ECHO
El Camino Homeless Organization
—EST. 2001—

Atascadero and Paso Robles

6370 Atascadero Ave Atascadero, CA
1134 Black Oak Drive Paso Robles, CA

Empowering people in SLO County to make positive change by providing food, shelter, and supportive services.
To learn more about ECHO visit our website at echoshelter.org or call 805-462-3663.

Services	Descriptions	Times
Dinner	Dinner served nightly 365 days per year. Open to the public	5-6pm
Nightly Shelter Stay Paso Robles Campus	Nightly shelter stay done on a lottery system	Sign up from 4:30-5:30pm daily. Stay from 6pm-7:00am
90 Day Program	Stay in shelter for 90 days with intensive case management services	Call or stop by during any of our services to learn more and apply
Showers	Showers including all toiletries and a towel. Open to the public	M-F 3:30-5pm

Case management services available to all.

ECHO
El Camino Homeless Organization

El Camino Homeless Organization (ECHO)

Admission Application **DATE ___ / ___ / ___**

Instructions: Please print and fill out one per adult and provide your ID.

Name: _____ Social Security Number: _____

Date of Birth: _____ Age: _____ ☐ Male ☐ Female ☐ Trans/Non-Binary ☐ Decline to State

Message/Contact Phone: _____ Location Preferred?: Atascadero __ Paso __ Either __

If you have children with you, please list their names and ages:

_____

Emergency Contact Name & Phone Number: _____ Relation: _____

Race (Check all that apply): ☐ American Indian/ Alaskan Native ☐ Asian ☐ Black / African American
☐ Native Hawaiian / Other Pacific Islander ☐ White / Caucasian ☐ Decline to State

Ethnicity (Choose 1): ☐ Non-Hispanic or Non-Latino ☐Hispanic or Latino ☐ Decline to State

Are you looking for work? _____ Receiving any income? _____ How much?_____

Source of Income? _____ If currently working, where? _____

Are you a Veteran? Yes or No

Are you pregnant: _____ Due Date: _____

Where did you stay last night? _____

Have you ever stayed in an encampment in or near the Salinas Riverbed?_____

Have you stayed in Paso Robles for the past 90 days or more? Yes or No

What caused you to lose housing? _____

1st time unhoused? Yes or No How long have you been unhoused? _____

Have you stayed at ECHO before? Yes or No What year? _____ Do you have a pet? Yes or No

Do you use drugs or alcohol? _____ *ECHO is a drug, alcohol and tobacco free facility.

Any Medical conditions: _____

Any Mental Health Concerns: _____

Current Medications: _____

I certify that this information is true and correct to the best of my ability and knowledge.

Signature of Applicant: _____ Date: _____

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ECHO Staff Use Only*

If possible, have the applicant provide ID and make a copy.

Meghan's Law Verification:_____ ECHO Staff: _____ Date: _____

EQUAL HOUSING OPPORTUNITY

Shelter Entry date:
_____/_____/_____

Interview date: _____
Interviewer: _____
Referral Source: _____

El Camino Homeless Organization
Atascadero & Paso Robles

SHELTER ENTRY INTERVIEW – ADULT

☐**Head of Household** ☐ **Adult Household Member**

Household Type: ☐Unaccompanied Individual ☐Single-Parent Family w/ Children ☐Two Parent Family w/ Children ☐Couple No Children

Household Size (# of members)**: _____**

Client ID #	**Name:** _____ _____ _____ _____
	First *Middle* *Last* *Suffix*

Date of Birth:_____ **Age:**_____ **Social Security Number:**_____

Sex: ☐ Male ☐ Female ☐ Transgender/Non-Binary ☐ Decline to State

Race (Check all that apply):	**Ethnicity (Choose 1):**	
☐ American Indian/ Alaskan Native ☐ Asian ☐ Black / African American ☐ Native Hawaiian / Other Pacific Islander ☐ White / Caucasian	☐ Non-Hispanic or Non-Latino ☐Hispanic or Latino	

