



**Maine Department of Health and Human Services  
Office of Behavioral Health**

**Permanent Supportive Housing Program (PSHP)  
Tenant-Based Rental Assistance (TBRA)**

**What is PSH?**

Permanent Supportive Housing (PSH) is permanent housing in which rental assistance and supportive services are provided to assist households experiencing homelessness with at least one member (adult or child) with a disability in achieving housing stability.

**What are the DHHS - PSHP Requirements?**

To be eligible for PSHP, the head of household must be (1) homeless as defined by the US Department of Housing and Urban Development (HUD), (2) a person who has a long-term disability **and**, (3) in need of supportive services and enrolled in full MaineCare coverage.

If you have been matched to PSHP in Maine's Coordinated Entry System please complete the attached application; please note that although documents verifying household income are not required to submit this application, documentation will be required for all household members before rental assistance can be provided.

While we hope you answer all the questions, we can begin processing your application as long as you answer all of the questions that have an asterisk \* next to them. Eventually you will need to answer all questions and provide documents verifying your answers. Eligibility documentation is required as stated below.

**Homeless Verification:**

Have a primary nighttime residence that is a public or private place not meant for human habitation; or

Be living in a publicly or privately operated shelter designated to provide temporary living arrangements, such as emergency shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs; or

Are exiting an institution where you have resided for 90 days or less and were considered homeless immediately before entering that institution (need to provide verification of prior homelessness); or

Are fleeing, or attempting to flee domestic violence, and you have no other residence and lack the resources or support networks to obtain other permanent housing.

Please see the "Documenting Homelessness" section of the application for the HUD established Order of Priority for documenting literal homelessness.

**Disability Verification:**

To verify your disability a Disability Verification Form must be completed by a qualified professional with one of the following credentials (MD, DO, LCPC, LCSW, APRN-BC, NP, PA, Psychologist; or any other person Licensed by the State of Maine to diagnose and treat persons with the conditions) or, if a qualified professional cannot complete the Disability Verification Form, then your disability can also be verified by providing one of the documents listed in the "Guide to PSHP Disability Verification" located on the OBH and Preble Street website.

**Supportive Service Verification:**

The Permanent Supportive Housing Program (PSHP) program is required to make available supportive services to program participants. The PSHP supportive services are provided through MaineCare and are intended to help participants obtain and maintain housing stability.

It must be verified that you are currently enrolled in MaineCare (Medicaid). MaineCare provides free and low-cost health insurance to Mainers who meet certain requirements, based on household composition, income, and/or disability status. MaineCare eligibility will be determined by the criteria set forth in the MaineCare Eligibility Manual.

**Where do I send my application?**

**In Person Dropoff:** Front Desk – 55 Portland Street Portland, ME 04101  
**Mail:** PSHP Applications – Preble Street 55 Portland Street Portland, ME 04101

**Fax:** 207-842-3614 Attn: PSHP Applications  
**Email:** [PSHP@preblestreet.org](mailto:PSHP@preblestreet.org)

**What happens after I have submitted my application?**

Once your application is received by our program, it can take up to 15 days to process. Once your application is processed you will receive a letter in the mail that reflects one of the following: a notification of award, a notification of conditional award, a notice that the application is incomplete, or a notice of denial letter with further instructions inclusive of appeal policy. If you do not receive a response after 15 days, please contact Preble Street.



**Date & Time Received:**

### Permanent Supportive Housing Program Application

Please complete the entire application as fully as possible. The application will not be considered complete unless all the questions that have an asterisk \* are completed. Attach any required documents and return them with the signed application to Preble Street. If you have any questions, please call 207-956-6579.

#### Head of Household (Applicant) Information

*Full Name:	
*Mailing Address:	
*Phone:	
Email:	
*Preferred Method of Contact:	<input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Mail
Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to answer
*Social Security Number:	
*Date of Birth	
Are you a Veteran?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Race (check all that apply)	<input type="checkbox"/> American Indian, Alaskan Native, or Indigenous <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black, African, or African-American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White or Caucasian <input type="checkbox"/> Other/Multi-Racial: _____
Are you Hispanic or Latina/o?	<input type="checkbox"/> No <input type="checkbox"/> Yes

*If you need assistance reading or filling out the application, please notify the program.*

