



Desert AIDS Project

care :: prevention :: advocacy

*1695 North Sunrise Way
Palm Springs, CA 92262
(760) 323-2118*

INTAKE

INFORMATION

PACKET

Please fill out as much of the information as you can before your appointment in order to save time for you and DAP staff

Thank you!

Dear Friend,

Below is a list of documents you will need to become a client of the Desert AIDS Project. Please complete the enclosed intake packet and bring it with you. If at any time you are unclear about any of the contents of the intake packet, the Community Center Manager is available by phone (760) 323-2118 ext. 295, to answer your questions.

If you have just moved to the area and are currently taking medications, please be sure you have access to **at least three month's supply** of your medications **as there is a 90 day residency requirement for services** and contact your insurance provider as there may be a delay while your insurance is transferred to this county's office.

Thank you.

Following is a list of all required items needed to become a client

- **Identification:** Drivers license, State ID, Immigration Card, School Identification, or Valid United States Passport.
- **Social Security Card/Medicare Card**
- **Residency:** Proof of residence in Riverside or San Bernardino Counties.
 - A post-marked letter 90 days prior to the date of service, **OR**
 - Utility bill that shows original date of service of 90 days or more **OR**
 - Rental Agreement showing original move-in date

- **Diagnosis Status:** Applicants are asked to provide one of the following at the initial and at each recertifying eligibility period:
 - Diagnosis information form, completed by the physician or licensed healthcare provider. **OR**
 - Lab results provided within the prior six months indicating the client's HIV status (Western Blot), CD4 count, HIV viral load test performed.

- **Insurance Information:** (all applicable cards should be brought to your appointment)
 - Medi-Cal Card
 - Medicare Card
 - Medicare Part D – Prescription Coverage Card
 - Private Insurance Card

□ **Financial Information:**

Federal Income Tax Return (form 1040, 1040A, or 1040EZ)

OR

California State Income Tax Return (form 540, 540A, or 540EZ)

OR

(ONE OF THE FOLLOWING)

- Pay Stubs for the last 3 months
- SSI/Disability Award Letter
- Unemployment Award Letter or stubs
- Benefit Receipt or Check Stub
- Support Affidavit (Letter of Support from family or friend)
- Self Employment Affidavit/Profit/Loss Quarterly statement

I understand that I may be asked to prove my statements and that my eligibility statements will be subject to verification by contact with my employer, bank institutions, credit verification, property searches, and other government programs such as MISP, Medi-Cal, Medicare, and/or the Veterans Administration.

I further understand services will not be available to me until all of the required documents are received.

Special Needs: _____

Primary Language Spoken: _____

Mother's Maiden Name

Client's Birth Date

Client's Birth City

Birth State

Birth Country

Current Living Situation: _____

How Long at Current Address? _____

If rent or own, do you have a signed lease, title, or tax receipt? Yes No

Living Situation in the last 12 months (check all that apply):

- | | |
|-------------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Homeless from the streets | <input type="checkbox"/> Living with Friends / Relatives |
| <input type="checkbox"/> Homeless from Emergency Shelter | <input type="checkbox"/> Rental Housing |
| <input type="checkbox"/> Transitional Housing | <input type="checkbox"/> Applicant-owned Housing |
| <input type="checkbox"/> Psychiatric Facility | <input type="checkbox"/> Board & Care / Assisted Living |
| <input type="checkbox"/> Substance Abuse Treatment Facility | <input type="checkbox"/> Rented room |
| <input type="checkbox"/> Hospital or other Medical Facility | <input type="checkbox"/> Refused to Answer |
| <input type="checkbox"/> Jail / Prison | <input type="checkbox"/> Other |
| <input type="checkbox"/> Domestic violence situation | <input type="checkbox"/> Unknown |

Agrees to Share Data? Yes No

Agency Status: Active Inactive

Status as of Date: _____

Agency Enrollment Date: _____

Referral Date: _____

Referral Source: _____

HIV Verification Document: Yes No Type: _____

Document Dated : _____

Source of Document: _____

Client Income: Monthly Annually

Source of Income: _____

Employed: Full Time Part Time

Wages: _____

Public Assistance: (Check those that apply):