Relationship to H of H:

☐ Self	☐Foster Child	☐ Niece/ Nephew	☐ Aunt/Uncle
☐ Son	☐ Grandchild	☐ Parent	☐ Spouse
☐Daughter	☐ Grandparent	☐ Sig. Other	☐ Step Child

Have you ever been on active duty in the US military? ☐ Yes ☐ No **Verified?** ☐ Yes ☐ No **Branch**: _____ **Year**: _____	**What brought you to this county:** ☐ Family ☐ Friends ☐Employment ☐Born or Raised Here ☐ Other: _____	**Citizenship status:** ☐ American ☐ Legal Immigrant ☐ Other

Education Level Reached (Check/Circle Highest Achieved to Date): ☐ None 1 2 3 4 5 6 7 8 9 10 11 12 ☐ HS Diploma ☐ GED ☐ Post-Secondary School **If post-secondary, please describe:** _____	**Are you a Farm Worker:** ☐ Yearly ☐ Migrant ☐ Seasonal ☐ N/A	**Are you pregnant?** ☐ Yes ☐ No **If yes, due date**: _____

Have you stayed at ECHO before?		

Client's Phone Number:	**Client's Mailing Address:**
Emergency Contact Person:	**Relationship:**
Phone number:	**Address:**

Where did you stay last night? (What best describes your current living situation?)

☐ Emergency Shelter, incl. hotel/motel paid for with voucher
☐ Foster care home or foster care group home
☐ Hospital or other residential non-psychiatric medical facility
☐ Hotel/motel paid for without emergency shelter voucher
☐ Jail prison or juvenile detention facility
☐ Long term care facility or nursing home
☐Owned by client, no ongoing housing subsidy
☐ Owned by client, with ongoing housing subsidy
☐ Permanent housing for formerly homeless persons
☐ Place not meant for human habitation (vehicle, abandoned . building, bus/train station/airport, outside)
☐ Psychiatric hospital or other psychiatric facility
☐ Rental by client, no ongoing housing subsidy
☐ Rental by client, with VASH housing subsidy
☐Rental by client, with GPD TIP subsidy
☐Rental by client, with other ongoing housing subsidy
☐Residential project/ halfway house with no homeless criteria
☐ Safe Haven
☐ Staying/ living in a family member's room, apartment/house
☐ Staying or living in a friend's room , apartment or house
☐Substance abuse treatment facility or detox center
☐Transitional housing for homeless persons
☐ Other (Please Specify): _____
☐Client doesn't Know
☐ Client refused
Comments:

How long have you been staying in the place marked above?

☐ One day or less
☐ Two days to 1 week
☐ More than one week, but less than 1 month
☐ One to 3 months
☐ More than 3 months, but less than one year
☐ One year or longer
☐ Client doesn't know
☐ Client refused

Where have you stayed in the last 15 days? _____
_____

What is the number of times you have been homeless in the past 3 years? Enter "1(homeless only this time)", "2", "3", or "4 or more" based on the number of times the client was homeless and living or residing in a place not fit for human habitation, an emergency shelter, and/or a Safe Haven over the past three years. Count an episode of homelessness that begins as of entering ECHO.

☐ 0
☐ 1
☐ 2
☐ 3 ☐ Client Doesn't Know
☐ 4 or more ☐ Client Refused

What is the total number of months homeless in the past three years? (Only answer this question, if the number of times homeless in the past three years is *4 or more,* count months the client was homeless in the past three years. Any single day or part of a month spent homeless should be counted as one month.)

_____

What is the total number of months continuously homeless immediately prior to entering ECHO? (Indicate the number of months the client has been continuously homeless including the day of entering ECHO. For partial months, 1 day to 30 days = 1 month.