Which County would you like to live in? (check all that apply)	<input type="checkbox"/> Androscoggin <input type="checkbox"/> Aroostook <input type="checkbox"/> Cumberland <input type="checkbox"/> Franklin
	<input type="checkbox"/> Hancock <input type="checkbox"/> Kennebec <input type="checkbox"/> Knox <input type="checkbox"/> Lincoln
	<input type="checkbox"/> Oxford <input type="checkbox"/> Penobscot <input type="checkbox"/> Piscataquis <input type="checkbox"/> Sagadahoc
	<input type="checkbox"/> Somerset <input type="checkbox"/> Waldo <input type="checkbox"/> Washington <input type="checkbox"/> York

Emergency Contact:	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please list name and phone number below</i>
Legal Guardian:	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please list name and phone number below</i>
Rep Payee:	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please list name and phone number below</i>
Service Provider/Case Manager:	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please list name and phone number below</i>

*If yes, please ensure there is a release of information collected or on file.*

*Per HUD, Domestic Violence includes dating violence, sexual assault, stalking, and other dangerous or life-threatening conditions that relate to violence against the individual or family member that either takes place in, or makes him or her afraid to return to, their primary nighttime residence (including human trafficking).*

Are you a victim or survivor of domestic violence?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, when:	<input type="checkbox"/> Within the past three months <input type="checkbox"/> Three to six months ago <input type="checkbox"/> Six to twelve months ago <input type="checkbox"/> More than a year ago <input type="checkbox"/> I Don't Know <input type="checkbox"/> Refused to Answer
If yes, are you currently fleeing?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Refused

### \*Household Composition

*List ALL persons who will live in the unit and complete their information.  
Please note: You will need to fill out a Household Member Form for everyone living in the household.*

Name of Household Member	Relationship to Applicant (Head of Household)

### \*Current Housing Situation

The U.S. Department of Housing and Urban Development requires documentation of homelessness and disability. *Please note: Verification of current living situation stating location, length of stay and dates of homelessness on agency letterhead must be attached – See below.*

- [Chronically Homeless, as defined by HUD](#)
- Living in a place not designed for habitation
- Living in an emergency shelter or hotel with emergency funds; or Hotel/Motel paid for by city or state government or charitable organization
- Transitional housing for formerly homeless
- Victim/Survivor of Domestic Violence Situation
- Other: Specify: \_\_\_\_\_

## Documenting Homelessness

HUD has established an Order of Priority for documenting literal homelessness. This order of priority establishes guidelines for how program staff should prioritize different forms of documentation, with attempts to collect higher-priority documentation before moving on to lower-priority documentation. Reasonable efforts should be made to follow the order of priority established by HUD. The order of priority is as follows:

1. **Third Party Verification** – Intake staff should make a reasonable effort to obtain third party documentation for current literal homelessness and for all 12 months showing chronic homelessness. For months that cannot be covered by third party documentation, the effort to do so should be recorded as due diligence.
2. **Intake Worker Observation** – Where applicable, intake worker observation should take priority over self-certification of literal homelessness.
3. **Self-Certification** – For any month that the applicant must document literal homelessness because third-party verification or intake-worker observation is not available, the applicant must provide self-certification of their living situation during that month.

Please Note: *All 12 months used to establish chronic homelessness must be covered by one of the following: third party verification, intake worker observation, or self-certification by applicant. (No more than 3 months of the 12 can be covered by self-certification only)*

**DISABILITY VERIFICATION FORM**

**INSTRUCTIONS:**

A qualified professional with one of the following credentials (MD, DO, LCPC, LCSW, APRN-BC, NP, PA, Psychologist; or any other person Licensed by the State of Maine to diagnose and treat persons with the conditions that they are confirming) must complete this form.

**Name:**

**DOB:**

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**SECTION 1: QUALIFYING DISABILITY**

In order to qualify for assistance, the individual must have a disability as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)). Under this definition, a qualifying disability is a:

1. Physical, mental or emotional impairment, including impairment caused by alcohol or drug abuse, post-traumatic stress disorder, brain injury or a chronic physical illness that:
  - o Is expected to be long-continuing or of indefinite duration; **and**
  - o Substantially impedes the person’s ability to live independently; **and**
  - o Could be improved by more suitable housing.
2. Developmental Disability: Defined in Section 102 of the Developmental Disability Assistance and Bill of Rights Act of 2000. Means a severe, chronic disability that:
  - o Is attributable to a mental or physical impairment or combination; **and**
  - o Is manifested before age 22; **and**
  - o Is likely to continue indefinitely; **and**
  - o Results in substantial limitations in three or more major life activities, **and**
    - Self-care
    - Receptive and expressive language
    - Learning
    - Mobility
    - Self-direction
    - Capacity for independent living
    - Economic self-sufficiency
  - o Reflects need for:
    - A combination and sequence of special, interdisciplinary, or generic services; **or**
    - Individualized supports; **or**
    - Other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

