OlyCAP
2120 W Sims Way ♦ Port Townsend, WA 98368 ♦ (360) 385-2571
228 W. 1st St. STE F ♦ Port Angeles, WA 98362 ♦ (360) 452-4726

General Intake

Application Date: _____

Head of Household Information

Location: □ Forks □ Port Angeles □ Port Townsend □ Sequim □ Other _____
County of Residence: □ Clallam □ Jefferson □ Other: _____

First Name: _____ Birthdate: _____
Middle Name: _____ SSN: _____
Last Name: _____ Gender: □ Male □ Female □ Other
Other Names: _____ Gender Other: _____

Contact Information

Cell Phone: _____ Office Phone: _____
Alt Phone: _____ Best Number: □ Cell Phone □ Work □ Alt Phone
Email: _____ Join email list: □ Yes □ No

Demographics (please mark all that apply)

Race	Ethnicity	Education	Disabled
□ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Pacific Islander □ White □ Biracial/Multiracial □ Other	□ Not Hispanic or Latino □ Hispanic or Latino **Military Status** □ No Affiliation □ Veteran □ Active	□ Grades 0-8 □ 9-12/Non-Graduate □ High School Grad □ GED □ 12 Grade + Some Post-Secondary □ 2 or 4 years College Graduate □ Graduate of other post-secondary	□ No □ Yes **Disconnected Youth*** □ No □ Yes *(age 14-24, not working and not in school)

Work Status	
□ Employed Full-Time □ Employed Part-Time □ Migrant Seasonal Farm Worker □ Unemployed (Short Term, 6 months or less)	□ Unemployed (Long-term, more than 6 months) □ Unemployed (Not in Labor Force) □ Retired

Health Insurance				
□ None □ Other	□ Direct-Purchase □ State Children	□ Military □ State Adult	□ Medicare □ Employment Based	□ Medicaid

Primary Language			
□ English □ Spanish □ African	□ European/Slavic □ Caribbean □ Middle Eastern/S Asia	□ East Asian □ Pacific Island □ Native American	□ Central/S America/Mex □ Other

Family Information	
Number in Household (including head of household): _____	
Family Type:	
□ Single Parent □ Two Parent Household □ Single Person (no children) □ Two adults (no children)	□ Multigenerational Household □ Extended Family □ Non-related Adults with Children □ Other
Housing: □ Rent □ Own □ Temporary Quarters □ Homeless □ Other:_____	

Physical Address: _____ Unit #: _____

State, City _____ ZIP: _____

Residence Type: □ 1-3 Unit □ 4+ Unit □ Hi-Rise (3 story or more) □ Mobile □ RV □ Other □ Shelter

Mailing Address _____ Unit #: _____

State, City _____ ZIP: _____

☐ Same as physical address

Income for Head of Household

Please fill in the total monthly amount of income above that you receive from all sources

Employment:		Unemployment:	
TANF:		L&I:	
SSA:		Disability:	
SSI/SSDI:		VA:	
Pension:		Child Support:	

☐ No Income (must complete no income statement form)

Other Income not listed above: (ABD, Spousal Support, Gifts, Etc.)

Household Needs (check all that apply)		
□ Food	□ Emergency Services	□ Nutrition for the Elderly
□ Day Care Programs	□ Weatherization	□ Employment Assistance
□ Head Start	□ Energy Assistance	□ Housing Assistance

By signing this *General Intake* form:

- I/we understand that no person may be denied assistance on the basis of race, color, age, handicap, religion, national origin, familial status, sexual orientation or political belief.
- If this application for assistance is approved, notification will be made in writing. No OlyCAP employee is authorized to give verbal assurance of assistance.
- I/we understand that willfully providing false information may be cause for denial or termination of assistance or services and could result in further legal consequences.
- I/we certify the above information is true and accurate.
- I/we understand that the information contained herein will be held in confidence and be used to determine eligibility and program planning, unless otherwise authorized by myself or my designee.

