☐ Employment Security Department and its employment partners: _____
   - ☐ Social Security Administration or other federal agency: _____
   - ☐ See attached list
   - ☐ Other:

2. Reason for disclosure: ☐ Continuity of care ☐ Legal ☐ Personal ☐ Other:

3. I authorize and consent to sharing the following records and information (check all that apply):
   - ☐ All my client records ☐ Records on attached list
   - ☐ Only the following records
     - ☐ Family, social and employment history
     - ☐ Treatment or care plans
     - ☐ Payment records
     - ☐ Individual assessments
     - ☐ School, education, and training
     - ☐ Mental health care information (specify):
     - ☐ Health care information (specify):
     - ☐ Other (list):

Client Identification		
NAME	DATE OF BIRTH	IDENTIFICATION NUMBER

Please note: If your client records include any of the following information, you must also complete this section to include these records.

I give my permission to disclose the following records (check all that apply):

☐ Mental health ☐ HIV/AIDS and STD test results, diagnosis, or treatment ☐ Substance Use Disorder

- **This consent is valid for one-year or ☐ until _____ (date or event).**
- **I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared.**
- **I understand that records shared under this consent may no longer be protected under the laws that apply to DSHS.**
- **A copy of this form is valid to give my permission to share records.**

SIGNATURE		DATE
WITNESS / NOTARY SIGNATURE, IF APPLICABLE	WITNESS / NOTARY PRINTED NAME	DATE
PARENT OR OTHER REPRESENTATIVE'S SIGNATURE (IF APPLICABLE)	TELEPHONE NUMBER (INCLUDE AREA CODE)	DATE

If I am not the subject of the records, I am authorized to sign because I am the: (attach proof of authority)

☐ Parent ☐ Legal Guardian (attach court order) ☐ Personal representative ☐ Other:

Notice to Recipients of Information: **If these records contain information about HIV, STDs, or AIDS, you may not further disclose that information without the client's specific permission.** If you have received information related to **drug or alcohol abuse** by the client, you must include the following statement when further disclosing information as required by 42 CFR 2.32:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Instructions for Completing the Consent Forms, DSHS 14-012

Use: Use this form when you need consent to use or share confidential information about a client on a continuing basis about a client within DSHS or to disclose that information to other agencies to coordinate services or for treatment, payment or agency operations or for other purposes recognized by law.

Fill out this form electronically if possible. You must complete **a separate form for each person, including children.** .

Parts of Form:

IDENTIFICATION:

- Name: Provide the name of only one client on each form. Include any former names that client may have used when receiving services.
- Date of Birth: Needed to identify client from persons with similar names.
- Identification Number: Provide a client identification number or other identifier such as a social security number (not required) to assist in identifying records and tracking history and services received.
- Other: Include in this box any additional information that may help to locate records, such as DSHS involved with services, names of family members, or other relevant information.

CONSENT (AUTHORIZATION):

- Reason for disclosure: This information is required before DSHS can share drug and alcohol or mental health records. If you do not fill in this field, DSHS will note the reason for disclosure as being at your request.
- Agencies or persons exchanging records: This completed form allows: (1) the use and disclosure of confidential information inside DSHS and with the agencies or persons listed; and (2) disclosure of confidential information to DSHS by the outside agencies or persons listed. You may also attach a list of agencies allowed to share information, which the client must also sign.
- Information included: Clients must indicate what records are covered by the consent. Clients may make all records available or may limit the included records by date, type or source of record. If a client does not sign a consent or does not specify a particular record, sharing of that record will still be allowed if permitted by law. You may attach a list of covered records that the client must also sign. If any records include information relating to mental health (RCW 71.05.620), HIV/AIDS or STD testing or treatment (RCW 70.02.220), or drug and alcohol services (42 CFR 2.31(a)(5)), the client must mark these areas specifically to give permission to share these records. This form is not valid to include psychotherapy notes under 45 CFR 164.508(b)(3)(ii); a separate form must be completed to include those records.
- Duration: Include an expiration date for the consent, if different than one year. The consent will expire in one year unless you identify a different date.
- Understanding: Be sure the client understands what permission is being granted and how and why information will be shared. If needed, use a translated form and interpreter or read the form aloud. If the client needs more information, provide an additional copy of the DSHS Notice of Privacy Practices or refer the client to the public disclosure officer for your unit.

SIGNATURES:

- Client: Have client or a child over age of consent (13 for mental health and drug and alcohol services; 14 for HIV/AIDS and other STDs; any age for birth control and abortions; 18 for health care and other records) sign this box and insert the date of signature. The client may substitute a mark in this box that you witness.
- Witness or Notary: A witness or notary may be needed to verify the client's identity if the client does not submit this form in person or if a program requests verification. This person should sign and print his or her name.
- Parent or Other Representative: If the client is a child under the age of consent, a parent or guardian must sign. If the child does not meet the age of consent for all records to be shared, both the child and the parent must sign. If the client has been declared legally incompetent, the court appointed guardian must sign and provide a copy of the order of appointment. If someone is signing in another capacity (including a person with a power of attorney or an estate representative), mark "other" and obtain a copy of the legal authority to act. The person signing must date the signature and give a telephone number or contact information.