For Immediate Release:  
Contact: Micheal Blizzard or Gina Harris  
August 30, 2022  
(757) 405-1800 or by email  
micheal.blizzard@dss.virginia.gov  
gharris@portsmouthva.gov

STOP Inc. Accepting Applications for Eviction Prevention
Individuals May Drop Off Applications at Department of Social Services

STOP Inc. is currently accepting applications for eviction prevention, and until Thursday, September 8th, the applications and required forms may be dropped off at the front desk in the Portsmouth Department of Social Services. The eviction prevention assistance is part of the STOP organization’s Financial Assistance Program, and until September 8th, the Portsmouth Department of Social Services is providing a convenient location for individuals to drop off their applications and required documents.

The Portsmouth Department of Social Services will not be processing the applications or making any determinations on them or the requests for assistance. All application packets that are dropped off will be turned in to the STOP organization.

Please print and complete the application packet documents that are attached or pick up a copy from the Department of Social Services. The documents are a cover letter, an application, and a consent to exchange information form. The following documents are required to be included with the completed application packet:

- Consent to Exchange Information form (attached to application packet)
- STOP Inc. Application for Financial Assistance Cover Page
- Copy of picture ID
- Eviction notice or statement indicating past due amount
- Landlord/Property Management Company contact information including phone number and payment address

Please drop off your completed application packet to the Portsmouth Department of Social Services, located at 1701 High Street. Applicants will be contacted directly by the STOP organization if additional information is needed and when payment has been made directly to the landlord or property management company.

For more information, please contact project coordinator, Micheal Blizzard or Gina Harris at 757-405-1800 or by email at micheal.blizzard@dss.virginia.gov or gharris@portsmouthva.gov.

#  #  #
Name: __________________________________________________

Address: _____________________________________________________________________

Benefits currently receiving from PDSS (check all that apply):

☐ SNAP

☐ TANF

☐ Medicaid

☐ Other: _____________________________________________

Signature: ____________________________________________ Date: ____________________
Introduction

Specified information can be shared among ALL of the agencies listed below, if the individual or his authorized representative agree, without having to obtain any additional signed authorization from the individual. The Authorization to Use and Exchange Information form was developed for use by the following agencies:

- Local departments of social services
- Area agencies on aging
- Centers for independent living
- Community services boards
- Department of Correctional Education
- Department of Youth and Family Services
- Health department clinics and programs
- Service delivery areas for the Workforce Investment Act
- Local/Regional Departments of Rehabilitative Services/Disability Services Boards
- Local school systems
- Regional offices, Department of Corrections
- Regional outreach offices, Department for the Deaf and Hard of Hearing
- Regional offices, Department for the Blind and Vision Impaired
- Virginia Employment Commission Offices

The “referring agency” is defined as the agency that initiates the completion of the Authorization to Use and Exchange Information form with the individual. The referring agency may use the form to request or to transmit information to other agencies. Agencies may be considered either a “referring” or an “other” agency, depending upon which agency is contacted first by the individual. If all parties agree, additional public and private agencies, facilities, and organizations may be included.

Agencies are assured that, when properly executed, this is a legally valid form that meets not only their own agency’s state and federal requirements, but also those of the other participating agencies. The Authorization to Use and Exchange Information form has been reviewed by the Office of the Attorney General to assure compliance with federal and state confidentiality requirements. Agencies may choose to use a different uniform release form that addresses their individual needs if it meets the state and federal confidentiality and release of information statutory and regulatory requirements of ALL involved agencies.

Purpose of the Authorization to Use and Exchange Information Form

The Authorization to Use and Exchange Information form is designed for use by agencies that work together to jointly provide or coordinate services for individuals with complex needs and should be used along with the referring agency’s specific procedures for obtaining a valid authorization to exchange information. It also can be used to assist agencies obtain information needed from other agencies to determine an individual’s eligibility for services or benefits. The completed form should reflect that the individual (or his or her representative) controlled the choices and understood the process. When using
this form, always keep in mind the importance of individual wishes, individual choices, and individual comprehension of the process.

