

TREASURE COAST HOMELESS SERVICES COUNCIL, INC.
CLIENT CONSENT FOR FOLLOW UP
90, 180 & 365 DAYS

CLIENT NAME: (FIRST, MIDDLE, LAST) _____

ADDRESS: (MAILING IF DIFFERENT) _____

PHONE NUMBER: (AT LEAST TWO CONTACT NUMBERS) _____

I HEREBY AUTHORIZE:

TREASURE COAST HOMELESS SERVICES COUNCIL
 2525 ST. LUCIE AVENUE
 VERO BEACH, FL 32960
 772-778-4234

To make contact with me for follow up within ninety days, one hundred eighty days and three hundred sixty five days after direct financial assistance have been provided by your agency. The specific purpose would be to verify my ability to maintain my household. I release the above cited individuals or facilities of any legal liability that may arise from the release of the information requested. I understand that the individual/institution or agency receiving this information may not re-release it to any other individual, institution or agency. I also understand that this authorization for release of information will expire on _____ (not to exceed one year).

 HEAD OF HOUSEHOLD SIGNATURE DATE

 SPOUSE/ SIGNIFICANT OTHER SIGNATURE DATE

 WITNESS NAME (print) WITNESS SIGNATURE DATE

OFFICE USE ONLY:
 Date assistance was provided: _____
 Follow up dates: 90 Days: _____
 180 Days: _____
 365 Days: _____
 The following entitlements were discussed with the client:

| | | | |
|---|----------------|---------------|--------------------|
| _____ Social Security Disability | _____ Receives | _____ Pending | _____ Applying for |
| _____ Food Stamps | _____ Receives | _____ Pending | _____ Applying for |
| _____ Medicaid | _____ Receives | _____ Pending | _____ Applying for |
| _____ Health Insurance for children | _____ Receives | _____ Pending | _____ Applying for |
| _____ Client's income exceeds eligibility criteria for these services | | | |
| _____ Referrals and assistance provided from entitlement specialist | | | |
| Referred to TCHSC by: _____ | | | |