



## **Thank you for applying to the YWCA Helena WINGS Program**

The first 4 pages that come before the application ***are for you to keep*** and will help you learn more about the YWCA WINGS Program and guide you through what is needed to fully complete your application.

### **Steps to apply:**

1. Please fill out each page of the YWCA WINGS Program Application completely to the best of your knowledge.
2. Remember to list three people on the reference page that you feel would be able to provide helpful information about how our program can best support you (for example: your Addiction Counselor, Mental Health Provider, Probation Officer, Social Worker, Medical Prover, etc.).
3. Include with the application your most recent Chemical Dependency Evaluation, also helpful to include with the application is your most recent Mental Health Assessment.
4. Submit your application in person to the YWCA at 501 North Park Avenue. You can also fax the application to 406-442-0428, or you can email the application to [kim@ywcahelena.org](mailto:kim@ywcahelena.org).
5. Follow up with a phone call to 406-442-8774 to check in on the status of your application, and always call to update information when necessary – especially if your contact information has changed (we want to be able to reach you)!

If at any point you have questions or need support with community resources, please reach out to us at 406-442-8774 and we will be happy to assist you.

**WINGS Program Expectations – please read carefully to determine if WINGS will be the right program for you and please let us know if you have questions:**

Upon move-in, all WINGS Participants are expected to sign the WINGS Program Agreement and Lease which outlines all Program Expectations and Housing expectations. Each Program and Housing Expectation is in place to help all Participants achieve the overall goal of obtaining permanent housing that she can sustain.

Primary expectations to be aware of **prior to move-in** are as follows:

- There is ZERO TOLERANCE for drug or alcohol use on the YWCA premises. There is also ZERO TOLERANCE for dishonesty about personal drug or alcohol use or aiding another WINGS Participant’s drug or alcohol use. If a participant has a lapse or relapse it is essential that the participant inform Staff immediately. This a place to find freedom and safe shelter from drug and alcohol use. HONESTY, OPENNESS and WILLINGNESS are key expectations of all Participants.
- Participants **are expected not to use alcohol or other drugs on or off** YWCA Helena premises.
  - Random urine analyses will be completed with all Participants. Daily call-ins to Community Solutions, Inc. are required. If the Participant’s name is on the random list, UA testing is mandatory on that day.
  - Random room inspections will be completed with all Participants.
- Participants will meet with her WINGS Addiction Counselor *at least* **once a week** to develop an action plan for sustainable recovery.
- Participants will meet with her WINGS Clinical Mental Health Counselor *at least* **once per week** to address co-occurring in our Integrated Co-Occurring Treatment model.
- Weekly meetings with WINGS Peer Supports are also a program expectation. Peer Supports will be a helpful part of participant’s early recovery processes and also work with individuals on case management strategies including 1) Employment/Education, 2) Permanent Housing, 3) Self-Care, 4) Community Connectivity, 5) Mental Health, and 6) Financial Budgeting as a part of this recovery plan.
- **According to the unique situation of each participant and within the first 90 days of programming**, each participant will engage with their treatment team to discuss employment readiness and opportunities. The expectation is to work up to

20 hours only to start, with a steady increase as readiness is determined by the participant and her treatment team.

- Participants are expected to seek support from community recovery groups (AA, NA, Celebrate Recovery, etc.) and seek Sponsorship support immediately through a Sponsor *outside* of the YWCA.
- Participants **attend a daily morning group from 8:30 – 9:30 am, Monday through Thursday.**
- **Participants attend trauma-sensitive and gender-specific recovery and relational groups including:** Relationship/Attachment, Women in Recovery, Seeking Safety, Beyond Trauma, Circle of Security (see next item below), and Love & Logic. Other activities may be added when designated as vital to Program completion and determined in collaboration with the participant and her treatment team.
- Because of the close association and interaction with Participant’s children in the WINGS Program, all WINGS Participant will be expected to complete the Circle of Security parenting class. WINGS Participants who have children will also be expected to sign a child addendum outlining child care expectations and to work closely with onsite parenting advocates to foster the healthiest mother/child relationship.
- Participants **must stay at YWCA Helena every night to be accountable to the program and one’s own sobriety.** Any plans that involve staying somewhere other than the YWCA overnight must be agreed upon and arranged with your treatment team at least a week in advance.
- Participants are to pay their housing fee on the first business day of every month while in the program.
  - Program fees are calculated as **25%** of the Participant’s annual gross income.
  - The lowest fee due is \$50 and the highest amount is \$250, dependent on income.
  - Participants are expected to give the Agency Coordinator (Marci) copies of all paystubs and proof of any other income so that appropriate calculations may be completed.
  - **Participants are expected to pay the full amount of the housing fee prior to move-in**