_____

Status documented? (Is there documentation in the client's paper file or in the HMIS of the client's length of homelessness?) No ☐ Yes

What was the last Permanent Residence which you stayed for 90 days or longer:

City: _____
State: _____
Zip Code:_____

Have you ever stayed in an encampment in or near the Salinas Riverbed?_____	**What was the start date of time on the street, in an emergency shelter, or safe haven, immediately prior to entering ECHO?** (If the client can't remember, please write the approximate start date) _____ / _____/ _____ (Month) (Day) (Year)

Substance Abuse Problem: ☐No ☐Alcohol Abuse ☐Drug Abuse ☐ Both Alcohol and Drug Abuse ☐Client Doesn't Know ☐Client Refused

IF ALCOHOL ABUSE, DRUG ABUSE, OR BOTH ALCOHOL AND DRUG ABUSE – MUST ANSWER QUESTIONS BELOW:

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?
☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused

Currently receiving services/treatment for this condition?
☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused

Physical Disability: ☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused

IF YES: Description:_____

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?
☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused

Currently receiving services/treatment for this condition?
☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused

Developmental Disability: ☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused

IF YES: Description:_____

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?
☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused

Currently receiving services/treatment for this condition?
☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused

Chronic Health Condition: ☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused

IF YES: Description:_____

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?
☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused

Currently receiving services/treatment for this condition?
☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused

HIV/AIDS: ☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused

IF YES:

Expected to substantially impair ability to live independently?
☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused

Currently receiving services/treatment for this condition?
☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused

Mental Health Problem: ☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused

IF YES: Description:_____

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused

Currently receiving services/treatment for this condition?

☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused

Domestic Violence Victim/Survivor: ☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused

If yes, when experience occurred?

☐ Within Past 3 Months ☐ 3-6 Months Ago ☐ 6-12 Months Ago ☐ More Than 1 Year Ago

☐Client Doesn't Know ☐ Client Refused

Currently Receiving Income From Any Source Listed Below? ☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused

If yes, enter type and amount below:

Yes:	Source	Amount:
	Earned Income (Employment)	
	Unemployment Insurance	
	Supplemental Soc Sec (SSI)	
	Soc. Sec. Disability (SSDI)	
	VA Service-Connected Disability Pension	
	VA Non-Service-Connected Disability Pension	
	Private Disability Insurance	

Yes:	Source:	Amount:
	Worker's Compensation	
	TANF (Cal-Works/AFDC)	
	General Assistance (GA)	
	Retirement from Social Sec.	
	Pension/Retirement Income From A Former Job	
	Child Support	
	Alimony/Spousal Support	
	Other:	
	TOTAL:	

Currently Receiving Non-Cash Benefit From Any Source? ☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused

If yes, check type below:

Yes:	Source
	Food Stamps (SNAP, CAL Fresh)
	WIC
	Sec. 8/PH/Rent Assistance
	Temporary Rental Assistance

Yes:	Source:
	TANF Child Care Services
	TANF Transportation Services
	Other TANF Funded Services
	Other:

Currently Covered By Health Insurance? ☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused

If yes, check type below:

Yes:	Source
	Medi-Cal/Cen-Cal (Medicaid)
	Medicare
	SCHIP (Healthy Families)
	VA Medical Services

Yes:	Source:
	Employer Provided Health Insurance
	Health Insurance Obtained Through COBRA
	Private Pay Health Insurance
	State Health Insurance For Adults

Currently taking any medications? ☐ Yes ☐ No

If yes, what type: _____

_____

_____

_____

_____

Name of doctor: _____

Known allergies: ☐ Yes ☐No **Description:**_____

_____

Served any jail time in the last 7 years?
☐ Yes ☐ No

☐ On Parole ☐ On Probation

PO Officer: _____

Description of offense and year:

