

GENERAL INFORMATION

Last Name		First Name			Middle Initial
Preferred Nickname (if applicable)		Mother's Maiden Name			Your Birthdate
Street Address		City	County	State	ZIP Code
How long at this address?	Social Security#				
Living Situation (Circle One)	Addictions Treatment Own Home	Homeless Rental	Friends/Family Transitional Housing	Describe your Living situation	Stable Temporary Unstable
Provide your previous address					
Have You Been a Client of D.A.P. Before?		Y	N		

COMMUNICATON PREFERENCES

Your Telephone #	Type of Telephone		Home	Mobile	Work
May we contact you by U.S. Mail?	Y	N	If <u>yes</u> , please provide your mailing address below		
Mailing Address or Same as above	City		State	ZIP Code	
Email address to sign up for D.A.P.'s Patient Portal					

DEMOGAPHIC INFORMATION AND HEALTHCARE INFORMATION

Emergency Contact		Relationship		Phone	
Are you a U.S. Veteran?	Y	N	Sex at Birth	M	F
Sexual Orientation	Gay/Lesbian		Straight(not gay/lesbian)		Bisexual
Other gender identity Preferred pronoun	HE/HIM SHE/HER THEY/THEM ZE/ZIM DECLINE TO ANSWER				
Marital Status (Circle one)	Co-Habitation		Divorced	Domestic Partner	Married
Race (Circle all that apply)	African-American		American Indian/Alaskan Native		Asian
Are you Latino?	Y	N	National Origin (Circle one)	C. American	Chinese
Primary Language Spoken	Do you need an interpreter?		Y	N	
Are You Hearing Impaired	Y	N	Other Special Needs	Y	N
For FQHC purposes we ask:	# of family in your household		Monthly income	\$	
Primary Care Physician	Contact Number				
Primary Insurance	ID#				
Secondary Insurance	ID#				
How did you hear about us?					
I certify that I am an individual living with HIV/AIDS		YES	NO	If NO STOP HERE. If YES CONTINUE ON BACK.	

Your Signature

Today's Date

HIV HEALTH HISTORY (if applicable)

Were you diagnosed with HIV with the last 12 months?	Y N	Date Tested HIV+	
Did you receive Post-Test counseling?	Y N	City, State tested HIV+	
What was the source of your HIV Test? (Circle one)	Medical Facility / Clinic HIV Test Event Hospital Self-test Other		
Have had HIV lab work completed by medical provider?	Y N	If yes, most recent date?	
Have you received HIV care in Riverside/San Bernardino Co. before?	Y N		
If YES, where?			
Have you received Ryan White-funded services before?	Y N	If yes, where?	

HIV EXPOSURE

Prior to HIV + Diagnosis, which of these factors were or are currently present? (Please Circle all that apply)			
Sex with Male	Sex with Female	Injection of non-Rx drugs	Work in health care / lab
Clotting Factor for Hemophilia		Coagulation Disorder	
Transfusion, Transplant, Artificial Insemination		Prenatal Transmission	Sexual Abuse
Heterosexual Contact Only – How were you exposed to HIV? (Please Circle all that apply)			
Bisexual Male	Person with Documented HIV/AIDS	Intravenous/injection Drug User	

Your Signature

Today's Date

Medical Services *Only*

CHECKLIST OF REQUIRED INITIAL DOCUMENTS

REQUIRED ELIGIBILITY DOUCMENTATION	✓	ACCEPTED FORMS OF DOCUMENTS
GOVERNMENT ISSUED IDENTIFICATION <i>(please provide at least one)</i>		Current Photo ID
		Current Driver's License
		Current Passport
PROOF OF INCOME <i>(please provide at least one)</i>		3 Current Paystubs
		3 Months Direct Deposit Bank Statements
		SSA, SSI, or SSDI Annual Award Letter
		Medi-Cal Acceptance Letter
		Letter from other Government Assistance
		Signed Affidavit from Person of Support
PROOF OF INSURANCE		Insurance Card(s) (Medical and/or Dental)

Social Services & Medical Services

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REQUIRED ELIGIBILITY DOUCMENTATION	✓	ACCEPTED FORMS OF DOCUMENTS
GOVERNMENT ISSUED IDENTIFICATION <i>(please provide at least one)</i>		Current Photo ID
		Current Driver's License
		Current Passport
PROOF OF RESIDENCY – Proof of Riverside/San Bernardino Co. Residency for a minimum of 30 days <i>(please provide two)</i>		Current Utility Bill (within 30 days)
		Current Rental / Lease Agreement
		Voter Registration Card / DMV Card
		Signed Affidavit of Residency from Co-habitant
PROOF OF HIV DIAGNOSIS <i>(please provide at least one)</i>		Letter of HIV Diagnosis Signed by MD, PA, NP
		Confirmatory HIV+ Lab with Individual's Name
PROOF OF INCOME <i>(please provide at least one)</i>		3 Current Paystubs
		3 Months Direct Deposit Bank Statements
		SSA, SSI, or SSDI Annual Award Letter
		Medi-Cal Acceptance Letter
		Letter from other Government Assistance
		Signed Affidavit from Person of Support
PROOF OF INSURANCE		Insurance Card(s) (Medical and/or Dental)