- **A refundable key deposit of \$75 is also required for each participant's room (\$25), mailbox (\$25), and kitchen cabinet key (\$25).**
- Upon move-in, Participants will be provided with one bin, if needed, to move in personal items. **This bin** may be put in a locked storage room in the basement of the building for added space in resident rooms, if needed.
  - A Participant that has children will be provided with one extra bin per child. These can be moved to locked storage downstairs, if needed.
  - Participants **may not** bring in extra furniture, a refrigerator, extension cords, or any other unnecessary items. Participants will discuss with their treatment team the possibility of having a television **PRIOR** to getting one.
- Upon move-out, Participants will remove all personal belongings from their resident room, either to an agreed upon storage space at the YWCA (can be stored for up to 30 days) or to a designated location off YWCA property. Anything left in the room will be discarded.

We look forward to receiving your completed application. Again, if you have questions or need assistance, please reach out to us at 406-442-8774.

**Thank you!**

# YWCA WINGS Program Application

## MISSION STATEMENT

The YWCA is dedicated to eliminating racism, empowering women and promoting peace, justice, freedom and dignity for all.

The YWCA of Helena is committed to providing women with safe, affordable housing and assistance in accessing community resources.

We ask a lot of questions in this application, so we can get to know the women interested in living at the YWCA and learn how we can support participants in achieving life goals.

## GENERAL INFORMATION

Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
First Middle Last

Mailing Address \_\_\_\_\_ Zip \_\_\_\_\_

Physical Address \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Is it safe to call/leave a message YES NO

Other contact/Message Numbers \_\_\_\_\_

Email \_\_\_\_\_

Birth date \_\_\_\_\_ Social Security Number \_\_\_\_\_

Who is your Emergency Contact? \_\_\_\_\_  
Phone Number? \_\_\_\_\_

Where are you coming from? Circle one:

Jail Prison Prerelease Treatment Other \_\_\_\_\_

Are you currently in Helena? YES No

How long have you been in Helena? \_\_\_\_\_

How did you hear about the YWCA? \_\_\_\_\_

Have you lived at the YWCA before? YES NO

If yes:

When did you live at the YWCA: \_\_\_\_\_

Why did you move out: \_\_\_\_\_

**Please check** any agencies you are currently working with or have worked with in the last year:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> AWARE                    | <input type="checkbox"/> Family Promise           | <input type="checkbox"/> Helena Indian Alliance |
| <input type="checkbox"/> Boyd Andrew              | <input type="checkbox"/> God's Love               | <input type="checkbox"/> Prison/prerelease      |
| <input type="checkbox"/> Center for Mental Health | <input type="checkbox"/> Good Samaritan           | <input type="checkbox"/> Probation and Parole   |
| <input type="checkbox"/> Pure View                | <input type="checkbox"/> Helena Industries        | <input type="checkbox"/> St. Peter's Hospital   |
| <input type="checkbox"/> Counseling               | <input type="checkbox"/> Job Service              | <input type="checkbox"/> Salvation Army         |
| <input type="checkbox"/> CTI                      | <input type="checkbox"/> Public Defender/attorney | <input type="checkbox"/> Voc-Rehab              |
| <input type="checkbox"/> DPHHS/CPS                | <input type="checkbox"/> Food Share               | Other: _____                                    |

**PERSONAL**

Have you experienced violence in any form since you turned 18? YES NO

If yes, did you get any counseling? YES NO

Do you currently feel safe? YES NO

If no, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Are you a single head of household? YES NO

