

# Ryan White Part A Client Registration Form



Today's Date:	Client URN:	Does the client need an interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what language:	
<input type="checkbox"/> Newly Diagnosed or New to Care <input type="checkbox"/> Returning Client (out of care for 12 months or more)		Assigned Case Manager:	
<b>DEMOGRAPHICS</b>			
Last Name:		First Name:	Middle Name:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (male to female) <input type="checkbox"/> Transgender (female to male) <input type="checkbox"/> Transgender (Unk) <input type="checkbox"/> Unknown	Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Non-Latino <input type="checkbox"/> Unknown/Unreported	Race: <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Multi-Racial	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Domestic Partner
Date of Birth:    /    /    ( <input type="checkbox"/> check if estimated)	Age:	Social Security Number:	
Home Address:		Apt #	City:
State:	County:		Zip Code:
<input type="checkbox"/> check if same as home address Mailing Address:		Apt #	City:
State:	County:		Zip Code:
May we contact you by mail at this address? <input type="checkbox"/> Yes, contact via mailing address <input type="checkbox"/> No			
Home phone#: (    )		Other phone#: (    )	
May we leave you a message at this phone number? <input type="checkbox"/> Yes, contact via home phone # <input type="checkbox"/> Yes, contact via other phone # <input type="checkbox"/> No			
Have you ever served in the military? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, please list your dates of services: _____ to _____			
What is your primary source of transportation: <input type="checkbox"/> Own a car <input type="checkbox"/> Public Transportation (bus) <input type="checkbox"/> Friends/relatives <input type="checkbox"/> Walking <input type="checkbox"/> Other: _____			

<b>HIV/AIDS STATUS AND MEDICAL INFORMATION</b>	
What is your HIV/AIDS status: <input type="checkbox"/> HIV-positive (not yet AIDS) <input type="checkbox"/> HIV-positive (AIDS status unknown) <input type="checkbox"/> AIDS <input type="checkbox"/> HIV-negative (affected) <input type="checkbox"/> Unknown <input type="checkbox"/> HIV-indeterminate (only if under 2 years of age)	How were you infected with HIV/AIDS: <input type="checkbox"/> Male to Male sexual contact <input type="checkbox"/> Injection Drug Use <input type="checkbox"/> Hemophilia/Coagulation Disorder <input type="checkbox"/> Heterosexual Contact <input type="checkbox"/> Perinatal Transmission <input type="checkbox"/> Undetermined/Unknown, risk not reported or identified <input type="checkbox"/> Recipient of transfusion of blood, blood components, or tissue <input type="checkbox"/> Other, please specify: _____
HIV Diagnosis Date: ( <input type="checkbox"/> check if estimated)	AIDS Diagnosis Date: ( <input type="checkbox"/> check if estimated)
Who is your Primary HIV Medical Provider or where do you go for HIV medical care:	
Location name:	
Results of your most recent Viral Load:	What is the date of that Viral Load:
Results of your most recent CD4 Count:	What is the date of that CD4 Count:

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Are you currently taking any prescribed medications?  Yes  No  Sometimes  
 If so, what medications are you taking:

Who is your primary insurance provider: <input type="checkbox"/> Medicaid/AHCCCS <input type="checkbox"/> Medicare <input type="checkbox"/> No Insurance <input type="checkbox"/> Other, please specify: _____ <input type="checkbox"/> Other public (e.g. Champus, VA) <input type="checkbox"/> Private Insurance <input type="checkbox"/> Unknown	Other Insurance (if any): <input type="checkbox"/> Medicaid/AHCCCS <input type="checkbox"/> Medicare <input type="checkbox"/> No Insurance <input type="checkbox"/> Other, please specify: _____ <input type="checkbox"/> Other public (e.g. Champus, VA) <input type="checkbox"/> Private Insurance <input type="checkbox"/> Unknown
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### EMERGENCY CONTACT INFORMATION

Contact name:		Relationship to you:	
Address:	City:	State:	Zip Code:
Home phone#: (     )     )	Other phone#: (     )     )	Is this contact aware of your diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	

