WELCOME TO APLA HEALTH

Hello and welcome to APLA Health.

APLA Health is one of the largest non-profit HIV/AIDS service organizations in the United States, provides bilingual direct services, prevention education, and leadership on HIV/AIDS related policy and legislation. Founded by four friends in 1982, APLA Health is a community-based, volunteer-supported organization with local, national and global reach.

At APLA Health, we provide a variety of programs and services designed to improve the health and quality of life of people living with or affected by HIV/AIDS. We have been doing this work since the beginning of the epidemic in Los Angeles, and we are here to help.

The information in this packet will assist you in becoming a registered client of the agency. To become a client at APLA Health, you will need to:

- Provide HIV/AIDS diagnosis (***if currently in medical care***)
- Submit proof of Los Angeles County residency
  (If you are new to Los Angeles, APLA Health will assist you with establishing residency)
- Complete all forms in this packet (***if you need assistance, please speak with the Clientline staff).***

Please note that individual programs may have additional service restrictions based on the geographic area of residence, income, and disabilities of an individual client, along with other criteria. All of the eligibility information will be reviewed during the initial assessment interview.

Take a moment to review the instructions on the following page and then fill out the packet in its entirety (***if you need assistance, please speak with the Clientline staff).***

Once completed, bring the original copies of this packet with you to APLA Health. Visit us at the address below anytime between 9:00 am and 3:30 pm, Monday through Friday. Please check in at the 3rd Floor reception desk. You do not need an appointment to register as a client at APLA Health.

APLA Health
The David Geffen Center, Third Floor
611 South Kingsley Drive
Los Angeles, CA 90005
Registration Line: 213.201.1500

Welcome to APLA Health. We look forward to seeing you soon.

Sincerely,

Craig E. Thompson

Craig E. Thompson
Executive Director

APLA
Health

REGISTRATION INSTRUCTIONS

Please check off an item as you complete it	Type of Form/Verification	Instructions	Page Number
☐	**Verification of Residence & Eligibility Requirements**	Read this two-page section to find out about verifying your residence in Los Angeles and eligibility requirements of APLA Health programs.	1 – 2
☐	**Registration Form**	Complete both pages, sign and date where noted by an X.	3 – 8
☐	**Physician Diagnosis Form** ***(Including TB test results)***	A licensed practicing physician in California must complete the form dated within one year of registration. A TB skin test clearance dated within a year or a chest x-ray date within two years is also required.	9
☐	**Compliance Assurance Notification for our Clients**	Read this important notice about the use of personal health information and the HIPAA Act of 1996.	10
☐	**HIPAA Consent Form**	Read, sign, and date where noted by an X.	11
☐	**Consent Form to Release Medical Information**	Read, sign, and date where noted by an X.	12
☐	**Casewatch Consent Form**	Read, sign, and date where noted by an X.	13-14
☐	**People with HIV/AIDS Bill of Rights and Responsibilities**	Read, sign, and date where noted by an X.	15-17
☐	**Client Grievance Procedures**	Read, sign, and date where noted by an X.	18
☐	**Financial Screening Form**	Read, sign, and date where noted by an X.	19-20
☐	**Income Verification**	Different from verification of residence. Please see the list of acceptable documents.	21
☐	**Photo Identification**	Upon completion of the registration packet, please present photo identification.	

Return the ***original forms*** *to us during your initial visit at APLA Health. Feel free to copy the forms for your own records. Please be aware that some services require additional information because of funding requirements.*

If you have any questions, please call the Registrar at 213.201.1500
or VP 213.674.4321 for the Deaf and Hard of Hearing.

ELIGIBILITY REQUIREMENTS (page 1 of 2)

APLA Health offers many programs and services for people infected with or affected by HIV/AIDS. Some programs require that you be a client of APLA Health in order to participate. Other programs simply require that you be a resident of Los Angeles County.

Please review the following eligibility information in order to gain access to services as quickly as possible. APLA Health wants to make sure that you receive services as soon as possible; however, in some instances the following documents are required beforehand.