Does the individual have a qualifying disability as defined above?     YES                       NO

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**SECTION 2: TYPE OF DISABILITY**

The individual named above is an individual with (a): (Check all that apply)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Mental Health Disorder   | <input type="checkbox"/> Chronic Alcohol Abuse   | <input type="checkbox"/> Other Disability _____ |
| <input type="checkbox"/> HIV/AIDS                 | <input type="checkbox"/> Chronic Substance Abuse |   |
| <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> Physical Disability     |   |

\_\_\_\_\_  
Name and Credentials of Provider

\_\_\_\_\_  
Agency and Telephone Number

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**\*Supportive Services**

MaineCare ID: \_\_\_\_\_

Please review the list of services below and check services that you have or had within the past year. Please include the provider and phone number if possible.

Service	✓	Provider	Phone
Alcohol or Substance Use Services			
Case Management			
Food (Meals on Wheels)/ Food Pantry			
Housing Navigation/ Counseling			
Legal Services			
Life Skills ( <i>Peer Support, In-Home</i> )			
Mental Health Services			
Outpatient Medical Services			
Outreach			
Non-Emergency Transportation			
Other: (Specify)			
Other: (Specify)			

Are there any services that you are not receiving that you would be interested in receiving information about?

No     Yes    *If yes, list below:*

\_\_\_\_\_

\_\_\_\_\_

If you are currently receiving case management services, please list the agency, provider, and contact information below:

\_\_\_\_\_

\_\_\_\_\_

**\*Household Member Form**

**Instructions:** Please complete a Household Member form for each household member, including head of household, who will be residing in the unit.

*Full Name:	
Relationship to HoH	
Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to answer
*Social Security Number:	
*Date of Birth	
Where are you currently residing or where was your last residence?	
Length of Stay and Zip Code of last residence:	
If coming from a homeless situation, how many separate times have you been on the streets or in a shelter in the past 3 years?	
Approximate date homelessness started:	
Are you a Veteran?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Race (check all that apply):	<input type="checkbox"/> American Indian, Alaskan Native, or Indigenous <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black, African, or African-American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White or Caucasian <input type="checkbox"/> Other/Multi-Racial: _____
Are you Hispanic or Latina/o?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have a disabling condition?	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please select all that apply:</i> <input type="checkbox"/> Mental Health Disorder <input type="checkbox"/> Chronic Alcohol Abuse <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Chronic Substance Abuse <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Physical Disability <input type="checkbox"/> Other Disability: _____
Are you a victim or survivor of domestic violence?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<i>If yes, when:</i>	<input type="checkbox"/> Within the past three months <input type="checkbox"/> Three to six months ago <input type="checkbox"/> Six to twelve months ago <input type="checkbox"/> More than a year ago <input type="checkbox"/> I Don't Know <input type="checkbox"/> Refused to Answer
<i>If yes, are you currently fleeing?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Refused
Are you a student?	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-Time <input type="checkbox"/> No

**\*Household Income/Assets**

Income is money or contributions paid to or for, a family member. Please provide the income expected for the coming 12 months for all family members, using the lists below of income and asset sources to help you. Including family members who are minors receiving unearned income.

Examples of Income Sources:

- Employment wages, including tips
- 1099 Employment
- State Supplement from DHHS
- Child Support payments
- TANF from DHHS
- Self -Employment Income, Income from a business you own
- General Assistance payments
- Support from family or friends (regularly occurring gifts, cash or noncash)
- Alimony payments
- Unemployment compensation
- Educational Grants & Scholarships
- Disability Income
- Pensions, retirement accounts

<b>Household Member:</b>				
<b>Name of Income Source:</b>				
<b>Gross Income:</b>	\$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly
<input type="checkbox"/> I have no source of income <i>If no income, you will need to sign a Certification of Zero Income</i>				

<b>Household Member:</b>				
<b>Name of Income Source:</b>				
<b>Gross Income:</b>	\$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly
<input type="checkbox"/> I have no source of income <i>If no income, you will need to sign a Certification of Zero Income</i>				

