Desert AIDS Project
care :: prevention :: advocacy

ENROLLMENT FORM

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 Homeless Friends/Family Own Home Rental 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 yes, 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	Gender identity	M F M/F F/M

Sexual Orientation	Gay/Lesbian Straight(not gay/lesbian) Bisexual Something else Choose not to disclose

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 Single Widowed

Race *(Circle all that apply)*	African-American American Indian/Alaskan Native Asian Caucasian Native Hawaiian/Pacific Islander

Are you Latino?	Y N	National Origin *(Circle one)*	C. American Chinese Cuban Filipino Korean Malaysian Mexican Puerto Rican S. American Other

Primary Language Spoken		Do you need an interpreter?	Y N

Are You Hearing Impaired	Y N	Other Special Needs	Y N	If Yes, Other	

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**

Form Active: Nov 11, 2014 Revised: Oct 04, 2016

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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**

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Medical Services *Only*

CHECKLIST OF REQUIRED INITIAL DOCUMENTS

REQUIRED ELIGIBILITY DOUCMENTATION	✓	ACCEPTED FORMS OF DOCUMENTS
GOVERNMENT ISSUED IDENTIFICATION *(please provide at least one)*		Current Photo ID
		Current Driver's License
		Current Passport
PROOF OF INCOME *(please provide at least one)*		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

CHECKLIST OF REQUIRED INITIAL DOCUMENTS

REQUIRED ELIGIBILITY DOUCMENTATION	✓	ACCEPTED FORMS OF DOCUMENTS
GOVERNMENT ISSUED IDENTIFICATION *(please provide at least one)*		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 *(please provide two)*		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 *(please provide at least one)*		Letter of HIV Diagnosis Signed by MD, PA, NP
		Confirmatory HIV+ Lab with Individual's Name
PROOF OF INCOME *(please provide at least one)*		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)