Do you have a service animal? YES NO

Have you ever served in the military? YES NO

If yes, when? \_\_\_\_\_

Are you receiving benefits? YES NO

Enrolled Tribal member? YES NO

**VEHICLE**

Do you own your own vehicle?                    YES            NO  
Do you have auto insurance?                    YES            NO  
Do you have a driver's license?                    YES            NO

If no, please explain \_\_\_\_\_

**HOUSING**

Are you homeless or about to become homeless?                    YES            NO

Where did you sleep last night? \_\_\_\_\_

Are you signed up for Helena Housing Authority?                    YES            NO

If yes, when? \_\_\_\_\_

If no, please explain \_\_\_\_\_

Please describe your current living situation (where are you living, for how long, circumstances leading up to now) \_\_\_\_\_

\_\_\_\_\_

Do you know any of the current or recent residents of the YWCA? If so, who do you know and how do you know them? \_\_\_\_\_

\_\_\_\_\_

**EMPLOYMENT AND INCOME**

Do you have the ability to work?                    YES            NO

If no, please explain: \_\_\_\_\_

\_\_\_\_\_

Are you currently employed?                    YES            NO

Name of Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

How many hours do you work each week? \_\_\_\_\_ What is your hourly pay? \_\_\_\_\_

What job skills do you have? \_\_\_\_\_

Do you have other sources of income?                      YES                      NO

**Please check all that apply**

Other Source of Income	<input checked="" type="checkbox"/>	Amount You Get Monthly
Social Security		
SSI		
SSDI		
Unemployment		
SNAP		
TANF		
Child Support		
Other:		

**EDUCATION**

Highest Level of Education	<input checked="" type="checkbox"/>
Some High School (please circle the grade) 9 10 11 12	
High School Diploma	
GED	
Some College or Trade School, no degree	
Some College and a Professional Certification	
Associates Degree	
Bachelors Degree	
Masters Degree	
PhD	

Mark your highest level of education, including partial completion.

Are you currently enrolled in school?    YES    NO  
 If yes, what school do you attend? \_\_\_\_\_

Do you plan on enrolling in school?    YES                      NO







Do you have any disabilities? YES NO      Receiving SSDI? YES NO  
 Please explain: \_\_\_\_\_

Do you need special accommodations? YES NO  
 Please explain (ambulatory devices, shower aids, service animal): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**LEGAL**

YWCA Helena serves women who have had legal system involvement, please be as specific as possible as this will not hinder acceptance into the WINGS program.

Charge	County, State	Date	Outcome (incarceration, probation, fines, etc)	Date Resolved

Additional information: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you have any unresolved legal charges    YES            NO

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have legal representation?    YES            NO

Representing attorney \_\_\_\_\_ Phone \_\_\_\_\_

County \_\_\_\_\_ Scheduled sentencing date \_\_\_\_\_

Are you on probation or parole?    YES            NO

Name of Parole/Probation Officer: \_\_\_\_\_

How long have you been on probation/parole? \_\_\_\_\_

Are you paying fines or restitution?    YES            NO

How many hours of community service: \_\_\_\_\_ Amount of fines/restitution: \_\_\_\_\_

**ALCOHOL AND OTHER DRUGS**

Are you currently dependent on alcohol and/or other drugs?    YES    NO

Other addictions, not alcohol or drugs: examples; work, sex, money: \_\_\_\_\_

Substance	Never Used	Age of First	Date of Last Use	Frequency	Typical Amount	Method of Use	System Involved
EXAMPLE: addiction		14	6/26/2017	3x a day	1 gram	snort	PO, Court, CPS
Alcohol							
Tobacco							
Tranquilizers							
Inhalants							
Marijuana							
Hallucinogens (LSD, Mushrooms)							
Amphetamines (Speed)							
Barbiturates (Downers)							
Methamphetamine (Crank, Crystal Meth)							
Opiates (Heroin)							
Cocain							
Prescription Pain Medication							
Adderall							
Suboxone or Naloxone							
Other:							

Do you experience withdrawal symptoms when you stop using? YES NO

What are your symptoms (seizures, DT's): \_\_\_\_\_

Are you currently experiencing withdrawal symptoms? YES NO

Have you attended **inpatient** chemical dependency treatment? YES NO

Treatment facility	City, State	Entry Date	Discharge Date	Still Attending?	Did you complete?	If no, why?