Applicant Signature _____ Date _____

Page for Additional Household Members Only

Last Name	First Name	MI	SSN (required)	DOB

Relationship to HoH	Gender	Race	Education	Disabled
□ Spouse □ Significant Other □ Child □ Foster Child □ Other:_____________	□ Male □ Female □ Non-Binary □ Other:_____________	□ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Pacific Islander □ White □ Biracial/Multiracial □ Other	□ Grades 0-8 □ 9-12/Non-Graduate □ High School Grad □ GED □ 12 Grade + Some College □ 2 or 4 years College Grad	□ No □ Yes
Ethnicity				Veteran
□ Not Hispanic or Latino □ Hispanic or Latino				□ No □ Yes

Gross Income for the previous month (for ages 18+ only)	
Source of Income: □ Employment □ SSI □ SSDI/SSA □ Other	Monthly Amount

Last Name	First Name	MI	SSN (required)	DOB

Relationship to HoH	Gender	Race	Education	Disabled
□ Spouse □ Significant Other □ Child □ Foster Child □ Other:_____________	□ Male □ Female □ Non-Binary □ Other:_____________	□ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Pacific Islander □ White □ Biracial/Multiracial □ Other	□ Grades 0-8 □ 9-12/Non-Graduate □ High School Grad □ GED □ 12 Grade + Some College □ 2 or 4 years College Grad	□ No □ Yes
Ethnicity				Veteran
□ Not Hispanic or Latino □ Hispanic or Latino				□ No □ Yes

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Ethnicity				Veteran
□ Not Hispanic or Latino □ Hispanic or Latino				□ No □ Yes

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Ethnicity				**Veteran**
☐ Not Hispanic or Latino ☐ Hispanic or Latino				☐ No ☐ Yes

Gross Income for the previous month (for ages 18+ only)	
Source of Income: ☐ Employment ☐ SSI ☐ SSDI/SSA ☐ Other	Monthly Amount

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Ethnicity				**Veteran**
☐ Not Hispanic or Latino ☐ Hispanic or Latino				☐ No ☐ Yes

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☐ Spouse ☐ Significant Other ☐ Child ☐ Foster Child ☐ Other:_____________	☐ Male ☐ Female ☐ Non-Binary ☐ Other:_____________	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Biracial/Multiracial ☐ Other	☐ Grades 0-8 ☐ 9-12/Non-Graduate ☐ High School Grad ☐ GED ☐ 12 Grade + Some College ☐ 2 or 4 years College Grad	☐ No ☐ Yes
Ethnicity				**Veteran**
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228 W 1st St, Ste F ♦ Port Angeles, WA 98362 ♦ (360) 452-4726
421 5th Ave ♦ Forks, WA 98331 ♦ (360) 374-6193

Notice of Privacy Practices Acknowledgement

By my signature on this Acknowledgement I confirm that I have received a copy of the *Notice of Privacy Practices* (Form 1032) of Olympic Community Action Programs (OlyCAP). I understand that the Notice provides a description of the uses and disclosures which OlyCAP may make of my protected information, including health information. It also informs me of my individual rights, how I may exercise these rights, and OlyCAP's legal duties with regard to my information.

I understand that OlyCAP reserves the right to modify the terms of its *Notice of Privacy Practices* and to make changes to all protected information which it maintains. Finally, I understand that I may always obtain a copy of the current *Notice of Privacy Practices,* without cost, from any OlyCAP office.

Name of Client (please print)

Signature

Date

Relationship to Client: check all that appliy
- ☐ Self
- ☐ Parent
- ☐ Legal Guardian
- ☐ Personal Representative
- ☐ Other (please specify)

For Agency Use Only

I hereby certify that I have attempted to obtain the above-named client's signature in acknowledgement of receipt of this agency's *Notice of Privacy Practices* (Form 1032), but was unable to do so for the reason(s) documented below.

