☐ **NOLP ENROLLMENT /**
☐ **6-MONTH CERTIFICATION FORM**
MARCH 1, 2021 – FEBRUARY 28, 2022 **NOLP #** _____

CLIENT INFORMATION

$_____
Monthly Income

Income Source
☐ SSI ☐ SSDI
☐ General Relief
☐ Employed / Unemployment
☐ Self Employed
☐ Other

_____ _____
Name **Age**

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

_____ _____ _____
Date of Birth **Social Security #** **E-mail (cannot guarantee privacy)**

_____
Address

_____ _____ (_____) _____
City **Zip Code** **Cell Phone** ☐YES ☐NO

Is it OK to call, text, and e-mail you? ☐YES ☐NO

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

_____ _____
Emergency Contact **Relationship**

(_____) _____
Phone

Aware of HIV status? ☐YES ☐NO
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:** _____

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 Information: **Date of First Diagnosis:** _____

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

_____
Coverage Begins

_____
Coverage Ends

Are you receiving medical care at an APLA Health clinic (GCHC, Olympic, Long Beach)? ☐ Yes ☐ No

Have you seen your doctor in the last 6 months?
☐ Yes ☐ No

My signature below indicates my understanding and certification of:

- **Address and income contained herein is accurate,**
- **NOLP Client Services Agreement (attached herein, pages 3-4),**
- **Casewatch Millennium® Client Share/Non-Share Consent Form (attached herein, pages 4-5),**
- **HIPAA Consent (attached herein, page 6)**

How did you hear about our NOLP Program?

☐ **Flyer**
☐ **PPE KIT**
☐ **NOLP Staff:** _____ **(Name)**
☐ **Other:** _____

_____ _____
Client Print Name **Date**

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

STAFF ONLY (BELOW THIS LINE)

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_____ _____
Administered By (Staff Print Name) **Agency Name**

_____ _____
Signature of Staff **Date**

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, 2020 - February 28, 2021.

1. **Photo Identification**
2. Completion of the **NOLP Enrollment / 6-Month Certification** (this document)
3. 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.
4. **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. (Only necessary if enrolling for the first time.)

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.

NOLP Locations and Hours

David Geffen Center
611 S. Kingsley Dr.
Los Angeles, CA 90005
Every Wednesday from
10:30 AM - 5PM
*Fridays from 10 AM-5PM

Hollywood
922 Vine St. Los
Angeles, CA 90038
Every Saturday from
12 PM - 4PM

East Hollywood
954 N. Vermont Ave.
Los Angeles, CA 90029
The 2nd and 4th Friday
of the month
10 AM - 2 PM

South Los Angeles
1807 E. 120th St.
Los Angeles, CA 90059 Every
Every Thursday from
10:30 AM - 1 PM

Pasadena
1845 N. Fair Oaks., G-125
Pasadena, CA 91103
Every Friday from 9 AM - 2 PM

Common Ground Venice
622 Rose Ave.
Venice, CA 90291
The 3rd Thursday
of the month from
1PM - 3 PM

San Fernando Valley
7336 Bellaire Ave
North Hollywood, CA 91605
Every Thursday from
10 AM - 4:30 PM
*Every third Thursday from
10:00 AM-3:00 PM

Claremont
233 W. Harrison Ave.
Claremont, CA 91711
The 2nd and 4rth Wednesday
of the month 2PM- 4PM

Long Beach
590 E. Willow St. Long
Beach, CA 90806
Tuesdays only from
9 AM - 2 PM

Lancaster
858 W. Jackman St.
Lancaster, CA 93534
The 1st and 3rd
Thursday of the month
10AM - 2 PM

* Note : The David Geffen Center is open the first Friday of the month for limited hours from **9:30am to 12:30pm, effective October 2, 2020.**

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

Casewatch Millennium®
Client Share/Non-Share Consent Form

I 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.

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.

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.

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.

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.