1. **VERIFICATION OF RESIDENCE IN LOS ANGELES COUNTY (The following documents can be provided to demonstrate proof of residency in the County of Los Angeles.)**

- Current California Driver License or California ID with Los Angeles county address

Or

- A copy of a current utility bill such as water, gas, electricity, telephone, cable TV, or a newspaper delivered daily that you have received within the last three (3) months showing your name, current address, and the date issued

Or

- A Medi-Cal, SSI, and/or SSD Award Letter with its mailing envelope; bank statement; or rental/lease agreement. All of these documents must show your name and current address and be dated within three (3) months, except for the rental/lease agreement, which can be accepted if dated within one (1) year

2. **CURRENT DIAGNOSIS FORM OR CURRENT LAB WORK (If applicable, dated within the last year)**

- Documentation from a licensed physician that you are currently receiving care
- Documentation of your most recent lab work, including CD4 count and viral load

*__NOTE: If you are HIV-positive but *not* in medical care we can help you find a medical provider and begin the process with getting the documents listed above.__

3. **PROOF OF INCOME**

- A copy of your bank statement showing direct deposit, an award letter of any type (SSI, SSDI, General Relief), a copy of a check, a check stub, or a letter of support from someone who is supporting you financially

APLA Health

ELIGIBILITY REQUIREMENTS (page 2 of 2)

4. OTHER REQUIREMENTS

Some programs have additional eligibility requirements such as:

Dental Services:

- CD4 count, viral load results and neutrophil count dated within the last 6 months
- Note of physician's approval for dental services
- Clients with private dental insurance or Medi-Cal must bring their insurance card

Home Health:

- Registered client of APLA Health
- Referral by Assessment, Clientline, or Case Management services. An assessment will be done by a registered nurse case manager to verify client's eligibility based on the State Office of AIDS Guidelines
- Symptomatic HIV or AIDS

Housing Support Services:

- Criteria are set by the governing bodies of either the Section 8 or HOPWA programs
- For more information about Housing Supportive Services, please call 213.201.1637

Group Counseling/Mental Health Services:

- Registered client of APLA Health
- Referral by Assessment, Clientline, or Case Management services
- Attend an interview with the support group facilitator
- For more information about Mental Health/Counseling Services please call 213.201.1621

Necessities of Life Program (NOLP) Food Pantries:

- Eligible clients may not have an income that exceeds $1,458.75 each month. For clients with dependents, add an additional $338 per dependent for income eligibility
  - Example: 1 dependent = monthly income may not exceed $1,796.75
  - Example: 2 dependents = monthly income may not exceed $2,134.75
- Complete an NOLP application
- Complete an annual nutrition screening

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REGISTRATION FORM

AP#________________ **Date**______/_______/______(MM/DD/YY)

Last Name: _______________________ First Name: _____________________ Middle Name: ____________

Date of Birth: ______/______/______ (MM/DD/YY) Social Security Number: _______-_______-_______

Mother's Maiden Name: ________________________

CONTACT INFORMATION

Your Home Address:

Street: ____ Apartment/Unit #: _________________

City: ____ State: _________ Zip Code: ______________

Is it okay to send mail with APLA Health on the envelope to this address? ☐Yes ☐No

Do you live, work, or go to school in the City of West Hollywood? ☐Yes ☐No

Daytime Phone: (______) ________-_________ May we leave a message indicating that the call is from APLA Health? ☐ Yes ☐ No

Evening Phone: (______) ________-_________ May we leave a message indicating that the call is from APLA Health? ☐ Yes ☐ No

Mobile Phone: (______) ________-_________ May we leave a message indicating that the call is from APLA Health? ☐ Yes ☐ No

May we contact you by e-mail? ☐ Yes ☐ No

If yes, please print email address: ____

Mailing address if different from above:

Street/ P.O. Box: ________________________________

Apartment/Unit #: _________________

City: ____ State: _________ Zip Code: ______________

Is it okay to send mail with APLA Health on the envelope to this address? ☐ Yes ☐ No

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If someone else were to answer your phone, who could APLA Health leave a message or speak with?