- [] Supplemental Security Income (SSI): Amount: _____
- [] Social Security Disability (SDI): Amount: _____
- [] Social Security Retirement: Amount: _____
- [] General Assistance / General Relief (GA / GR): Amount: _____
- [] Unemployment (UI): Amount: _____
- [] State Disability Insurance (SDI): Amount: _____
- [] Long-Term Disability (LTD): Amount: _____
- [] Worker's compensation: Amount: _____
- [] TANF / CalWorks: Amount: _____
- [] Veteran's Benefits (VA): Amount: _____
- [] Alimony / Child Support: Amount: _____
- [] Retirement: Amount: _____
- [] Investments / Dividends: Amount: _____
- [] Gift: Amount: _____
- [] Letter of Support: (Source): _____ Amount: _____
- [] Other: Amount: _____
- [] No Source of Income:

Total: _____

Household Income: [] Monthly [] Annually Amount: _____

People in Household: _____ Children in Household: _____

HIV+ People in Household: _____ Federal Poverty Level (%): _____

Family Income: [] Monthly [] Annually Amount: _____

People in Family: _____ Federal Poverty Level (%): _____

Assets:

Do you own a house? [] Yes [] No A Car? [] Yes [] No

Do you have other Assets? [] Yes [] No Value of Assets: _____

Insurance: [] Yes [] No Source Type: _____

Primary Insurance: _____ Primary HIV Insurance: _____

Carrier / Policy # : _____ Start Date: _____ End Date: _____

Monthly Premium Amount: _____ Pending? Yes No
Insurance: (Check those that apply):

COBRA HIPP CARE/HIPP Other

MISP: Yes No Pending Expiration Date _____

MediCare: Yes No # _____

MediCal: Yes No # _____ County: _____

MediCal Pending: Yes No County: _____

ADAP: Yes No County: _____

ADAP First Enrollment Date: _____

PRIMARY HIV HEALTH CARE SOURCE (PLEASE CHECK ONE)

Private Practice, solo or group, not HMO
Name: _____ Phone: _____ Last Visit: _____

Health Maintenance organization – HMO
Name: _____ Phone: _____ Last Visit: _____

Public-funded community health center
Name: _____ Phone: _____ Last Visit: _____

Hospital out-patient clinic or department
Name: _____ Phone: _____ Last Visit: _____

Other private community-based organization
Name: _____ Phone: _____ Last Visit: _____

VA / Military Hospital / Out-Patient Clinic
Name: _____ Phone: _____ Last Visit: _____

Emergency room
Name: _____ Phone: _____ Last Visit: _____

Other public clinic or department
Name: _____ Phone: _____ Last Visit: _____

Other
Name: _____ Phone: _____ Last Visit: _____

[] None

Disease Stage:

CDC Disease Stage: _____ Source: _____

Year First Tested HIV+: _____ Location: _____ AIDS Diagnosis Date: _____

State: _____ County: _____ Source: _____

HIV Test Date:

Result: _____ County: _____ State: _____ Source: _____

Pre-Test Counseling: [] Yes [] No Post-test Counseling: [] Yes [] No

AIDS-Defining Conditions:

Condition: _____ Diagnosis Date: _____ Treatment Date: _____

Partner Notification Offered: [] Yes [] No Date: _____

Partners Notified by Client: _____ # Partners Notified by Health Dept. _____

Date Health Department Notified: _____

Karnofsky / CFA: _____ Date: _____

Acuity Tool: 1. _____ Date: _____

2. _____ Date: _____

3. _____ Date: _____

Current Weight: _____ Date: _____

Usual Weight: _____ Date: _____

Are you medically unable to work? [] Yes [] No Effective Date: _____

Other Chronic Medical Conditions: (Please list all known): _____

Medical History:

