NOLP ENROLLMENT FORM
MARCH 1, 2019 – FEBRUARY 29, 2020

NOLP # _____

CLIENT INFORMATION

_____ _____
Name **Age**

Gender: ☐M ☐F ☐Trans M to F ☐Trans F to M ☐Non-Binary

_____ _____
Date of Birth **Social Security #**

_____
Address

_____ _____ (_____) _____
City **Zip Code** **Phone**

Is it OK to call you? ☐YES ☐NO

Is it OK to leave a message identifying APLA Health? ☐YES ☐NO

_____ _____
Emergency Contact **Relationship**

(_____) _____ **Aware of HIV status?** ☐YES ☐NO
Phone **OK to disclose?** ☐YES ☐NO

Race:

☐White / Caucasian
☐Black / African American
☐Native American / Alaskan
☐Native Hawaiian / Pacific Islander
☐Asian
☐Other (please specify) _____

Of Latino/Hispanic descent? ☐YES ☐NO

Level of Education:

☐None
☐Grades 1-8
☐Some High School
☐High School Graduate / GED
☐Some College / AA / Tech
☐Bachelor's
☐Master's / Doctorate

_____ _____
Birth Country **How long in U.S.?**

Total Number of Legal Dependents: _____ **Ages of Legal Dependents:** _____

$_____ $_____
Monthly Income **Annual Income**

Are you a veteran? ☐YES ☐NO
Are you chronically homeless? ☐YES ☐NO
Are you a domestic violence survivor? ☐YES ☐NO

Jail or Prison History:

☐None
☐Jail/prison within the past 6 months
☐Jail/prison within the past 2 years
☐Jail/prison over 2 years ago

Current Living Situation:

☐Rental (apartment, home, or room)
☐Client-Owned Housing
☐Emergency Shelter (motel voucher)
☐Transitional Housing for Homeless
☐Substance Abuse or Psychiatric Facility
☐Other (please specify) _____
☐Staying with family / friend (no rent)
☐Homeless (street, car, bus)
☐Hotel / Motel (not paid by voucher)
☐Permanent Housing (Shelter+Care, SRO)
☐Jail / Prison / Juvenile Facility

Number of Bedrooms: _____

Medical Insurance:

☐Private
☐Medicare
☐Medi-Cal
☐Other Public
☐ADAP
☐Healthy Way LA
☐Other
☐Unknown
☐No insurance

_____
Coverage Begins

_____
Coverage Ends

THE CLIENT SERVICES AGREEMENT – How the Program Works

NOLP is a supplemental food assistance and nutrition education program designed to serve qualifying low-income individuals living with HIV / AIDS in Los Angeles County.

ELIGIBILTY GUIDELINES

To receive food assistance through NOLP, the following documents are required.

NOTE: All documentation must be dated between March 1, 2019 - February 29, 2020.

1. **Photo Identification**
2. **Proof of Income**
3. **Proof of Residency** (i.e. gas, water, or electric bill, lease agreement, or letter from a residential service provider or treatment center)
4. Have a **Nutrition Screen** reviewed and signed by a dietitian or medical provider (MD, PA, NP, RN), *or*
   Have a **Signed Nutrition Education Form** from an APLA Health nutrition class. NOLP staff can assist you with class information.
5. **Proof of HIV:** letter signed by a physician or diagnosis form containing a physician or licensed healthcare provider (Nurse Practitioner or Physician Assistant) signature or laboratory results containing the name of the laboratory and indicating HIV status, CD4 count, HIV viral load, and type of HIV viral load test performed (within last 12 months), or two (2) rapid testing algorithm (RTA) results in which both tests contain positive results. Both tests should indicate the agency name, HIV counselor name, and the client's name.

NOLP Eligibility Assessment Update

- It is your responsibility to submit an updated NOLP Eligibility Assessment annually.
- Items 1 – 5 above are required.
- Even if you are not reminded by NOLP staff of the due dates, you will still be expected to submit this information.
- If you are unsure when your eligibility assessment is due, please ask NOLP staff.

