CalAIM MCP Staff Verification for HMIS Access

Homeless Management Information System (HMIS)

Continuum of Care: ■ Sacramento

Organization Name: _____

Program Name: _____

Employee Name: _____ HMIS Access Level: Read Only Access

Employee Work Email: _____ Work Phone: _____

Immediate Supervisor: _____

Supervisor Work E-Mail: _____ Work Phone: _____

AUTHORIZATION & CONFIDENTIALITY STATEMENT

☐ My agency agrees to maintain strict confidentiality of information obtained through the Homeless Management Information System. This information will be used only for the legitimate client services and administration of the above name organization. I understand that it is the responsibility of the Agency's Executive Director, or the above employee's immediate supervisor, to notify the HMIS Administrator of the employee's termination from the agency, placement on disciplinary probation, or upon any change in duties not necessitating access to HMIS System information within one business day of the occurrence.

BACKGROUND CHECK STATEMENT & VERIFICATION

☐ My agency has conducted a background check on the above mentioned staff and has determined that they have not been convicted of any crimes of identity theft, fraud or stalking as listed in the HMIS Privacy and Security Plan.

By signing below, you are indicating that understand and agree to comply with all requirements set in the Authorization and Confidentiality Statement and you are confirming that this employee has passed a background check to meet the requirements of the HMIS Privacy and Security Plan.

X_____ _____ _____

Supervisor's Signature **Printed Name** **Date**

If you have any questions, please contact HMIS Support at hmis@sacstepsforward.org.