Name:	
Relationship:	
Name:	
Relationship:	

CLIENT INFORMATION

1. What is your gender?
   - ☐ Male ☐ Transgender Male to Female
   - ☐ Female ☐ Transgender Female to Male

2. What is your ethnicity?
   - ☐ Latino (Hispanic) ☐ Black/African American (Non-Hispanic)
   - ☐ White (Non-Hispanic) ☐ Native American/ Aleutian/ Native Alaskan
   - ☐ Asian/Pacific Islander ☐ Other (please specify)_________________________

3. What is your primary language?
   - ☐ English ☐ American Sign Language ☐ Russian
   - ☐ Spanish ☐ Armenian ☐ Other (please specify)________________

4. Do you speak English fluently? ☐ Yes ☐ NoDo you read and write English? ☐ Yes ☐ No

5. What is your birth country? ______________________________
   - Length of time in the U.S.______________ (in months)

6. Check all that apply
   - ☐ Physically challenged ☐ Blind or partially sighted
   - ☐ Deaf or hard of hearing

CLIENT'S SOURCE(S) OF MEDICAL INSURANCE

7. Do you currently receive ADAP (AIDS Drug Assistance Program) benefits? ☐ Yes ☐ No
8. What type of medical insurance do you have?

☐ Medi-Cal *without* share cost ☐ HMO/PPO ☐ None
☐ Medi-Cal with share cost ☐ Private
☐ Medicare ☐ VA and/or other government benefits
☐ Both Medi-Cal and Medicare ☐ Other (please specify)___________________

9. Have you applied for Medi-Cal benefits recently? ☐ Yes ☐ No

   a. If "Yes", Medi-Cal date of application__________________ (MM/DD/YY)

   b. What is the status of your application

   ____

10. If you have private insurance through an HMO or a PPO, what is the name of your carrier?

____

   a. What is your insurance ID#? ____________________
   b. Eligibility date______________
   c. How much is your medical visit co-pay?_____________________
   d. How much is your prescription co-pay?____________

INCOME

11. Please indicate your gross monthly income:

   ☐ Less than $747 ☐ $748-$1,197 ☐ $1,198 - $2,234
   ☐ $2,235 - $2,992 ☐ More than $2,993

12. Are you medically able to work? ☐ Yes ☐ No

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13. Do you receive any of the following? *(If so, please check all boxes and indicate amount)*

			Amount received monthly
Social Security Disability Insurance (SSDI)	☐ Yes	☐ No	$
Supplemental Security Income (SSI)	☐ Yes	☐ No	$
CalWORKs (TANF)	☐ Yes	☐ No	$
State Disability Insurance (SDI)	☐ Yes	☐ No	$
General Relief (GR)	☐ Yes	☐ No	$
Food Stamps	☐ Yes	☐ No	$
CAPI	☐ Yes	☐ No	$
Unemployment Insurance (UI)	☐ Yes	☐ No	$
Veterans Benefits (VA)	☐ Yes	☐ No	$
Other Income (support from friends/famil **Please specify source:__________________**	☐ Yes	☐ No	$

HIV HISTORY

In order to provide services that best meet your needs, please answer the following questions.

14. How did you become infected with HIV? *(Check all that apply)*

- ☐ Male to female sex (heterosexual contact)
- ☐ Male to male sex
- ☐ Male to male sex and injection drug use
- ☐ Blood transfusion or other blood or tissue products
- ☐ Injection drug use
- ☐ Infected at birth
- ☐ Hemophilia/coagulation disorder
- ☐ Other (specify)________________

15. What have been or are the gender(s) of your sexual partner(s)? *(Check all that apply)*

- ☐ Male
- ☐ Female
- ☐ Male to female transgender
- ☐ Female to male transgender
- ☐ No sexual partners

LIVING/HOUSING ARRANGEMENT:

16. What is your household size (how many people live with you)? ________________

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17. Marital Status (check all that applies)

☐ Single
☐ Partnered/not legally married
☐ Separated/Divorced
☐ Widowed ____________years
☐ Married/Domestic partnership ☐ Male partner ☐ Transgender male to female partner
_____________ years ☐ Female partner ☐ Transgender female to male partner

18. What is your housing situation?

☐ Stable and permanent (living in apartment, house, leasing)
☐ Non-permanent (homeless, transient)
☐ Institution (correctional, health care center, mental health) ______________________________
☐ Other (Please Specify)__________

19. Do you have any *dependent* children? ☐ Yes ☐ No

If "Yes," What is the number of dependent children? ______________________

20. Have you ever been in jail or prison? ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

In the event of an emergency whom may we contact, indicating that the call is from APLA Health, and if need be, providing personal information about you?