Explanation:

Signature

Name/Title (Print Please)

Date

Client ID

Date Posted or Uploaded

2500 W Sims Way, Ste 201 ♦ Port Townsend, WA 98368 ♦ 360-385-2571

Notice of Privacy Practices

To our clients: *In the course of applying for and receiving services from Olympic Community Action Program (OlyCAP), clients frequently must disclose certain health and other types of personal information. This Notice describes how such information about you may be used and disclosed by OlyCAP and how you can get access to it. Please review this Notice carefully; you will be asked to sign an acknowledgement that you have received it.*

How we may use and disclose your personal information:

In accordance with federal law, without your specific consent or authorization, your personal information may only be used and disclosed for the following reasons:

- *Treatment* — Your personal health information may be used to provide you with appropriate medical treatment, care and services. In order to provide the best care, we may need to know specific medical conditions about you, such as your allergies.
- *Payment* — Your personal health information may be disclosed so that the medical treatment, care and/or services that you received from this agency may be billed and payment may be obtained from you, Medicaid or a third-party. We may need to share such information as your name, address or social security number and other information in order to identify you as a recipient of such services.
- *Operations* — Other personal information may be used to evaluate and assure quality services. We may use and disclose your personal information to conduct and arrange for services including for quality review, accounting, legal, risk-management, audit functions, fraud and abuse detection and contractual compliance purposes. We may contact you to set up appointments, provide appointment reminders or to provide you with information on other benefits that may be of interest to you.
- *Other Uses or Disclosures* — Your personal information may be used or disclosed for court-ordered purposes, to report any suspicion of child or vulnerable adult abuse or neglect, to report the potential for harm to self or others or to avert a serious threat to public health or safety.

Uses and disclosures requiring your written authorization:

Except as described in this Notice or in the laws that apply to the operations of this Agency, other uses and disclosures of your personal information will be made only with your written consent. We will ask you to sign a “release of information” form identifying specifically with whom we may share your personal information in order to provide you with appropriate coordination of services. If you sign such a release, you may revoke or change it, in writing, at any time.

Your individual rights:

The specific records containing your personal information and any billing records which we may create and store are the property of Olympic Community Action Programs. The protected information contained in those records, however, generally belongs to you.

Accordingly, you have the following rights:

- *You have the right* to receive, read and ask questions about this Notice.
- *You have the right* to ask us to restrict certain uses and disclosures. You must make this

request in writing and specify what information you would like restricted. We are not necessarily required to agree with your request.

- *You have the right* to request how and where the Agency should send communications about your personal information. These requests must be made in writing and we will accommodate all reasonable requests.
- *You have the right* to request, in writing, to inspect and/or copy your personal information. If you request a copy of this information, we reserve the right to charge a fee to cover the cost of copying, mailing or other expenses associated with the request. We may deny your request in certain very limited circumstances.
- *You have the right* to request, in writing, that an amendment or a correction be made to your personal information if you believe our records to be incorrect or incomplete. If the information was not created by OlyCAP, however, we may be unable to change it. If we deny your request, you have the right to submit a written statement of disagreement that will be kept in your file.
- *You have the right* to obtain an accounting of some of our disclosures of your personal information. We are not required by the Health Insurance Portability and Accountability Act (HIPAA) to include disclosures for purposes of treatment, billing or agency operations. Your request must be made in writing and must include the time period for which you want to receive a list of disclosures. This time period may not include dates before January 1, 2018, and may not cover a period of more than six (6) years. You may obtain from us, without charge, one accounting in twelve months. A fee will be charged for any additional requests.
- *You have the right* to file a complaint, in writing, if you believe that your privacy rights have been violated by this agency. You may file a complaint with the privacy officer and/or the executive director of Olympic Community Action Programs at 2500 W Sims Way, Ste 201, Port Townsend, WA 98368. You also have the right to file a complaint directly with the Secretary of the United States Department of Health and Human Services. You will not be penalized or discriminated against by this agency because you file a complaint.

OlyCAP responsibilities:

Olympic Community Action Programs is required to:

- Keep your protected information private;
- Give you this Notice of Privacy Practices; and,
- Abide by the terms of this Notice.

We reserve the right to change the terms of our *Notice of Privacy Practices* and to make the provisions of any new notice effective for all protected information that we maintain. We will publish our Notice of Privacy Practices on our web site (http://www.olycap.org), including any revisions. Copies of the Notice will always be maintained in any of our offices and may be requested at any time without charge to you.