_____

Do you have a vehicle? ☐ Yes ☐ No **Year:** _____ **Make:** _____

Model: _____ **Color:** _____ **License Plate**: _____

Currently Employed? ☐ No ☐ Yes **Employer Name:**_____ **City:**_____
In Job Training? ☐ No ☐ Yes
Looking for a Job? ☐ No ☐ Yes ☐ Temporary ☐ Permanent ☐ Full Time ☐ Part Time

What do you hope to accomplish while at ECHO (Be specific)? _____

_____

Other Comments:_____

_____

Staff Comments:

Form 815 (English)	COUNTY OF SAN LUIS OBISPO MULTI-AGENCY REFERRAL AND CLIENT **RELEASE OF INFORMATION** FOR TELEPHONIC SIGNATURES READ THE AUTHORIZATION TO DISCLOSURE VERBATIM	Authorization Page 1 of 2 Rev. 5/18/2021

Date: Last Name: First Name: Middle Initial:

Address: City/State: Zip Code:

Home Number: Cellular: OK to Leave Message: Choose Language: Other Date of Birth:

Parent/Guardian: Case Type: Other Case Number:

AUTHORIZATION TO DISCLOSE AND EXCHANGE MY HEALTH CARE OR PERSONAL INFORMATION

I authorize the agencies initialed below to share my health care and personal information with each other. If I am signing as the guardian or representative for another person, I authorize the agencies that I have initialized below to share that person's health care and personal information with each other. I understand that this authorization is voluntary and that I do not have to sign it.

PLEASE INITIAL FOR EACH AGENCY AUTHORIZED TO EXCHANGE YOUR INFORMATION:

Note: The organizations listed below may only exchange information described in this document and may only exchange the information for the purposes described.

Initial Here		Initial Here	
Initial Here	Aegis Treatment Center, LLC		Homeless Services:
Initial Here	Allan Hancock EOPS/CalWORKs	Initial Here	40 Prado Homeless Services Center
	Community Action Partnership of SLO (CAPSLO):	Initial Here	5-Cities Homeless Coalition
Initial Here	Child Care Resource Connection	Initial Here	CAPSLO- SSVF
Initial Here	Family Preservation/Parent Education	Initial Here	El Camino Homeless Organization (ECHO)
Initial Here	Head Start/Early Head Start	Initial Here	Good Samaritan- SSVF
Initial Here	Teen Academic Parenting Program	Initial Here	Housing Support Program (DSS & FCNI)
Initial Here	CenCal Health	Initial Here	Independent Living Resource Center
Initial Here	Community Health Centers (CHC)	Initial Here	Salvation Army
	County of SLO Health Agency:	Initial Here	Transitional Food & Shelter
Initial Here	Drug and Alcohol Services (DAS)	Initial Here	Transitional Mental Health Association
Initial Here	Mental Health	Initial Here	Hospital: Choose
Initial Here	Martha's Place	Initial Here	Job Centers: Choose
Initial Here	Public Health Department	Initial Here	RISE
Initial Here	Public Guardian	Initial Here	Salvation Army
Initial Here	Probation Department: Choose	Initial Here	School District: Choose
Initial Here	Cuesta College: Choose	Initial Here	Seneca Family of Agencies
Initial Here	Department of Rehabilitation	Initial Here	SLO County Office of Education (SLOCOE)
	Department of Social Services (DSS):	Initial Here	Stand Strong
Initial Here	Adult Services	Initial Here	Transitional Food & Shelter
Initial Here	Child Welfare Services	Initial Here	Transitions-Mental Health Association(T-MHA)
Initial Here	Participant Services	Initial Here	Tri-Counties Regional Center (TCRC)
Initial Here	Family Resource Centers: Choose	Initial Here	Veterans Services Department – County of SLO
Initial Here	Foster Family Agency:Choose	Initial Here	Victim/Witness Program – County SLO D.A.
Initial Here	Family Care Network, Inc. (FCNI)	Initial Here	Other: Behavioral Health
Initial Here	Housing Authority of San Luis Obispo (HASLO)	Initial Here	Other:
Initial Here	HMIS Database	Initial Here	Other:
Initial Here	Other:	Initial Here	Other:

*Due to COVID-19, a verbal consent, fax or scanned can be accepted with the expectation that a wet signature will be collected within 30 days. Workers must write "V" for verbal consent in the initial box and "Verbal Consent" in the client signature box.