Agency staff and the authorizing person shall first determine whether the individual might be eligible for services or benefits provided by other agencies. This determination should be based upon the needs, interests, and circumstances of the individual as well as staff’s knowledge of other agencies’ services or benefits and eligibility requirements.

Referring agency staff shall explain the following to the individual:

- Potential services and benefits that might be available from other agencies.
- What information these agencies might need and for what purpose(s).
- The purpose of the form.
- The consequences of signing or not signing this authorization.
- Key provisions and protections (e.g., revocation, access to agencies’ written record).

Staff shall make every attempt to ensure that the authorizing person understands the provisions of the form and should make appropriate efforts to accommodate the special needs of the authorizing person. If the authorizing person is unable to read or is blind or visually impaired, staff shall read the form to him or her. Interpreters should be made available for people who do not speak English and for those who are deaf or hearing impaired. If the authorizing person does not appear to comprehend the meaning of the form, it should be explained. If staff have ANY doubts that the authorizing person is not comprehending the purpose and provisions of the form, they should ask the authorizing person questions about the form (what the form allows the agency to do, etc.).

Based upon these answers, if staff determine that the authorizing person is NOT comprehending the purpose and provisions of the form, staff should follow their agency’s procedures for assuring that the form is signed by a legally authorized authorizing person who fully comprehends the purpose and provisions of the form. The signature of an authorizing person who does NOT comprehend what he or she is signing is not valid.

If the authorizing person agrees, the form should be completed. This should be done by the authorizing person, wherever possible. The authorizing person must sign the form and insert the date in the indicated place. Staff explaining the form to the authorizing person must sign the form in the indicated place. For those agencies with procedures requiring a witness (e.g., for a person who cannot write), space is provided for a witness to sign the form. The witness must observe the authorizing person signing or placing a mark on the form and then must sign as indicated. The referring agency must give a copy of the completed form to the authorizing person.

**Sharing Information with Other Agencies**

It is important for the referring agency to notify the other listed agencies that they are parties to this agreement to exchange information. This notification can be by telephone or through written correspondence. This notification must be entered into the individual’s record. If the referring agency
wants to receive information from other agencies, it must provide a copy of the signed authorization form with its initial request for information from each listed agency.

**Government Data Collection and Dissemination Practices Act**

To ensure compliance with the Government Data Collection and Dissemination Practices Act each time information is disclosed by any of the listed agencies, staff of the disclosing agency must enter the following information into the individual’s record:

- Name of the agency and the name of the individual receiving the information.
- Type and source of the information disclosed.
- Reason or purpose for the disclosure.
- Date the information was disclosed.

This requirement can be met by using a disclosure log (a sample can be found in the User’s Manual: Virginia Uniform Assessment Instrument, Appendix B) or through the agency’s own record keeping policies and procedures.

NOTE: The authorizing person has the right to review the records of disclosure of the referring and other agencies upon request during the agencies’ normal business hours.

**Agency Record Keeping Policies and Procedures**

**Referring Agency:** The original signed copy of the Authorization to Use and Exchange Information form, disclosure record, and any related materials shall be maintained in accordance with the agency’s record keeping policies and procedures.

**Other Agencies:** A copy of the Authorization to Use and Exchange Information form, disclosure record, and any related materials shall be maintained in accordance with the agency’s record keeping policies and procedures.

**Renewing or Amending the Authorization Form**

For No Wrong Door this authorization is valid for one year from date of signature, unless the individual or his or her authorized representative specifies an expiration date, event or condition that will occur prior to one year from the date of signature.

**Revocation of Authorization**

Authorization to exchange information will expire on the date or condition agreed to by the authorizing person. However, anytime prior to the expiration, the authorizing person may choose to revoke or cancel this authorization either with all or with selected agencies.
The authorizing person may revoke his or her authorization by informing any of the involved agencies in writing, by telephone, or in person. This notification must be noted on the back of the *Authorization to Use and Exchange Information* form and signed and dated by the agency staff person receiving the request to revoke the authorization.