CD4 T-Cell Count: _____ Date: _____ %: _____

Viral Load: _____ Date: _____ Relation Value: _____

STD's: _____ Test Date: _____ Treatment: [] Yes [] No

Hepatitis: _____ Test Date: _____ Treatment: [] Yes [] No

Treatment Start Date: _____ Treatment End Date: _____

Tuberculosis: TB Test Medically Indicated [] Yes [] No Date: _____

Date PPD Placed: _____ Date PPD Test Read: _____ PPD/TST Test Result: _____

Chest X-Ray Date: _____ Chest X-Ray Result: _____

TB Diagnosis: [] Yes [] No Date: _____ Notes: _____

Treatment Start Date: _____ Treatment End Date: _____

TB Treatment Type: _____ Treatment Status: _____

Immunizations: Type: _____ Date: _____
Type: _____ Date: _____

Emergency Room / Hospital Visits:

Date: _____ Reason: _____

Hospitalized? [] Yes [] No If Hospitalized, # of Days: _____

Medications: Allergies [] Yes [] No Type: _____

1. Name of Medication: _____ Prescribed by: _____
Used For: _____ Start Date: _____ End Date: _____

2. Name of Medication: _____ Prescribed by: _____
Used For: _____ Start Date: _____ End Date: _____

3. Name of Medication: _____ Prescribed by: _____
Used For: _____ Start Date: _____ End Date: _____

4. Name of Medication: _____ Prescribed by: _____
Used For: _____ Start Date: _____ End Date: _____

In the last three days, not including today, how many days did you take your medications at the times and in the amounts prescribed by your doctor? _____

List ALL Other Medications: _____

Pharmacy #1 Name: _____ Phone: _____

Pharmacy #2 Name: _____ Phone: _____

Adherence: In the last three days, not including today, how many times did you take your ART medications at the times and in the amounts prescribed by your doctor? _____

Describe your adherence to HIV Treatment for the past four weeks?

Always Most of the time Sometimes Not Very Often Never

Genotypic / Phenotypic testing performed to determine resistance to HIV Medications?

Date of Test: _____ Notes: _____

Risk Factors:

- Sex with a male
- Sex with a female
- Injection of non-prescription drugs
- Received clotting factor for Hemophilia / Coagulation Disorder
- Received transfusion of blood, transplant, or artificial insemination
- Worked in Healthcare of clinical lab setting
- Mother HIV Infected / Perinatal transmission
- Sexual Abuse (Pediatric Only)
- Other
- Unknown

Sex Partner Risk Factor, Heterosexual Contact Only:

- Intravenous/Injection drug user
- Bisexual male
- Person with AIDS or Documented HIV
- Other (person with Hemophilia, transfusion, or transplant with documented HIV)
- Unknown

Primary HIV Exposure: _____

Secondary HIV Exposure: _____

Substance Abuse:

Do you have a history of substance abuse? [] Yes [] No

Age first used: _____ Type of Substance: _____ Frequency: _____

Have you ever been in Treatment? [] Yes [] No Treatment Status: _____

Treatment Start Date: _____ Treatment End Date: _____

Mental Health:

Do you have a history of mental health problems? [] Yes [] No

Have you ever been in Treatment? [] Yes [] No Treatment Status: _____

Treatment Start Date: _____ Treatment End Date: _____

Emergency Contact Information:

Name of Contact: _____

Address: _____
Street City State Zip Code

Telephone Number #1: (____) _____ Confidential? [] Yes [] No

Telephone Number #2: (____) _____ Confidential? [] Yes [] No

Relationship to you: _____

Have you recently relocated to the Riverside County area: [] Yes [] No

If "Yes" to above, reason for your relocation:

- [] To be near family and friends
- [] Cost of living issues
- [] Access to HIV related services
- [] Other: _____

If yes, and you have recently moved to the area, do you have enough medication for the next 1-2 months? [] Yes [] No

D.A.P. CLIENT NEEDS/PROBLEMS INTAKE QUESTIONNAIRE
Necesidades y problemas del cliente D.A.P. – cuestionario de admision

The following are some of the needs/problems D.A.P. clients commonly have. Please review the list and check each box next to the needs/problems that apply to you.