Form 815 (English)	COUNTY OF SAN LUIS OBISPO MULTI-AGENCY REFERRAL AND CLIENT RELEASE OF INFORMATION	Authorization Page 2 of 2 Rev. 5/18/2021

HEALTHCARE OR PERSONAL INFORMATION THAT CAN BE SHARED BY THE IDENTIFIED AGENCIES

NOTE: THIS AUTHORIZATION FORM ALLOWS DISCLOSURE OF ALL OF YOUR HEALTH AND SOCIAL SERVICES RECORDS UNLESS YOU SPECIFY A SPECIFIC LIMITATION.

The identified agencies can share any and all information from your health care records or personal records or from the healthcare records or personal records of the person for whom you are authorizing this disclosure, for the purposes listed below. The information may come from your San Luis Obispo County physical health records, mental health records, or drug and alcohol treatment records. The information may also come from your Social Services records or the records of any other agency you authorized to share your information. The information used, disclosed or shared may be written or oral, and will only include information necessary to achieve the intended purpose or referral.

Initial Here **Initial here to indicate you understand we will share your mental health information.**

Initial Here **Initial here to indicate you understand we will share your Drug and Alcohol Program Information.**

Describe the type and amount of Drug and Alcohol Program Information that can be disclosed:

Initial Here	Drug and Alcohol Test Results	Initial Here	Substance Use Diagnosis
Initial Here	Drug and Alcohol Treatment Plan	Initial Here	Drug and Alcohol Program Attendance
Initial Here	Drug and Alcohol Payment Information	Initial Here	Discussions with my Drug and Alcohol Counselor

PURPOSE AND LIMITATIONS ON THE USE OF YOUR HEALTHCARE OR PERSONAL INFORMATION

The information will be used by the identifed agencies to refer you to and request services from agencies that you authorized in this document. The information may also be used to coordinate care or to coordinate services between the agencies. These services may be in areas such as health care, housing, employment, education, nutrition, parenting, child welfare, and/or other traditional social services.

This authorization to release the above information will **expire two years from the date signed** or will expire on: _____ **(Not more than 2 years.)**

I understand that:

- I understand that I have a right to receive a copy of this authorization.
- I have the right to revoke this authorization verbally, or by sending a signed notice to:
  - County Privacy Officer: 2180 Johnson Ave., San Luis Obispo, CA, 93401
  - Or via e-mail at privacy@co.slo.ca.us ; or call (855) 326-9623
  - This authorization will cease on the date my valid revocation request is received. I also understand that any information released prior to a revocation of this authorization shall not be a breach of my confidentiality.
- A form known as The Notice of Privacy Practices which is given to clients who receive medical services, provides instructions should I chose to revoke my authorization and includes limitations on my revocation. I can access this notice on the internet at: http://www.slocounty.ca.gov/Departments/Health-Agency.aspx
- My treatment, enrollment, or eligibility for benefits will not be affected if I do not sign this authorization.
- Upon request, I may inspect or obtain a copy of the health information that I allow to be disclosed.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA); for example, if I allow disclosure to a family member.
- Records and copies obtained relating to outpatient psychotherapy shall be returned or destroyed at the expiration date of this authorization except those obtained for treatment and diagnosis purposes.
- I understand that alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 C.F.R. Pts. 160 and 164, and cannot be re-disclosed without my written consent unless otherwise provided for in the regulations.