If the authorizing person exercises the option of revoking his or her authorization (in entirety or with selected agencies) to share information under the agreement, the agency receiving this notice shall inform all other listed agencies that are authorized to exchange information under the agreement of the revocation of the authorization.

**Individuals Who Refuse to Sign the Authorization Form**

It is absolutely essential that the individual understand and appreciate what will happen as a result of signing this form. The individual also needs to understand that there is no requirement to sign this form, but that not signing the form will result in specific consequences. If the form is not signed, the individual must deal with each agency individually to obtain needed information, and/or the agency may not be able to provide services. If the form is signed, the process for applying for and receiving services may be easier for both the individual and the involved agencies.

**When Not to Use This Form**

The *Authorization to Use and Exchange Information* form should not be used with:

- Individuals who do not comprehend the purpose and substance of the authorization form; or
- Individuals for whom drug or alcohol abuse diagnostic or treatment information is being shared. In these cases, a separate authorization form (attached) should be used.

**Can Other Interagency Authorization Forms Be Used?**

Agencies should accept the *Authorization to Use and Exchange Information* form as a legally valid form. However, they may choose to use a different authorization form that addresses their individual needs IF it meets the state and federal confidentiality statutory and regulatory requirements of ALL the involved agencies.
I understand that different agencies provide different services and benefits. Each agency must have specific information to provide services and benefits. By signing this form, I allow agencies to use and exchange certain information about me, including information in an electronic database, so it will be easier for them to work together efficiently to provide or coordinate these services or benefits.

I, ____________________________, am signing this form for

(FULL PRINTED NAME OF AUTHORIZING PERSON OR PERSONS)

________________________________________

(FULL PRINTED NAME OF INDIVIDUAL)

________________________________________

(individual’s address) (individual’s birth date) (individual’s SSN – optional)

My relationship to the individual is: ☐ Self ☐ Parent ☐ Power of Attorney
☐ Guardian ☐ Other Legally Authorized Representative

I want the following confidential information about the individual to be exchanged:

Yes  No  Yes  No  Yes  No
☒ ☐ Assessment Information ☐ ☐ Medical Diagnosis ☐ ☐ Educational
☐ ☐ Financial Information ☐ ☐ Mental Health Diagnosis ☐ ☐ Psychiatric
☒ ☐ Benefits/Services Needed, ☐ ☐ Medical Records ☐ ☐ Criminal Justice
Records Planned, and/or Received ☐ ☐ Psychological Records ☐ ☐ Employment
Records ☐ ☐ Substance Abuse Records ☐ ☐ All of the Above

Other Information (write in): ____________________ __________________

I want _______________ STOP Inc. Organization

______________________________

(NAME AND ADDRESS OF REFERRING AGENCY AND STAFF CONTACT PERSON)

and the following entities to be able to use and exchange this information among themselves:

Yes  No  Identify By Name
<table>
<thead>
<tr>
<th>Department/Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>DMHMRSAS</td>
</tr>
<tr>
<td>Dept. of Education</td>
</tr>
<tr>
<td>Dept. of Juvenile Justice</td>
</tr>
<tr>
<td>CASA</td>
</tr>
<tr>
<td>Legal Counsel</td>
</tr>
<tr>
<td>Hospitals/Clincs</td>
</tr>
<tr>
<td>Other:</td>
</tr>
<tr>
<td>Local Health Departments</td>
</tr>
<tr>
<td>Physicians/Psychiatrist</td>
</tr>
<tr>
<td>Dentist/Orthodontist</td>
</tr>
<tr>
<td>Mental Health Provider</td>
</tr>
</tbody>
</table>

**I want this information to be exchanged ONLY for the following purpose(s):**

- [ ] Service Coordination and Treatment Planning
- [ ] Eligibility Determination
- [ ] Other: ____________________________

