**Request for New Agency HMIS Access**

Date of Request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Organization Requesting Access**
	1. **Organization Name (include branch, division, department, etc.):**
	2. **Associated Programs**
	3. **Street Address or P.O. Box:**
	4. **City/State/Zip Code:**
	5. **Telephone (include area code):**
	6. **E-mail:**
2. **Rationale for Requesting Access**

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1. **Mission of Organization and Associated programs**

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1. **Continuum of Care where services are provided (i.e. Partners in Care or Bridging the Gap)**

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1. **Services provided by Organization and Associated Programs**

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1. **Number of individuals or families experiencing homelessness that are served annually**

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1. **Number of users needing access**

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1. **Describe how access to HMIS or the Coordinated Entry System will benefit clients experiencing homelessness (assessing clients, referring clients, getting clients document ready, involvement in case conferencing, and navigation through the housing program)**

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**Submitted by:**

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

**(Name) (Title)**

Statewide Data Committee Recommendation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Recommendation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Statewide Data Committee Chair Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_