Have you attended **out-patient** chemical dependency treatment? YES NO

Treatment facility or Provider	City, State	Entry Date	Discharge Date	Still Attending?	Did you complete?	If no, why?

Have you ever experienced life difficulties or problems because of alcohol or other drugs?

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Has anyone ever expressed concerns about your use of alcohol or other drugs?

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Do you attend AA or NA? YES NO

Are you working with an Addiction Counselor? YES NO

Or Have you worked with an Addiction Counselor in the past? YES NO

If yes, who? \_\_\_\_\_ Phone \_\_\_\_\_

**Future Plans**

Are your family members supportive of your sobriety at this time?                      YES      NO

Why do you want to come to YWCA Helena?

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Why are you seeking treatment at this time?

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Please mark the number that best describes your readiness to change your life:  
1 being I do not want to change and 5 being I will do whatever it takes

   1                      2                      3                      4                      5

Do you have a long-term sobriety plan?

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Please check all that apply:

- Signed up for IOP/OP
- Created a plan with Probation Officer
- Started GED
- Searching for employment
- Signed up for SNAP, Medicaid, etc
- AA or NA groups
- Working with or signed up with an Addiction Counselor
- Working with or signed up with a mental health counselor
- Applied for housing

## STATISTICAL INFORMATION

Please make a checkmark in the appropriate box. In some cases, you may need to place a checkmark in more than box. Public use of this information will not be connected to individuals and is YWCA Helena population statistics only.

Racial Identification	✓
American Indian/Alaskan Native	
Asian	
Black/African American	
Hispanic	
Native Hawaiian/Other Pacific Islander	
White	
American Indian/Alaskan Native & White	
Asian & White	
Black/African American & White	
American Indian/Alaskan Native & Black/African American	
Other Multi-Racial	
Preferred Not to Answer	

Where did you sleep last night?	✓
Non-housing (street, park, car, etc.)	
Emergency shelter	
Transitional housing	
Psychiatric facility*	
Substance abuse treatment facility*	
Hospital*	
Jail/prison*	
Domestic violence situation	
Living with relatives/friends	
Rental housing	
Other (please specify)	
Could be kicked out of where you are staying in next 14 days without a place to go?	
<b>Housing History</b>	
Have you been without a home 4 or more times in the last 3 years?	
<b>Age Ranges</b>	
17 and under	
18-30	
31-50	



51-61	
62 and over	

<b>Relationship Status</b>	✓
Single	
In a Relationship	
Married	
Separated	
Divorced	
Widowed	
<b>Medical Information</b>	
Physical Disability	
Developmental Disability	
Chronic Health Condition	
HIV/AIDS	
<b>Would you like information or assistance on any of the following?</b>	
Mental Illness	
Alcohol Abuse	
Drug abuse	
HIV/AIDS and related diseases	
Developmental disability	
Physical disability	
Sexual Assault	
Legal Services	
Accessing SNAP and other Assistance	
Financial Education	
Domestic Violence	
Other (please specify)	

## REFERENCES

Please provide three (3) references. Some examples of references include employers, case managers, counselors, landlords, co-workers, and teachers.

Name: \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_ City and State \_\_\_\_\_

How does this person know you? \_\_\_\_\_ How long? \_\_\_\_\_

Name: \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_ City and State \_\_\_\_\_

How does this person know you? \_\_\_\_\_ How long? \_\_\_\_\_

Name: \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_ City and State \_\_\_\_\_

How does this person know you? \_\_\_\_\_ How long? \_\_\_\_\_

### Applicant Statement

My signature below certifies that all information on this application is true, correct, and complete to the best of my knowledge, and contains no willful falsifications or misrepresentations. I authorize the YWCA to contact my present and past employers and the references listed above to obtain information deemed appropriate to consider my application for the WINGS program. **I agree to take a drug test, paid for by the YWCA, before being accepted into the WINGS Program.**

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date



Thank you for taking the time to fill out this application

### Adverse Childhood Experiences (ACE's) Score Questionnaire

Many stressful life experiences are listed in the table below. Please answer the questions for yourself if you are our client, or for your child if you are completing this questionnaire as a parent or guardian.