**I want this information to be shared by the following means: (check all that apply)**

- [ ] Written Information
- [ ] In Meetings or By Phone
- [ ] Computerized Data
- [ ] Fax

I want to share additional information received after this authorization is signed:  
- [ ] Yes  
- [ ] No

**This authorization is effective:**  

(DATE)

**This authorization is good until:**  

- [ ] My service case is closed.  
- [ ] Other: ____________________________

I can withdraw this authorization at any time by telling the referring agency. The listed agencies must stop sharing information after they know my authorization has been withdrawn. I have the right to know what information about me has been shared, and why, when, and with whom it was shared. If I ask, each agency will show me this information. I want all agencies to accept a copy of this form as valid authorization to share information. **If I do not sign this form, information will not be shared and I will have to contact each agency individually to give information about me that is needed.** However, I understand that treatment and services cannot be conditioned upon whether I sign this authorization. There is a potential for information disclosed pursuant to this authorization to be re-disclosed by the recipient and not be subject to the HIPAA Privacy Rule.

Signature(s): ___________________________________________ Date: ______________________

(AUTHORIZING PERSON OR PERSONS)

Person Explaining Form:

___________________________________________________________________________________

(Name) (Address) (Phone Number)
COMMONWEALTH OF VIRGINIA
UNIFORM AUTHORIZATION TO USE AND EXCHANGE INFORMATION

Full Printed Name of Individual:
____________________________________________________________________

FOR AGENCY USE ONLY

AUTHORIZATION HAS BEEN:

☐ Revoked in entirety
☐ Partially revoked as follows:

NOTIFICATION THAT AUTHORIZATION WAS REVOKED WAS BY:

☐ Letter (Attach Copy) ☐ Telephone ☐ In Person

DATE REQUEST RECEIVED: ________________

AGENCY REPRESENTATIVE RECEIVING REQUEST:
PURPOSE - The “Authorization to Use and Exchange Information” form is designed for use by agencies that work together to jointly provide or coordinate services for individuals with complex needs. It also can be used to assist agencies to obtain information needed from other agencies to determine an individual’s eligibility for services or benefits.

This form should be viewed as the end product of a discussion between the worker and the individual or the individual’s authorized representative which documents the individual’s decision on when and what type of information can be released or obtained. This form should NOT BE USED with an individual who does not comprehend the purpose and substance of the Authorization Form.

WHEN PROPERLY EXECUTED, THIS IS A LEGALLY VALID DOCUMENT FOR EXCHANGING INDIVIDUAL INFORMATION. TO BE PROPERLY EXECUTED ALL STATEMENTS MUST BE COMPLETED WITH THE APPROPRIATE INFORMATION AND/OR BY CHECKING THE APPROPRIATE YES OR NO BOX.

AUTHORIZING PERSON OR PERSONS - Enter the full name of the person/persons authorizing the exchange of information.

NAME OF INDIVIDUAL - Enter the full name of the individual about whom the information will be shared.

INDIVIDUAL’S ADDRESS, BIRTHDATE, SOCIAL SECURITY NUMBER (SSN) - Enter the individual’s address, date of birth, and social security number (SSN). NOTE: Section 2.2-3808 of the Code of Virginia makes it unlawful to require an individual’s social security number in order to obtain benefits or services unless a specific law allows the agency to require it.

RELATIONSHIP TO INDIVIDUAL - Check the authorizing person’s relationship to the individual. Note: A legally valid authorization requires that one of the listed relationships be present.

INFORMATION TO EXCHANGE - Check the appropriate box next to the information the individual wishes to exchange among the listed agencies. If necessary, write in any other information the individual wishes to exchange. NOTE: If the individual wishes to limit some of the information to be exchanged in any category, the limitations must be recorded on the back of the form. An individual may want to exchange most, but not ALL, of the specific information checked “Yes” (e.g., a reference to past psychiatric hospitalization contained in psychiatric records). If the individual wants some specific parts of a record to remain confidential, the referring agency MUST exclude this information when that record is shared with the other agencies).

