



Desert AIDS Project

care :: prevention :: advocacy

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

INTAKE

INFORMATION

PACKET

Please fill out **ALL** of the information before your appointment.

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 30 day residency requirement for services and contact your insurance provider as there may be a delay while your insurance is transferred to this office.

Thank you!

DAP Intake Class – Every Wednesday at 2pm
**Must call or email Ray Robertson at 760-323-2118 x295
or rroberston@desertaidproject.org for an intake appt.**

**REQUIRED ITEMS (WITH INTAKE PACKET) NEEDED TO ATTEND THE
DAP INTAKE CLASS:**

WHO ARE YOU?

- Photo Identification

PROOF YOU LIVE HERE:

- Proof you live in Riverside or San Bernardino Counties for at least 30 days

2 of the following indicating Name and Address

- 30 days current utility bills
- Current Rental or Lease Agreement showing at least 30 days
- California Drivers license/California Identification Card showing current address
- Voter Registration Card
- Signed Affidavit of Residency from person you live with

PROOF OF HIV:

Diagnosis information form or letter completed by a physician , physician's assistant, or nurse practitioner indicating that the individual is HIV Positive

OR

A HIV positive laboratory result that includes the individual's name

WHAT IS YOUR INCOME?

Current copy of one or more of the following

- 3 current pay stubs
- 3 months current bank statements
- SSA, SSI, or SSDI Award letter
- MISP/CMSP/Medi-Cal Award letter
- Letter from other form of Government assistance
- Signed Affidavit of Support from the person who supports you

Proof of Insurance if you are planning on becoming a patient of DAP HIV Health Center

Primary Language Spoken: _____

Mother's Maiden Name: _____

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 |

INSURANCE: List insurance type or check if none

- _____ None

PRIMARY HIV HEALTH CARE SOURCE:

Where have you been receiving your primary care/HIV Medical Care for the past 12 months

Name: _____ Phone: _____ Last Visit: _____

DISEASE STAGE:

Year First Tested HIV+: _____

State: _____ County: _____ Source: _____

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

Print Name

Signature

Date

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 / Prenatal 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

EMERGENCY CONTACT INFORMATION:

Name of Contact: _____

Address: _____
 Street City State Zip Code

Telephone Number #1: (____) _____

Telephone Number #2: (____) _____

Relationship to you: _____

Print Name

Signature

Date

HIV/AIDS HEALTH CARE HISTORY:

Were you diagnosed with HIV within the last year?

Yes No don't know

Have you ever had HIV lab work completed by a medical provider?

Yes No don't know

If YES, have you had HIV lab work completed within the last year?

Yes No don't know

Were you first diagnosed with HIV by a medical provider outside of Riverside or San Bernardino Counties?

Yes No don't know

If YES, have you ever received HIV-specific medical care or social services in Riverside or San Bernardino Counties before?

Yes No don't know

Have you ever received Ryan White-funded services before?

Yes No don't know

Have you ever been a client of D.A.P. before?

Yes No don't know

Print Name

Signature

Date

Date Entry: _____ **initials**