Client Signature*:	**Print Name:**	**Date:**
Representative Signature:	**Relation:**	**Date:**
Employee Name:	**Organization:**	
Employee Signature:	**Employee Title:**	**Date:**

*Due to COVID-19, a verbal consent, fax or scanned can be accepted with the expectation that a wet signature will be collected within 30 days. Workers must write "V" for verbal consent in the initial box and "Verbal Consent" in the client signature box.

Form 815 (English)	COUNTY OF SAN LUIS OBISPO MULTI-AGENCY REFERRAL AND CLIENT RELEASE OF INFORMATION	Re-disclosure Addendum Page 1 of 1 Rev. 5/18/2021

ADDITIONAL CONSENT FOR RECIPIENTS OF PROTECTED DRUG AND ALCOHOL TREATMENT INFORMATION TO SHARE THE INFORMATION WITH OTHERS

NOTE: This page is to be filled out if Drug and Alcohol Treatment information that was shared by the client's Drug and Alcohol Treatment provider is intended to be further disclosed (re-disclosed) by the initial recipients to another individual agency (such as the Superior Court, District Attorney, Probation, Department of Social Services). **If completed, this page must be attached to page 1 and 2 of this Authorization form.**

Full Client Name:		**Date of Birth:**	

I authorize the disclosure of my Drug and Alcohol Treatment information or the information for the person for whom I am signing, to be shared by the following agencies:

Initial Here	Name of Agency:	
Initial Here	Name of Agency:	
Initial Here	Name of Agency:	
Initial Here	Name of Agency:	
Initial Here	Name of Agency:	
Initial Here	Name of Agency:	
Initial Here	Name of Agency:	
Initial Here	Name of Agency:	
Initial Here	Name of Agency:	

DRUG AND ALCOHOL TREATMENT INFORMATION THAT CAN BE SHARED BY THE IDENTIFIED AGENCIES

Initial Here	Any information related to your participation in the Drug and Alcohol Program including your status as a patient, date of admission, initial evaluation, assessment results/ history, attendance, date of discharge, discharge plan and discharge status.
Initial Here	Summary of your treatment plan, progress in the program, and compliance.
Initial Here	Any drug test results including urinalysis, breathalyzer/ patching test results.
Initial Here	Any personal information about your household, relationships and children including observations and evaluations of minors with whom you interact.

PURPOSES AND LIMITATIONS ON THE USE OF YOUR DRUG AND ALCOHOL SERVICES INFORMATION

The information described above may be used, disclosed and/or re-disclosed by and between the agencies listed above to assist them in handling your Department of Social Services case, your Family Court case, your Probation case, your court/criminal Justice case and/or any other matter related to this authorization.

I voluntarily sign this authorization to disclose my Drug and Alcohol Program information to the agencies listed above. I understand these agencies will share this information with each other.

Client Signature*:	**Print Name:**	**Date:**
Representative Signature:	**Relation:**	**Date:**
Employee Name:	**Organization:**	
Employee Signature:	**Employee Title:**	**Date:**

*Due to COVID-19, a verbal consent, fax or scanned can be accepted with the expectation that a wet signature will be collected within 30 days. Workers must write "V" for verbal consent in the initial box and "Verbal Consent" in the client signature box.

County of San Luis Obispo Continuum of Care
Homeless Management Information System (HMIS)
Consent for Release of Information

The County of San Luis Obispo Continuum of Care Homeless Management Information System (HMIS) is an electronic database that securely records information (data) about clients accessing housing and homeless services within San Luis Obispo County. This organization participates in the HMIS database and shares information with other organizations that use this database. This database helps us to better understand homelessness, to improve service delivery to the homeless, and to evaluate the effectiveness of services provided to the homeless. The information you provide for the HMIS database helps us coordinate the most effective services for you and your household members.

What information is shared in the HMIS Database?