REFERRING AGENCY AND STAFF CONTACT PERSON - Enter the name and address of the agency, which initiates the completion of the form. The staff contact person is the name of the staff person who
discussed/explained the use of the form with the individual and, if appropriate, assisted the individual in completing the form.

**SHARING AGENCIES** - Check the type of agencies with which the information will be exchanged. If more space is needed, additional agencies can be listed on the back of the form. The authorizing person(s) must place his or her signature or initials beside the name(s) of each agency listed on the back. The referring agency should notify the listed agencies that they are parties to the AUTHORIZATION TO EXCHANGE INFORMATION. This notification can be by telephone or written correspondence. This notification must be recorded in the individual’s record. If the referring agency wants to obtain information from the listed agencies, it must provide a copy of the signed authorization form. The copy may be mailed or faxed.

**PURPOSE OF EXCHANGE** - Check the appropriate box(es) or enter other purposes in the designated space.

**HOW THE INFORMATION IS EXCHANGED** - Check all appropriate boxes.

**SHARING OF NEW INFORMATION** - The individual can limit the exchange of information contained in the record as of the date of the authorization by checking the NO box. Information not in the record after the authorization is signed can be exchanged by checking the YES box.

**EXPIRATION** - The length of time the authorization is valid should bear a relationship to the individual’s participation in a project, service plan or treatment plan, and should be the individual’s choice. The authorization form may NOT be valid “forever”, “indefinitely” or for extremely long periods of time. Unless the individual specifies a particular date or circumstances, acceptable length of time would be “until placement” or “until my case is closed”. For No Wrong Door this authorization is valid for one year from date of signature, unless the individual or his authorized representative specify an expiration date, event or condition that will occur prior to one year from the date of signature.

**SIGNATURES** - The authorizing person(s) must sign and date the form. A copy of the signed authorization form must be given to the authorizing person(s). If the authorizing person cannot write, he or she will put his or her mark (i.e., initials, an “X”) in the signature space. The staff person explaining the form to the authorizing person(s) must sign the form and enter identifying information and a telephone number. If the agency procedures require a witness to an authorizing person’s mark, space is provided for his or her signature. The witness must observe the authorizing person sign or place a mark on the form.

**REVOCATION OF AUTHORIZATION** - The authorization to exchange information will expire on the date or circumstances agreed to by the authorizing person(s). The authorizing person(s) may revoke all or part of the authorization at any time prior to the expiration by notifying any of the involved agencies. This notification can be by telephone, in writing, or in person. This notification to revoke must be documented on the back of the authorization form by checking the appropriate boxes and entering the applicable information.
NOTIFICATION OF REVOCATION - The agency receiving the revocation notice must notify in writing all listed agencies of the individual’s revocation of his or her authorization, either entirely or partially. Notification must be recorded in the case record.

RENEWING OR AMENDING THE CONSENT AUTHORIZATION FORM - The referring agency can renew or amend (e.g., by adding additional agencies) the original signed copy of the Authorization to Use and Exchange Information form by having the authorizing person complete and sign a new form. The referring agency must give a copy of the new form to the authorizing person and forward a copy of the new form to each of the listed agencies. For No Wrong Door this authorization is valid for one year from date of signature, unless the individual or his or her authorized representative specifies an expiration date, event or condition that will occur prior to one year from the date of signature.
1. Last Name, First, M.I.                                      Last 4 Digits of SSN

   XXX-XX-

   Address                                      City/County          State Zip

   Phone #                                      Cell #               Email

   ( )                                           ( )                    