<b>Household Member:</b>				
<b>Name of Income Source:</b>				
<b>Gross Income:</b>	\$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly
<input type="checkbox"/> I have no source of income <i>If no income, you will need to sign a Certification of Zero Income</i>				

<b>Household Member:</b>				
<b>Name of Income Source:</b>				
<b>Gross Income:</b>	\$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly
<input type="checkbox"/> I have no source of income <i>If no income, you will need to sign a Certification of Zero Income</i>				

Examples of Asset Sources:

- Bank statements reflecting Savings and Checking account balances
- Assets valuing more than \$5000 that have been sold or given away in the past two years
- Real Estate property that you own. Please provide current year property tax statement
- Investment statement for stocks, bonds, trusts, IRAs, and other investments
- Life insurance policies
- Settlements for personal losses

- Any large, lump sum payments, including lottery winnings

Household Member:				
Type of Asset:				
Amount:	\$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly
Household Member:				
Type of Asset:				
Amount:	\$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly
Household Member:				
Type of Asset:				
Amount:	\$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly
Household Member:				
Type of Asset:				
Amount:	\$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly

## Non-Discrimination Notice

The Department of Health and Human Services (DHHS) does not discriminate on the basis of disability, race, color, creed, gender, sexual orientation, age, or national origin, in admission to, access to, or operations of its programs, services, or activities, or its hiring or employment practices. This notice is provided as required by Title II of the Americans with Disabilities Act of 1990 and in accordance with the Civil Rights Act of 1964 as amended, Section 504 of the Rehabilitation Act of 1973, as amended, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972 and the Maine Human Rights Act and Executive Order Regarding State of Maine Contracts for Services. Questions, concerns, complaints or requests for additional information regarding the ADA may be forwarded to DHHS' ADA Compliance/EEO Coordinators, 11 State House Station – 221 State Street, Augusta, Maine 04333, 207-287-4289 (V), 207-287-3488 (V), 1-800-606-0215 (TTY). Individuals who need auxiliary aids for effective communication in program and services of DHHS are invited to make their needs and preferences known to the ADA Compliance/EEO Coordinators. This notice is available in alternate formats, upon request.



Privacy Act Statement: The information on this form is being collected on behalf of the Department of Housing and Urban Development (HUD) to help determine an applicant's eligibility. It will be used to provide the basis for managing the program covered by this form, for protecting the Government's financial interest and for verifying the accuracy of the information furnished. Penalty for false or fraudulent statements: U.S.C. Title 18, Sec 1001, provides that "Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than \$10,000 or imprisoned not more than five years, or both." Applicant(s) Statement: I understand that false statements or information are punishable under federal law

\_\_\_\_\_  
*\*Applicant or Guardian Signature*

\_\_\_\_\_  
*\*Date*

Guardian Address & Phone Number: \_\_\_\_\_

Prepared/Reviewed by: \_\_\_\_\_  
**Please sign name and credentials**

Agency: \_\_\_\_\_

Telephone: \_\_\_\_\_

## Maine's HMIS Authorization to Disclose Information

**Agency:**

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**For:**

Print First, Middle, and Last Name (Complete one form for each adult)

Date of Birth

**Children/Incapacitated Persons:**

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Date of Birth

Date of Birth

Your personal information is confidential. We and anyone with access to the information we collect from you must keep your information confidential and protect the information under strict safeguards. Your personal information and that of the above listed persons for whom you have authorization to sign will be collected by the above Agency and entered into Maine's Homeless Management Information System (HMIS). With your consent, your personal information, including historical information in HMIS, will be made available to other agencies providing services to you through HMIS for the purposes of coordinating care and facilitating access to housing resources.

A list of agencies participating in HMIS that may have access to your information if you sign this authorization is at [www.mainehmis.org](http://www.mainehmis.org) and available from Agency.

### Why disclose your information to other agencies?

- Sharing reduces the amount of time you have to spend answering basic questions about your situation.
- Sharing allows agencies to focus on quickly meeting your unique needs.
- Sharing makes it easier for multiple agencies to coordinate housing and services for you and your family.