EMPLOYMENT AND ASSET INFORMATION	INCOME INFORMATION
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What is your current occupation: _____ Who is your current employer: _____ Do you have any assets (savings, CD, cash, ect.)? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what is the total amount of those assets? \$ _____ Do you own a home or other property? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you own more than one registered vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No	List below all income you and those living in your household-including spouses, domestic partners and any dependents that could be claimed on your taxes-receive from the following sources on a monthly basis: <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>Alimony</td><td style="text-align: right;">\$</td></tr> <tr><td>Child Support</td><td style="text-align: right;">\$</td></tr> <tr><td>Wages from Employment</td><td style="text-align: right;">\$</td></tr> <tr><td>Food Stamps</td><td style="text-align: right;">\$</td></tr> <tr><td>State Disability Insurance/SDI</td><td style="text-align: right;">\$</td></tr> <tr><td>Long-Term Disability/LTD</td><td style="text-align: right;">\$</td></tr> <tr><td>VA Benefits</td><td style="text-align: right;">\$</td></tr> <tr><td>Supplemental Security Income/SSI</td><td style="text-align: right;">\$</td></tr> <tr><td>Social Security Disability Income/SSDI</td><td style="text-align: right;">\$</td></tr> <tr><td>Social Security Retirement</td><td style="text-align: right;">\$</td></tr> <tr><td>TANF</td><td style="text-align: right;">\$</td></tr> <tr><td>Retirement</td><td style="text-align: right;">\$</td></tr> <tr><td>Gifts</td><td style="text-align: right;">\$</td></tr> <tr><td>Other (specify):</td><td style="text-align: right;">\$</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td><b>Total Monthly Household Income</b></td><td style="text-align: right;"><b>\$</b></td></tr> <tr><td><b>Total Annual Household Income</b></td><td style="text-align: right;"><b>\$</b></td></tr> </table>	Alimony	\$	Child Support	\$	Wages from Employment	\$	Food Stamps	\$	State Disability Insurance/SDI	\$	Long-Term Disability/LTD	\$	VA Benefits	\$	Supplemental Security Income/SSI	\$	Social Security Disability Income/SSDI	\$	Social Security Retirement	\$	TANF	\$	Retirement	\$	Gifts	\$	Other (specify):	\$					<b>Total Monthly Household Income</b>	<b>\$</b>	<b>Total Annual Household Income</b>	<b>\$</b>
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What services are you in need of today, (please check all that apply): <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> Housing Assistance</td> <td><input type="checkbox"/> Employment Assistance</td> </tr> <tr> <td><input type="checkbox"/> Emergency Financial Assistance</td> <td><input type="checkbox"/> Food Bank</td> </tr> <tr> <td><input type="checkbox"/> Support Groups</td> <td><input type="checkbox"/> HIV/AIDS Information</td> </tr> <tr> <td><input type="checkbox"/> Individual Counseling</td> <td><input type="checkbox"/> Vision Care</td> </tr> <tr> <td><input type="checkbox"/> Nutrition Therapy</td> <td><input type="checkbox"/> Transportation Assistance</td> </tr> <tr> <td><input type="checkbox"/> HIV/AIDS Medical Provider</td> <td><input type="checkbox"/> Substance Use Treatment/Counseling</td> </tr> <tr> <td><input type="checkbox"/> HIV/AIDS Medication</td> <td><input type="checkbox"/> Mental Health Treatment/Counseling</td> </tr> <tr> <td><input type="checkbox"/> Assistance with Medication Co-Pays</td> <td><input type="checkbox"/> Eligibility for Ryan White Services</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Other:</td> </tr> </table>		<input type="checkbox"/> Housing Assistance	<input type="checkbox"/> Employment Assistance	<input type="checkbox"/> Emergency Financial Assistance	<input type="checkbox"/> Food Bank	<input type="checkbox"/> Support Groups	<input type="checkbox"/> HIV/AIDS Information	<input type="checkbox"/> Individual Counseling	<input type="checkbox"/> Vision Care	<input type="checkbox"/> Nutrition Therapy	<input type="checkbox"/> Transportation Assistance	<input type="checkbox"/> HIV/AIDS Medical Provider	<input type="checkbox"/> Substance Use Treatment/Counseling	<input type="checkbox"/> HIV/AIDS Medication	<input type="checkbox"/> Mental Health Treatment/Counseling	<input type="checkbox"/> Assistance with Medication Co-Pays	<input type="checkbox"/> Eligibility for Ryan White Services	<input type="checkbox"/> Other:																			
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## LIVING STATUS AND RELATIONSHIP INFORMATION

What is your current living /housing arrangement: <input type="checkbox"/> Stable/Permanent <input type="checkbox"/> Unstable <input type="checkbox"/> Other: _____ <input type="checkbox"/> Institution <input type="checkbox"/> Non-permanently housed		How many people live with you: _____ Please list everyone who lives with you in the provided space below.	
<i>Name</i>	<i>Relationship to you</i>	<i>Gender</i>	<i>Date of birth</i> ( <input type="checkbox"/> check if estimated)
			( <input type="checkbox"/> check if estimated)
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## ADDITIONAL REFERRALS

Please list any additional referrals (not listed above) provided to the client for Ryan White or non-Ryan White Community Resources.

Service Needed:	Organization Referred to:

## CASE MANAGEMENT NOTES

If documented in CAREWare or another location please specify.

- Client agrees to participate in Case Management Services.
- Client elects not to participate in the program at this time.
- Client is not eligible for Ryan White Part A and will be referred to resources they are eligible for.

Today's Date: \_\_\_\_\_

Case Managers Signature: \_\_\_\_\_

Next Eligibility Redetermination Date: \_\_\_\_\_

The Case Management Program has been explained to me and any questions I had have been answered. I agree to participate in Case Management Services.

Today's Date: \_\_\_\_\_

Clients Signature: \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_