2. CLIENT HOUSEHOLD DEMOGRAPHICS: CHECK ALL INFORMATION AVAILABLE FOR YOU

<table>
<thead>
<tr>
<th>Household Members by Age Group</th>
<th>Ethnicity</th>
<th>Military Status</th>
<th>Work Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE NUMBER</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 - 5</td>
<td>Hispanic</td>
<td>Veteran</td>
<td></td>
</tr>
<tr>
<td>6 - 13</td>
<td>Non-Hispanic</td>
<td>Active Military</td>
<td></td>
</tr>
<tr>
<td>14 - 17</td>
<td>Unknown</td>
<td>Not Reported</td>
<td></td>
</tr>
<tr>
<td>18 - 24</td>
<td>Race</td>
<td>Never Served</td>
<td></td>
</tr>
<tr>
<td>25 - 44</td>
<td>African American</td>
<td></td>
<td></td>
</tr>
<tr>
<td>45 - 54</td>
<td>Asian</td>
<td>Full-Time</td>
<td></td>
</tr>
<tr>
<td>55 - 59</td>
<td>American Indian</td>
<td>Part-Time</td>
<td></td>
</tr>
<tr>
<td>60 - 64</td>
<td>Alaska Native</td>
<td>Migrant FW</td>
<td></td>
</tr>
<tr>
<td>65 - 74</td>
<td>Caucasian</td>
<td>Unemployed &gt; 6 months</td>
<td></td>
</tr>
<tr>
<td>75+</td>
<td>Native Hawaiian/Pacific Islander</td>
<td>Unemployed &lt; 6 months</td>
<td></td>
</tr>
<tr>
<td>Not Reported</td>
<td>Multi-race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>Other</td>
<td>Retired</td>
<td></td>
</tr>
</tbody>
</table>

Employed                         SSDI [ ]                      VA Service Connected Comp. [ ] Worker’s Compensation [ ] SNAP [ ]
Unemployment Insurance [ ]       TANF [ ]                        VA Non-Service Disability Pension [ ] Retirement Income [ ] Other, Identify: [ ]
SSI [ ]                          Pension [ ]                      Private Disability [ ] Allimony/Spousal Support [ ] Other, Identify: [ ]

AUGUST 2022

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### 3. CLIENT ASSISTANCE REQUESTED

<table>
<thead>
<tr>
<th>No assistance will be provided for any arrears payments dated prior to March 13, 2020</th>
<th>HEADCOUNT/# WEEKS</th>
<th>TOTAL AMOUNT REQUESTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Current Rent payment and/or</strong></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>2. Rent payment, <strong>in arrears</strong>, and/or</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>3. Rental Deposit payment and/or</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>4. <strong>Current Utility payments and/or</strong></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>5. Utility payments, <strong>in arrears</strong>, and/or</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>6. Deposits to turn on Utilities and/or</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>7. Fuel - <strong>not for automobile</strong> (for up to 3 mos.) and/or</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>8. Bus Tickets for working adults (up to $100 per mo., per adult, for up to 3 mos. each) and/or</td>
<td>___ / ___</td>
<td>$</td>
</tr>
<tr>
<td>9. Gas for automobile(s) of working adults (up to $100 per mo., per adult, for up to 3 mos. each) and/or</td>
<td>___ / ___</td>
<td></td>
</tr>
<tr>
<td>10. <strong>Current Childcare Assistance</strong> for working parent(s) for eligible children in household (for up to 6 wks, ending Sept. 30, 2022), provide # of children per wk. and/or</td>
<td>___ / ___</td>
<td>$</td>
</tr>
<tr>
<td>11. Childcare Assistance, <strong>in arrears</strong>, for working parent(s) for eligible children in household, provide # of children per wk. and/or</td>
<td>___ / ___</td>
<td>$</td>
</tr>
<tr>
<td>12. Supermarket Gift Card – household and hygiene items, school supplies, etc. ($100 per head of eligible household members) No alcohol or tobacco products allowed with gift card purchase.</td>
<td>___ / Members</td>
<td>$</td>
</tr>
</tbody>
</table>

**TOTAL AMOUNT REQUESTED**

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### 4.

Via my signature below, I attest that client eligibility for financial assistance is based upon the LDSS already established standards, procedures, processes and protocols for this existing client.

---

**Printed Name / Signature: DSS Representative**

**Submission Date**