Las siguiente son algunas a necesidades y problemas comunes del cliente de D.A.P. Por favor marcar los que le corresponden a usted.

(Nombre) _____ (Fecha) _____
 Client Name: _____ Date: _____

<input type="checkbox"/> I need information about HIV or AIDS.	<input type="checkbox"/> Necesito informacion sobre el VIH y el SIDA.
<input type="checkbox"/> I need HIV related medical services.	<input type="checkbox"/> Necesito servicios medicos para el VIH.
<input type="checkbox"/> I have no place to live.	<input type="checkbox"/> No tengo vivienda.
<input type="checkbox"/> My living environment is unsafe.	<input type="checkbox"/> El lugar donde vivo es peligroso.
<input type="checkbox"/> I have no means of transportation.	<input type="checkbox"/> No tengo medios de transporte.
<input type="checkbox"/> I need child care services to get to medical appointments or support groups.	<input type="checkbox"/> Necesito servicio de cuidado de ninos para poder asistir a mis citas medicas o grupos de apoyo.
<input type="checkbox"/> I am homebound because of my illness.	<input type="checkbox"/> Permanesco en casa por causa de mi enfermedad.
<input type="checkbox"/> My income is not sufficient to cover my basic needs.	<input type="checkbox"/> Mis ingresos no son suficientes para a cubrir mis necesidades basicas.
<input type="checkbox"/> I have little emotional support from family or friends.	<input type="checkbox"/> Yo tengo muy poco apoyo emocional por parte de mi familia o amigos.
<input type="checkbox"/> I am unable to adequately care for or control the behavior of my children.	<input type="checkbox"/> No dispongo del cuidado adecuado o el control en el comportamiento de mis hijos.
<input type="checkbox"/> I am geographically isolated.	<input type="checkbox"/> Estoy geograficamente aislado.
<input type="checkbox"/> I am socially isolated.	<input type="checkbox"/> Estoy socialmente aislado.
<input type="checkbox"/> I do not speak English.	<input type="checkbox"/> No hablo inglés.
<input type="checkbox"/> I am anxious because of my HIV status.	<input type="checkbox"/> Padesco de ansiedad por mi estado de VIH.
<input type="checkbox"/> I am anxious about telling a partner or family member about my HIV status.	<input type="checkbox"/> Estoy desesperada(o) por comunicarle a mi pareja o familia acerca de mi estado.
<input type="checkbox"/> There is conflict in my relationship with a partner or significant other because of my HIV status.	<input type="checkbox"/> Hay conflicto en mi relacion de pareja por mi estado.
<input type="checkbox"/> I have lost my employment.	<input type="checkbox"/> He perdido mi empleo (trabajo).
<input type="checkbox"/> I am unable to work for medical reasons.	<input type="checkbox"/> No estoy disponible para a trabajar por razones de salud.
<input type="checkbox"/> I am dependent on drugs and/or alcohol.	<input type="checkbox"/> Soy dependiente de drogas y del alcohol.
<input type="checkbox"/> I often feel depressed.	<input type="checkbox"/> Me deprimio con frecuencia.
<input type="checkbox"/> I experience frequent severe mood swings.	<input type="checkbox"/> Padesco de mal humor.
<input type="checkbox"/> I have thought about suicide.	<input type="checkbox"/> Tengo pensamientos suicidas.
<input type="checkbox"/> I am experiencing anxiety because of symptoms of AIDS.	<input type="checkbox"/> Estoy experimentando angustia por sintomas del SIDA.
<input type="checkbox"/> I am lacking opportunities to participate in productive or fulfilling activities.	<input type="checkbox"/> Careso de oportunidades para participar y desempenar actividades positivas.
<input type="checkbox"/> I am grieving the loss of a loved one.	<input type="checkbox"/> Estoy afligida(o) por la perdida de un ser querido.

Other needs (please list on reverse).

[Otras necesidades (por favor enliste al reverso)]