- Your Name
- Your Date of Birth
- Your Social Security Number
- Your Gender
- Your Ethnicity
- Your Race
- Your Veteran Status
- Your history of homelessness and housing (including your current housing status, and where and when you have accessed services)
- Your household composition
- Your self-reported medical history (including any physical disability, developmental disability, chronic health condition, HIV/AIDS, mental health problem or substance abuse)
- Your disability status
- Your health insurance
- Your contact information
- Your income and sources; and non-cash benefits
- Any history of domestic violence

Who can have access to your information?

Your information will be shared with other County of San Luis Obispo Continuum of Care HMIS participating agencies (both public and private) as well as our service referral system Octavia; all of which agree to maintain the security and confidentiality of the information. These organizations may include homeless service providers, housing groups, healthcare providers and any other appropriate service providers. A list of participating agencies within the County of San Luis Obispo Continuum of Care HMIS is available upon request.

How is your personal information protected?

The information that is collected in the HMIS database is protected by limiting access to the database and by limiting with whom the information may be shared, in compliance with the standards set forth of federal, state, and local regulations governing confidentiality of client records. Each person and agency that is authorized to read or enter information into the database has signed an agreement to maintain the security and confidentiality of the information. HMIS data is secured by passwords and encryption technology.

BY SIGNING THIS FORM, I UNDERSTAND AND AGREE THAT:

- The information gathered and prepared by this agency will be included in a HMIS database of participating agencies (list available), and only shared with participating agencies, who have entered into an HMIS Agency Participating Agreement.
- You have the right to receive services, even if you do not sign this consent form.
- You have a right to receive a copy of this consent form.
- You have the right to revoke your consent, in writing, at any time. The revocation will not apply to information that has already been shared or until the provider receives the revocation. Upon receipt of your revocation, we will remove your Personal Protected Information (PPI) from the shared HMIS database.
- This consent and release is valid for two (2) years after the date of signature below, unless I revoke my consent in writing.
- You have the right to file a grievance with any HMIS participating agency.

SIGNATURE AND ACKNOWLEDGEMENT

Your signature below indicates that you have read (or been read) this client consent form, have received answers to your questions, and you freely consent to have your information, and that of your dependent children (if any), entered into the HMIS database and shared with other participating organizations as described in this consent form.

CLIENT NAME	SIGNATURE OF CLIENT	DATE

SPOUSE NAME	SIGNATURE OF SPOUSE	DATE

List all dependent children under 18 in household (if any):

☐ I DO NOT WISH TO PARTICPATE IN HAVING MY PERSONAL INFORMATION SHARED IN THE HMIS SYSTEM

NAME OF ORGANIZATION STAFF	ORGANIZATION NAME	DATE

TO REVOKE CONSENT:

I, _____ revoke consent as of _____

SIGNATURE OF CLIENT DATE

Organization Staff:_____ Date:_____

County of San Luis Obispo Department of Social Services Website: https://www.slocounty.ca.gov/Departments/Social-Services.aspx

ECHO
El Camino Homeless Organization
—EST. 2001—

Photo & Media Release

I, the undersigned, hereby give the El Camino Homeless Organization and its affiliates, representatives, and collaborators (herein collectively known as the "ECHO") the absolute right and permission to use my name, my image, my voice, still or video photographs or recordings of me, and/or my biographical information for publicity purposes and to make reproductions in any media, including but not limited to the Internet, and to publish and/or market such images in the ECHO's sole and absolute discretion without compensation.

I agree that the right herein granted includes the right for ECHO to edit, alter, reproduce, use and distribute the picture(s) in any manner stated above, and I waive any right to inspect or approve the final product. ECHO shall be under no obligation to actually use my name, likeness or biographical information in any media.

The rights herein shall insure to the benefit of ECHO, its licensees, successors, and assigns. This release is subject to the laws of the state of California.

I have read and fully understand the meaning and effect of this release and, intending to be legally bound under this release, sign this release.

I am also signing this release on behalf of the following minors, if applicable:

_____ _____

Full Name (Please print) Age

_____ _____

Signature (person in photo or legal guardian if younger than 18 years) **Date**