For additional information about this Notice, please contact the agency's privacy officer by telephone at (360) 385-2571 or by e-mail at info@olycap.org. The agency's principal business office is located at 2500 W Sims Way, Ste 201, Port Townsend, WA 98368.

OlyCAP

2120 W Sims Way◆ Port Townsend, WA 98368 ◆ (360) 385-2571

AUTHORIZATION FOR RELEASE OF INFORMATION

To Our Clients: We can help you better if we are able to work with other agencies and individuals that know you and your family. By signing this *Release of Information* you are giving permission for these entities to share information about your situation.

1. Name of Client:

2. Date of Birth:

3. Authorization:

*I hereby authorize the following individual or agency to provide personal or household information to—or to receive such information from—*Olympic Community Action Programs:

☐ Jefferson Healthcare ☐ Discovery Behavioral Healthcare ☐ Employer
☐ REAL Team ☐ Peninsula Behavioral Health ☐ Other:_____

This authorization specifically includes (YES) and excludes (NO) the following types of information:

☐ YES ☐ NO Income Verification
☐ YES ☐ NO Family History
☐ YES ☐ NO Employment/Unemployment Information
☐ YES ☐ NO Educational Records
☐ YES ☐ NO Alcohol/Substance Abuse Information
☐ YES ☐ NO Mental Health Services
☐ YES ☐ NO Medical/Dental Treatment
☐ YES ☐ NO Financial Assistance
☐ YES ☐ NO Probation Records
☐ YES ☐ NO Housing Record (including rental history)
☐ YES ☐ NO Background Check

☐ YES ☐ NO Other as specified:

_____
_____
_____
_____
_____

For the purpose of this Release of Information, the terms "Alcohol/Substance Abuse Information," "Mental Health Services," and "Medical/Dental Treatment" include all aspects of diagnosis, treatment and prognosis. "Educational Records" include both behavioral and progress reports. "Financial Assistance" information includes all forms of assistance to me or my family.

I specifically authorize the agencies and individuals listed above to share and exchange information about me and my family circumstances in order to better evaluate my request(s) for assistance and to plan for and coordinate services for me and my family.

This permission is good for two (2) years or until the _____ day of _____, 20____. I understand that I can cancel this Authorization at any time, but I also understand that the cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by State and Federal law. I approve the release of this information. I understand what this Authorization means. I am signing on my own free will and have not been pressured into doing so.

Signatures:

☐ Client
☐ Parent
☐ Legal Guardian

Date:

Witness

Date:

TO THOSE RECEIVING INFORMATION PURSUANT TO THIS AUTHORIZATION: Information disclosed to you pursuant to this Authorization should be considered protected by the privacy laws of the State of Washington and the United States of America. You are not authorized to release it to any agency or individual not listed on this Authorization without the specific written consent of the person or persons to whom it pertains or unless otherwise specifically authorized by statute.

CERTIFIED to be a true copy of the original Authorization retained by Olympic Community Action Programs:

_____
Authorized Signature Date

2500 W Sims Way STE 201
Port Townsend, WA 98368 ♦ (360) 385-2571

Media Release Form

Release form for Publicity, Media and/or OlyCAP Agency Use

I _____ , on this_____ day of _____,
(Please Print) (Day) (Month)

Hereby: ☐ give OlyCAP and all of its division and volunteer programs permission

☐ Do not give OlyCAP and all of its division and volunteer programs permission

To use my name, photo or appearance in any media format, written, photographic or electronic, in perpetuity. I understand these will only be used to further the mission of OlyCAP, a non-profit.

By giving permission, I hereby release OlyCAP, its programs, staff, volunteers and Board of Directors from any liability in connection with the use of my identity in any of the above formats. I understand that this release and consent are voluntary and no financial arrangements are involved.

Please check one: ☐ Employee ☐ Client

☐ Volunteer Volunteer Site Location: _____

Signature _____ Date _____

A parent or guardian's signature is required if under 18 years of age. A signature may be required of a parent and/or guardian in certain instances for employees, clients or volunteers over the age of 18.

Signature _____ Date _____

ECSs Program Use Only: _____
Event

Additional Client Information

Address: _____

Phone Contact: _____

Best time to contact by phone: _____