Name ____

Relationship to you__________________________

Address___________________________________ Apartment/Unit #___________________

City_____________________________ State__________________

Zip Code____________

Daytime Phone (______)___________-____________

Evening Phone (______)___________-____________

Mobile Phone: (______)___________-____________

Language spoken ____
Is this person aware of your HIV status? ☐Yes ☐No
Is it okay to disclose your information? ☐Yes ☐No

21. Do you have a Durable Power of Attorney (DPA) for Healthcare? ☐Yes ☐No

If "Yes," what is the name of the person assigned as the DPA? ____

- Phone Number (______)___________-____________

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22. Where do you primarily receive medical care? *(such as Kaiser Permanente, AIDS Healthcare Foundation (AHF), County/USC Hospital (5P21), Jeffrey Goodman Clinic, etc)* ____

Name of physician _____________________________

Phone number (______)___________-____________

Name of nurse (if any)__________________________

Phone number (______)___________-____________

Name of social worker (if any)____________________

Phone number(______)___________-____________

Are you satisfied with your medical care? ❒Yes ❒No

I hereby certify that the information I provided above is true and correct to the best of my knowledge.

X____ ______/_______/________
Signature of Client Date (MM/DD/YY)

Personal information is reported anonymously and not linked to you individually. Your name and other identifying information will be kept CONFIDENTIAL. Please answer every question.

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PHYSICIAN'S DIAGNOSIS FORM

PHYSICIANS: A licensed, practicing physician in California is required to complete as much of this form as possible. If you do not respond to a question, we will assume that you do not have an answer to that particular question. Return to APLA Health Registrar by FAX (213) 201-1392 or mail to The David Geffen Center, 611 S. Kingsley Drive, Los Angeles, CA 90005

Patient's Name: ______________________ **Date of Birth** ______________________
Last **First** **MI** **MM** **DD** **YYYY**

Social Security #: ______ - ______ - _______ **Phone Number** (____) ______ ________

➔ DIAGNOSIS: (Choose only one)

- ❒ HIV+ Asymptomatic (No Symptoms)
- ❒ AIDS Asymptomatic (No Symptoms)
- ❒ HIV+ Symptomatic
- ❒ AIDS Symptomatic

- What was the date of this diagnosis? _____ / _____ / _____ Year of first positive test for HIV _______________
- Symptoms that substantiate this diagnosis:
  - ❒ Diarrhea
  - ❒ Fevers
  - ❒ Fatigue
  - ❒ Other ____________________________

  Opportunistic infections that substantiate this diagnosis:
  - ❒ CD4 < 200/14% Date:__________________________
  - ❒ KS Date:__________________________
  - ❒ PCP Date:__________________________
  - ❒ Other (include date)__________________________________

➔ **CURRENT SYMPTOMS RELATED TO HIV or TREATMENT INCLUDE:**

____

____

➔ **LAB DATA:**

- CD4 count/percentage_______/_______% as of _____ / _____ / _____
- HIV viral load______________________________ as of _____ / _____ / _____
  - ➢ Viral Load Test Type: ❒ PCR ❒ bDNA ❒ NASBA
- Neutrophil count __________________cells/mm3 as of _____ / _____ / _____ (required for dental)
- Platelet count ____________________ cells/mm3 as of _____ / _____ / _____ (required for dental)

➔ **OTHER ILLNESSES: Are there any other illness we need to be aware of?** (If yes, please describe)

____

____

➔ **DENTAL:** Is this patient medically able to receive routine dental care and/or oral procedures? ❒Yes ❒ No
➔ **FOOD & NUTRITION:** Is this patient in need of food and nutrition services? ❒Yes ❒ No
➔ **TUBERCULOSIS:** Has this patient been screened for TB? ❒ Yes ❒ No

TB skin test date _____/_____/_____ ❒ Positive ❒ Negative

TB chest X-ray _____/_____/_____ ❒ Positive ❒ Negative

This patient is currently ❒ receiving preventive TB treatment ❒ not receiving treatment
❒ receiving treatment for active TB ❒ non-compliant with recommended treatment

I am the physician responsible for the above patient's HIV care. I certify that the above information is correct and based on a review of the patient's HIV treatment needs.