 _____ ***My initials here indicate I have read and understand this.***

NOLP Card

Once enrolled you will be issued a NOLP card, which is an identification card that each client uses to access the program. Upon pick up, you will need to show your NOLP Card or a picture I.D. If you are unable to shop, you can send a friend in your absence. Your substitute shopper will need a note from you stating that he's able to shop in your absence as well as your NOLP Card.

Program Access

Present your card to the NOLP staff member. Sign the sign in sheet and voucher. NOLP clients are allowed to pick up groceries once a week. During your visits, you will receive a variety of items such as: fresh produce, canned goods, pasta, rice, dry beans, frozen meats, beverages, snacks, hygiene and cleaning supplies.

Grievance Procedures

If a client has a grievance with the program, staff, or volunteer of the program, the client should try to resolve the matter with the Site Coordinator. If a solution is not reached, contact the program's Administrative Coordinator. If a solution is still not reached, the client should contact the Program Manager. If you have questions or concerns please call 213.201.1433.

Termination

APLA reserves the right to suspend/terminate a client's shopping privileges if there is evidence of abuse or misuse (e.g., theft, reselling NOLP food, inappropriate behavior). Verbal abuse or threats to staff, volunteers, or other clients are cause for immediate termination of NOLP services.

Fee Determination

All food and nutrition education services provided through the APLA Health Vance North Necessities of Life Program are free.

Locations

San Fernando Valley: 7336 Bellaire Ave, North Hollywood 91605
Thursday: 10:30 AM – 5:30 PM

Mid-City L.A.: Geffen Center, 611 S. Kingsley Drive, Los Angeles 90005
Wednesday & Friday*: 10:30 AM – Noon, 1:30 PM – 5:30 PM
**Closed the first Friday of the month.*

Long Beach: AIDS Food Store in Long Beach
1066 Atlantic Avenue Suite A, Long Beach 90813
Tuesday: 10:30 AM – Noon, 1:30 PM – 3:00 PM

South LA: OASIS Clinic
1807 E 120th Street, Los Angeles 90059
Thursday: 10:30 AM – 1:00 PM

Community partners distribute NOLP in Claremont, Lancaster, Pasadena, Pomona, and Santa Monica. Please call 213.201.1433 for information on accessing those sites.

_____ _____
Client Signature **Date**

_____ _____
Agency Representative Date

Casewatch Millennium®
Client Share/Non-Share Consent Form

I, _____ (print full name) wish to register with Ryan White Program/Casewatch Millennium® in order to receive services funded by the Ryan White Program or the Department of Public Health (DHP), Division of HIV and STD Programs (DHSP). During registration, I will be asked to provide information about myself, including my name, race, gender, birth date, income and other demographic data. Depending upon the agency or program I am registering with, I may also be asked questions about my CD4 cell count, viral load, use of HIV medications, risk behaviors, my general physical and medical condition and medical history.

In addition to providing information, I will provide an original letter of diagnosis signed and dated by my doctor, or have a blood test that shows that I am HIV positive. By signing this form, I verify that I reside in Los Angeles County.

I understand that certain services may be available to HIV-negative partners, family members, or other caregivers affected by HIV, and registration and service information for these clients will not be shared between agencies regardless of my own share status. I understand that my name and information will not be shared outside the Ryan White Program/Casewatch Millennium® system unless I provide my specific, informed consent for such a disclosure. A list of Ryan White Program/Casewatch Millennium® agencies is available upon request.

Additionally, as a condition of receiving Ryan White Program services, I agree that my information will be made available to my local health department, to fiscal agents that fund services I receive, to DPH/DHSP, and to the State of California Department of Public Health (CDPH), Office of AIDS, AIDS Regional Information and Evaluation System (ARIES) for mandated care and treatment reporting, program monitoring, statistical analysis and research activities. This information includes the minimum necessary, but is not limited to gender, ethnicity, birth date, zip code, diagnosis status, and service data. No identifying information, such as name and social security number, will be released, published, or used against me without my consent, except as allowed by law.

