

Institute for Community Alliances WI Service Point

Client Informed Consent and Release of Information

PERMISSION TO SHARE CONFIDENTIAL INFORMATION TO SECURE NECESSARY SERVICES

Please read the following notice and authorization (or ask to have it read to you) before signing.

This agency _____ participates in Wisconsin Service Point (WISP). Agencies that participate in the Wisconsin Service Point System belong to an internet-based network. This network is administered by the Institute for Community Alliances.

BENEFITS TO DATA SHARING FOR THE CONSUMER

Eliminates Duplicate intakes	Faster access to the Coordinated Entry System, resulting in receiving services more quickly
Reduces the amount of time spent answering basic questions regarding your situation	Allows agencies to focus on meeting your unique service needs
Reduces the amount of times you have to tell your story to service providers	Multiple Services can be easily coordinated and streamlined

Wisconsin ServicePoint ensures the security of its system. Please see below for detailed information on security measures.

Because this network is made up of many service providers in Wisconsin, you have the option to share your information with other service providers from whom you might be seeking services. Your identity and information collected in Wisconsin Service Point will be shared, with your written consent, in the network. Wisconsin Service Point includes your demographic information and other essential personal information needed to best determine your service needs.

The computer program used for this purpose has industry standard security protocols, and is updated regularly to meet these security requirements. The information you provide will only be shared with this agency, the network, and limited staff of the Institute for Community Alliances. No personally identifying information will be shared by our network with any department in the State of Wisconsin or the Federal Government. Information collected is housed in a secure server located at Bowman Systems, LLC. in Shreveport, Louisiana. Limited Bowman Systems staff have access to this server and the data for the purposes of network support and maintenance. Data collected for the network will be maintained for at least seven years from the last date of service.

The list of agencies participating in the network can be accessed at www.icalliances.org. This list may change.

Please note if you grant permission for your information to be shared, that agreement will be in effect until you revoke it in writing. You may end your agreement in writing and your personal and service information will no longer be shared from that date going forward. If you do not give permission for this agency to release your information, no other agency in the network will have access to it.

Maintaining the privacy and the safety of those using our services is very important. Your record will only be shared if you give permission. You cannot be denied services that you would otherwise qualify for if you choose not to share information. However, even if you choose not to share your information with other agencies, federal and state regulations may require limited data collection for funding purposes.

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Type of Information to be shared:

- Personal Identifying Information: Name (First, Middle and Last), Social Security Number, Date of Birth, Ethnicity, Gender, Last Residence Information, Military Status
- Housing/Program Specific: Entry/Exits, Agency Assessments, Services, Coordinated Entry, Case Notes, Referrals
- Assessment Specific: Income, Non-cash Benefits, Disability, Domestic Violence

Please indicate your choice regarding data sharing:

Option 1:

- _____ By initialing here I agree to share my and my child/children's above specified information and coordinate services with all participating agencies in the network.
- Verbal Consent

Option 2:

- _____ By initialing here, I agree to limit sharing of my and my child/children's above specified information and coordination of services to this agency and the agencies listed below:

_____	_____
_____	_____
_____	_____
_____	_____

- Verbal Consent

Option 3:

- _____ By initialing here, I agree I do not want to share my and my child/children's above specified information and coordinate services with other agencies.
- Verbal Consent

I understand that signing below relates only to data sharing within the WI Service Point and does not guarantee I will receive assistance. Alternatively, I understand that I will NOT be denied services if I refuse to consent to data sharing.

Client Signature: _____ **Date:** _____

Print Name: _____

Client Signature: _____ **Date:** _____

Print Name: _____

Verbal Consent obtained by phone (Agency Staff Initials): _____ **Date:** _____