### What information might be disclosed to other agencies?

- Family/Household Information
- Name, birthdate, Social Security Number
- Gender, race, ethnicity
- Reasons for seeking services
- Living situation and housing history
- Services you receive
- If you are homeless or not
- Your income and income sources
- Disabling condition(s)
- Public benefits you receive
- History of domestic violence
- Educational background
- Employment information
- Military history
- Health information, including physical health, HIV status, behavioral health (mental health and substance use disorder information)

**Please check (✓) a box:**

**€ DISCLOSE (Share):** I consent to have the information collected by Agency about me and historical information about me already in HMIS disclosed through Maine's HMIS to other partner agencies in order to improve services to me and the services offered to others. I intend that this authorization permit Agency to disclose, through the HMIS system, any HIV status, mental health and substance abuse or substance use disorder information Agency may collect about me. Maine law requires us to tell you that releasing HIV status information may have implications. Release of HIV status information may help us better serve you. However, misuse of the information could result in discrimination.

This consent does not apply to any information collected by:

- Milestone Recovery;
- All Youth Emergency Shelters;
- Maine DHHS Youth Outreach Services;
- Any Runaway and Homeless Youth Program;
- Any other Youth program entering data for clients 17 years of age and younger.

This consent does apply to information collected for Youth Homeless Demonstration Project projects (18 plus)

## Maine's HMIS Authorization to Disclose Information

€ **YOUTH PROVIDER DISCLOSE:** *I am an individual seeking services at a youth emergency shelter, Maine DHHS Youth Outreach Services, or a Runaway and Homeless Youth Program, and my record is locked down. For the purposes of accessing the Maine Coordinated Entry System, I consent to having only my Client Record information (Name, Social Security Number, and Veteran Status) and my Coordinated Entry Assessment Information shared.*

€ **DO NOT DISCLOSE (Do Not Share):** I do **not** want **any** of the information collected by Agency about me disclosed (shared) to any other agencies through Maine's HMIS. I understand that not disclosing my information to other agencies may affect the ability to quickly and appropriately identify services for me.

**When you sign this form, it shows that you understand the following:**

- You have the right to refuse to sign this authorization.
- **Agency will not** deny you help if you do not want us to disclose your personal information to other agencies. At the same time, disclosing your information does not guarantee that you will receive assistance from the recipient agency.
- If you permit us to disclose your information to other agencies:
  - This consent is valid for five (5) years.
  - You have the right to review any mental health information that may be disclosed under this authorization, upon request prior to signing this authorization.
  - You may change your mind and cancel this authorization at any time. If Agency is a Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entity, see Agency's HIPAA Notice of Privacy Practices on how to revoke this authorization. If you cancel this authorization, your information will no longer be disclosed from that date forward, except to the extent that your authorization has already been relied upon by Agency or others.
- Subsequent disclosures may be made under this same authorization.
- A (1) separate sub-contractor of Agency or (2) social service agency may be collecting my information on behalf of the above listed Agency to send to the above listed Agency. This sub-contractor or social service agency is bound by the same privacy rules in handling your personal information as Agency is.
- You have the right to receive a copy of this authorization.

\_\_\_\_\_  
SIGNATURE OF CLIENT OR AUTHORIZED  
REPRESENTATIVE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF AGENCY WITNESS

\_\_\_\_\_  
DATE

€ **Verbal Authorization obtained by phone (Agency Staff Signature):**

**Date:**

**If client chooses not to disclose their information, ask that they put a check mark next to the "Do Not Disclose" box and sign the document. Fax to: HMIS Team 207-624-5768. Visibility from this point forward will be removed.**



## Authorization to Release Information

We are committed to the privacy of your information.  
Please read this form carefully.

Which office(s) should help you? Please check.

<input type="checkbox"/> Office of MaineCare Services	<input checked="" type="checkbox"/> Office of Behavioral Health
<input type="checkbox"/> Office for Family Independence and Medical Review Team	<input type="checkbox"/> Office of Child and Family Services
<input type="checkbox"/> Maine Center for Disease Control and Prevention	<input type="checkbox"/> Office of Aging and Disability Services
<input type="checkbox"/> Dorothea Dix Psychiatric Center	<input type="checkbox"/> Division of Administrative Hearings
<input type="checkbox"/> Riverview Psychiatric Center	<input type="checkbox"/> Other:
<input type="checkbox"/> Division of Licensing and Certification	<input type="checkbox"/> Other:

Whose information will be disclosed? Please print clearly.

Individual's Name	Date of Birth		
Home Address	Town/City	State	Zip Code
Telephone	Email address of individual/personal representative (optional)		

Please check:  Release/Send my information to:  Obtain/Get my information from:

Name of Individual	Organization	Preble Street	
Address	City/State	Zip Code	
55 Portland Street	Portland ME	04101	
Telephone	Email address (optional)		
207-956-6579	PSHP@preblestreet.org		

What is the purpose of the disclosure?

