

HIV HEALTH HISTORY

Were you diagnosed with HIV within the last 12 months?	Y N	Date Tested HIV+	
City, State tested HIV+			
Did you receive Pre-Test counseling?	Y N	Did you receive Post-Test counseling?	Y N
What was the source of your HIV Test? <i>(Circle one)</i>	Medical Facility	HIV Test Event	Hospital Self-test
Have you 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? <i>(Please Circle all that apply)</i>			
Sex with Male	Sex with Female	Injection of unprescribed 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? <i>(Please Circle all that apply)</i>			
Bisexual Male	Person with Documented HIV/AIDS	Intravenous/injection Drug User	

Your Signature

Today's Date

Social Services & Medical Services

CHECKLIST OF REQUIRED INITIAL DOCUMENTS

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

Medical Services Only

CHECKLIST OF REQUIRED INITIAL DOCUMENTS

REQUIRED ELIGIBILITY DOCUMENTATION	✓	ACCEPTED FORMS OF DOCUMENTS
<p style="text-align: center;">IDENTIFICATION <i>(please provide at least one)</i></p>		Current Photo ID
		Current Driver's License
		Current Passport
<p style="text-align: center;">PROOF OF INCOME <i>(please provide at least one)</i></p>		3 Current Paystubs
		3 Months Direct Deposit Bank Statements
		SSA, SSI, or SSDI Annual Award Letter
		Letter from other Government Assistance
		Signed Affidavit from Person of Support
<p style="text-align: center;">PROOF OF INSURANCE</p>		Insurance Card(s) (Medical and/or Dental)