In the left-hand column, answer "Yes" if you've had the experience or "No" if you have not.

Then in the two columns on the right, rate how much the experience bothered you when it happened, and how much it bothers you now, using the 0-10 scale from "Not at All" to "Very Much".

Have You Had This Experience?	Description of Life Experience	How Much Did This Experience Bother You At The Time It Happened?	How Much Does This Experience Bother You Now?
Enter Yes or No	<b>While I was growing up, during my first 18 years of life...</b>	0 – Not at all to 10 – Very Much	0 – Not at all to 10 – Very Much
1	A parent or other adult in my home <b>often or very often</b> ... swore at me, insulted me, put me down, or humiliated me. Or – acted in a way that made me afraid that I might be physically hurt.		
2	A parent or other adult in my home <b>often or very often</b> ... pushed, grabbed, slapped, spanked, choked, or threw something at me. Or – <b>ever</b> , even just once, hit me so hard that I had marks or I was injured.		
3	An adult or person at least 5 years older than me <b>ever</b> , even just once... touched or fondled me or had me touch their body in a sexual way. Or – attempted or actually had oral, anal, or vaginal intercourse with me.		
4	I <b>often or very often</b> ... felt that no one in my family loved me or no one in my family thought I was important or special. Or – my family members didn't look out for each other, feel close to each other or support each other.		
5	I <b>often or very often</b> felt that... I did not have enough to eat, had to wear dirty clothes, and had no one to protect me. Or my parents were too drunk or high to take care of me or take me to the doctor if I needed it.		
6	My parents were <b>ever</b> separated or divorced, even if they got back together.		
7	My mother or stepmother <b>often or very often</b> was pushed, grabbed, slapped or had something thrown at her. Or <b>sometimes, often or very often</b> was kicked, bitten, hit with a fist, or hit with something hard. Or <b>ever</b> was repeatedly hit at least a few minutes or threatened with a gun or knife.		
8	I lived with someone who was a problem drinker or alcoholic or used street drugs.		
9	A parent or other adult in my home was depressed, or was mentally ill, or attempted suicide.		
10	A parent or other adult in my home went to prison.		

Client Name: \_\_\_\_\_

Date: \_\_\_\_\_

## RESILIENCE Questionnaire

Please circle the most accurate answer under each statement:

I believe that my mother loved me when I was little.

Definitely true   Probably true   Not sure   Probably Not True   Definitely Not True

I believe that my father loved me when I was little.

Definitely true   Probably true   Not sure   Probably Not True   Definitely Not True

When I was little, other people helped my mother and father take care of me and they seemed to love me.

Definitely true   Probably true   Not sure   Probably Not True   Definitely Not True

I've heard that when I was an infant someone in my family enjoyed playing with me, and I enjoyed it, too.

Definitely true   Probably true   Not sure   Probably Not True   Definitely Not True

When I was a child, there were relatives in my family who made me feel better if I was sad or worried.

Definitely true   Probably true   Not sure   Probably Not True   Definitely Not True

When I was a child, neighbors or my friends' parents seemed to like me.

Definitely true   Probably true   Not sure   Probably Not True   Definitely Not True

When I was a child, teachers, coaches, youth leaders or ministers were there to help me.

Definitely true   Probably true   Not sure   Probably Not True   Definitely Not True

Someone in my family cared about how I was doing in school.

Definitely true   Probably true   Not sure   Probably Not True   Definitely Not True

My family, neighbors and friends talked often about making our lives better.

Definitely true   Probably true   Not sure   Probably Not True   Definitely Not True

We had rules in our house and were expected to keep them.

Definitely true   Probably true   Not sure   Probably Not True   Definitely Not True

When I felt really bad, I could almost always find someone I trusted to talk to.

Definitely true   Probably true   Not sure   Probably Not True   Definitely Not True

As a youth, people noticed that I was capable and could get things done.