<input type="checkbox"/> Personal request	<input type="checkbox"/> To coordinate or manage my care
<input type="checkbox"/> For a legal matter, including testimony	<input type="checkbox"/> To see whether I qualify for insurance coverage, services, or benefits
<input checked="" type="checkbox"/> Other: For program eligibility	

To share the information with others by EMAIL, please read, initial and complete the following:

I understand that email and the internet have risks that the office sharing my information cannot control. It is possible that my emailed information could be read by a third party. I ACCEPT THOSE RISKS and still ask to send my information by email. INITIALHERE _____
Please print the email address where you want your information sent:

What should be released or obtained about the individual named on this form? Please check all that apply.

<p><b>General permission:</b></p> <p><input type="checkbox"/> All health information from the office(s) checked above</p> <p><input type="checkbox"/> Insurance Claims or encounter data (information about visits to health care providers)</p> <p><input type="checkbox"/> Financial information including billing, payment, income, banking, assets</p> <p><input type="checkbox"/> Limit to the following date(s) or type(s) of information: (e.g., "Lab test dated June 2, 2025" or "Claims from 2024") _____</p> <p><input checked="" type="checkbox"/> Other: <u>program eligibility, rental assistance and supportive service information</u></p>	<p><b>Special permission: Drug/Alcohol Treatment or Referral</b></p> <p><input type="checkbox"/> Include <b>all</b> drug/alcohol information in the release</p> <p><input type="checkbox"/> Include only the <b>specific</b> drug/alcohol records checked:</p> <p><input type="checkbox"/> Diagnosis and treatment</p> <p><input type="checkbox"/> Clinical notes and discharge summaries</p> <p><input type="checkbox"/> Drug/Alcohol history or summary</p> <p><input type="checkbox"/> Payment or claims information</p> <p><input type="checkbox"/> Living situation and social supports</p> <p><input type="checkbox"/> Medication, dosages or supplies</p> <p><input type="checkbox"/> Lab results</p> <p><input type="checkbox"/> Other: _____</p>
<p><b>Special permission: Mental/Behavioral Health Services</b></p> <p><input type="checkbox"/> Include this information in the release</p> <p><input type="checkbox"/> I want to review my mental health/behavioral health record before release. I understand that the review will be supervised.</p> <p><b>Please note:</b> Maine law lets us share this information with other health care providers and health plans to coordinate and manage your care (to help take care of you). We will make a reasonable effort to notify you of the release.</p>	<p><b>Special permission: HIV/AIDS Status/Test Results</b></p> <p><input type="checkbox"/> Include this information in the release</p> <p><b>Please note:</b> Maine law requires us to tell you of possible effects of releasing HIV/AIDS information. For example, you may receive more complete care if you release this information, but you could experience discrimination if it is misused. Your HIV/AIDS-related information, and all of your data, will be protected as the law requires.</p>

**I understand and agree that:**

- I am signing this form voluntarily. I have the right to a signed copy of this form if I request one.
- My treatment, payment for services, or benefits will not depend on whether I sign this form unless I am requesting or disclosing information to apply for benefits.
- "Information" may be in written, spoken and/or electronic format, and includes information about me from other healthcare providers (such as doctors, hospitals, and counselors) that is included in my files. My signature allows the people/offices named on the reverse to discuss my information for the purposes noted on this form.
- My information will be kept confidential as required by law. If I choose to share my information with others who are not required by law to keep it private, it may no longer be protected by federal confidentiality laws.
- If alcohol or drug treatment or program (substance use disorder) records are included in this release, a notice will be included with the records saying that such information may not be re-released or shared without my written permission.
- I may revoke (take back) my permission to release my information by filling out the Revocation Form found at <http://www.maine.gov/dhhs/privacy/index.shtml> and sending it to the office that shared my information. The Revocation Form is effective only after it is received and does not apply to information that was already shared.
- If I take back my permission or refuse to release some or all of my information, my choice could lead to an improper diagnosis or treatment, or denial of insurance.
- This form expires **one year** from the date below unless I write an earlier date here: \_\_\_\_\_
- Additional releases of information are permitted until this form expires.

**Please check:**  I affirm that the written or digital signature below is mine, and that I have the authority to sign this document.

**Date:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Printed name:** \_\_\_\_\_

**Personal Representative's authority to sign:**  Parent  Legal Guardian  Conservator  Other (Explain): \_\_\_\_\_