By initialing "I AGREE and UNDERSTAND" below, I understand that my relevant health, including HIV status, and income information will be shared with my local health department, fiscal agents that fund services I receive, the Department of Public Health, Division of HIV and STD Programs, and the State of California Department of Public Health (CDPH), Office of AIDS, AIDS Regional Information and Evaluation System (ARIES) when I request enrollment in care or access to services at a Ryan White Program agency. Only authorized personnel at each agency will have access to my information on a need-to-know basis. The information shared may include information about services received or my treatment at a particular agency. Mental health, legal and/or substance abuse services will only be shared as allowed by law.

In most cases, I will not need to re-register (in Casewatch Millennium®) or provide a letter of HIV diagnosis when I require services from an agency providing services funded by the Ryan White Program or the DPH/Division of HIV and STD Programs.

_____ **I AGREE AND UNDERSTAND**

My registration in Ryan White Program/Casewatch Millennium® does not guarantee services from any agency. Waiting lists or eligibility requirements may exclude me from services at other Ryan White Program/Casewatch Millennium® agencies.

By signing this form I acknowledge that I have been offered a copy of this consent form, and have discussed it with the staff person indicated below. I understand that this form will be stored in my paper file and that this consent form remains in effect for three (3) years from the date I sign this form.

_____ _____

Signature of Client or Parent/Guardian of Minor **Date**

For Local Health Care Agency Use Only:

_____ _____

Administered By Agency Name

_____ _____

Signature Date

HIPAA CONSENT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your health care information regarding treatment, payment or health care operations, in order to provide health care that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our Privacy Notice (Compliance Assurance Notification to Our Patients), to request restrictions and revoke consent in writing.

_____ _____

Client Signature **Date**

Necessities of Life Program (NOLP)

DATE_____	NOLP SITE: ☐ David Geffen Center ☐ N. Hollywood ☐ South LA ☐ Long Beach ☐ Common Ground ☐ Bartz Altadonna ☐ FAP ☐ JWCH

Please take a moment to provide feedback about your experience receiving services through NOLP.

1. *How often do you receive food items from APLA <u>each month</u>?*
   ☐ *1x* ☐ *2x* ☐ *3x* ☐ *4x*

2. *What percentage of the food provided by NOLP do you use?*
   ☐ *Under 50%* ☐ *50-75%* ☐ *Over 75%*

3. *Do you use the recipes provided by NOLP?* ☐ *Yes* ☐ *No*

4. *Do you use the nutrition fact sheets provided by NOLP?* ☐ *Yes* ☐ *No*

What nutrition information or recipes would you like NOLP to provide in the future?

_____

_____

_____

	Rate on a scale of 4 (strongly agree) to 1 (strongly disagree):	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
1	NOLP staff served me in a timely fashion	◯	◯	◯	◯
2	NOLP staff is courteous	◯	◯	◯	◯
3	NOLP staff provided me with a better understanding of the importance of nutrition and managing HIV	◯	◯	◯	◯
4	I am satisfied by the food provided by NOLP. Please use the space below to share additional comments.	◯	◯	◯	◯

I would like to receive more of: _____

I would like to receive less of: _____

Please write additional comments in the following space:

NOLP # _____

Requested Referrals
Necessities of Life Program (NOLP)

DATE_____	NOLP SITE: ☐ David Geffen Center ☐ N. Hollywood ☐ South LA ☐ Long Beach ☐ Common Ground ☐ Bartz Altadonna ☐ FAP ☐ JWCH

1. What additional referrals or services can we help you with?
   - ☐ Other Food Providers
   - ☐ Nutrition counseling
   - ☐ Benefits (Social Security, Health Insurance, ADAP Enrollment Assistance, Cal Fresh/Food Stamps)
   - ☐ Housing
   - ☐ Home Health
   - ☐ Dental
   - ☐ Medical Care
   - ☐ Behavioral Health
   - ☐ Counseling Services/therapy
   - ☐ Transportation
   - ☐ I do not need any other services at this time

If you are interested in referrals, please complete the following 5 questions.
If not, please skip to the bottom and sign.

2. Client Name: _____

3. Date of Birth: _____

4. Phone Number: _____

5. Is it okay for us to call you?
   ☐ Yes ☐ No

6. Is it okay for us to leave you a message?
   ☐ Yes ☐ No

I acknowledge that APLA Health offered me referrals to other services. ☐ (Please check the box)

Client Signature _____ Date _____