Definitely true   Probably true   Not sure   Probably Not True   Definitely Not True

I was independent and a go-getter.

Definitely true   Probably true   Not sure   Probably Not True   Definitely Not True

I believed that life is what you make it.

Definitely true   Probably true   Not sure   Probably Not True   Definitely Not True

How many of these 14 protective factors did I have as a child and youth? (How many of the 14 were circled "Definitely True" or "Probably True"?) \_\_\_\_\_ Of these circled, how many are still true for me? \_\_\_\_\_

<http://acestoohigh.com/got-your-ace-score/> 2

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## Head Trauma History

Please put "Yes" or "No"

H = Hit on head

Have you ever:

Been hit in the face or head? With what?

Has your head been slammed into a wall or another object?

Been pushed so that you fell and hit your head?

Has anyone ever shaken you?

Have you ever been strangled or choked, or had anything else that made it hard for you to breathe?

Have you ever had an injury to your face, head or throat in any other way?

Have you ever been in a car accident?

If yes:

Has anything happened more than once?

E = Emergency room treatment

Did you ever go to the emergency room after hitting your head? Why?

If yes:

Did they ask whether you had been hit on the head or say that they suspected that you had a head injury or concussion?

Did you think you got all the treatment you needed?

If no:

Was there ever a time when you thought you should go to the ER after an injury to your head, but didn't go?

L = Loss of consciousness

Have you ever lost consciousness or black out as result of a hit to the head or being choked?

P = Problems

Have you been having trouble concentrating or remembering things?

Are you having trouble finishing things you start to do?

Have people told you that you're not acting like yourself?

Have you been having trouble doing what you need to do at work, school, or home?

Are you having mood swings that you don't understand?

Has it gotten harder for you to function when you're under stress?

S = Sickness

Have you had any physical problems since your partner assaulted you? What kind?

Do you have any recurring headaches or fatigue?

Have you had any changes in your vision, hearing, or sense of smell or taste?

Do you find yourself dizzy or experiencing a lack of balance?

The next page contains an Authorization for Release, Disclosure and Exchange of Health Information. Please copy and sign one for each current agency or former provider of social services, or physical, mental health or substance use treatment that you are working with. Thank you



# YWCA Helena

## Authorization for Release, Disclosure, and Exchange of Health Information

I, \_\_\_\_\_, \_\_\_\_\_ hereby authorize the disclosure of information from my health record.  
Participant's Name Birthdate

I authorize YWCA Helena to obtain information FROM the following agency or individual:

I authorize YWCA Helena to send information TO the following agency or individual:

Name of Agency/Individual: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

The information to be disclosed from my health record:

Medical Records  Discharge Summaries  Substance Use Treatment Reports

Clinical Mental Health & Substance Use Disorder Assessments  Treatment Plans

Medication Records  Insurance, Billing, and Claim Records  Routine Clinical Assessments

Other: \_\_\_\_\_  
(Please Specify)

By signing this authorization, I understand that:

- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment at YWCA Helena
- That my alcohol and drug treatment records are protected under federal regulations governing the confidentiality of alcohol and drug abuse patient records 42 CFR Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for by the regulations. Persons receiving information may not further disclose such information if the information concerns drug or alcohol use or treatment. However, I also understand that persons receiving other types of confidential information may have the ability to disclose. I have the right to revoke this information at any time in writing, except to the extent that YWCA Helena has already provided the information.
- I may revoke this Authorization in writing at any time, except to the extent this Authorization has already been acted upon prior to the effective date of revocation. A written revocation of this Authorization must be submitted to the Executive Director of YWCA Helena at 501 N. Park, Helena, MT 59601, or email [jenifer@ywcahelena.org](mailto:jenifer@ywcahelena.org) and that revocation will only be effective upon receipt.
- If the specific record information that is the subject of the Authorization contains information related to HIV infection, AIDS or AIDS related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing, the disclosure I am hereby authorizing will include that information.
- This authorization will expire 12 months from the date below unless I revoke authorization prior to that time.

Client Printed Name Client Signature Date

Authorized Representative Printed Name Authorized Representative Signature Date

### Revocation Section

I no longer want my information shared.

Signature Date