Physician's Name: ____________________________________ License Number: ____

Address: ____________________________________ City: ___________________________ State: ______ Zip: ____________

Signature: _______________________________Date Completed: _____ / _____ / _____ Phone:(____) ________________

COMPLIANCE ASSURANCE
NOTIFICATION FOR APLA HEALTH CLIENTS

To Our Valued Clients,

The misuse of personal health information has been identified as a national problem. We want you to know that all of our employees, managers, and volunteers continually undergo training so that they understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act of 1996 (HIPAA), with particular emphasis on the "Privacy Rule." We strive to achieve the highest standards of ethics and integrity in providing services for our clients.

It is our policy to properly determine the appropriate use of personal health information in accordance with governmental rules, laws, and regulations, except in cases where the law mandates us to report this information. This includes instances where you are a threat to yourself (suicidal or homicidal ideations) or instances of child or elder abuse. As part of this plan, we have implemented a compliance program that oversees the prevention of any inappropriate use of personal health information.

Because we believe that there is always room for improvement, our policy is to listen to our employees and our clients without any thought of penalty if they feel that an event in any way compromises our policy of integrity. We welcome your input regarding any service problem so that we may remedy the situation promptly.

HIPPA Compliance Officer

HIPAA PATIENT CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a "Privacy Rule" to help ensure 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 a patient consent to disclose health information about the patient in order to carry out treatment, payment, or health care operations.

APLA Health wants you to know that we respect the privacy of your personal health information 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 only the minimum necessary information 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 physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. This includes instances where you are a threat to yourself (suicide or homicide ideations) or instances of child or elder abuse. As part of this plan, we have implemented a Compliance Program that oversees the prevention of any inappropriate use of Personal Health Information. 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.

___________________________ ___________________________

Print Name Date

____

Signature

CONSENT TO RELEASE MEDICAL INFORMATION

Your health and medical information is considered sensitive and private and is afforded protection under the law. APLA Health will make every effort to keep all client records secure. However, as a client of APLA Health there are circumstances that will require the exchange of information about me through phone, faxing, e-mailing, and mailing.

I understand that APLA Health will represent me in these exchanges, and that APLA Health cannot be held responsible if any person becomes aware that I am a client at APLA Health.

Signing this Consent to Release Medical Information allows you the flexibility to determine what types of information are to be released and under what circumstances. In addition, this form complies with the HIPAA (Health Insurance Portability and Accountability Act) Privacy Rules.

I, _________________________________ hereby authorize ____

(Name of Client) (Name of Doctor or Medical Group)

to give information from my record with no limitations on the date of illness, history of illness, diagnosis, or therapeutic information to AIDS Project Los Angeles for the purpose of verification of diagnosis and/or providing or referring for dental treatment and/or nutritional counseling. I understand that this authorization may be revoked at any time, except to the extent that the action has already occurred.

CONSENT TO RELEASE INFORMATION PROCEDURES

I, _____________________________________, authorize staff from AIDS Healthcare Foundation (AHF), APLA Health, Asian Pacific AIDS Intervention Team, City of Pasadena, Andrew Escajeda Clinic, ALTAMED Health Service Corp, Automated Case Management Systems (ACMS), Being Alive, Children's Hospital, Division of Adolescent Medicine, Bienestar, Cedars Sinai, Central City Clinic, City of Long Beach -AIDS Program, East Valley Community Health Center, El Proyecto del Barrio, Foothill AIDS Project, Greater Los Angeles Council on Deafness, Harbor/UCLA Medical Center, High Desert Health System, Hubert Humphrey, JWCH Institute, Inc., Kaiser Permanente, LAC-USC (5p21, Maternal Child/Adolescent, EIP, Weingart), L.A. Gay & Lesbian Center, Memorial Miller Children's Hospital, Minority AIDS Project, Northeast Valley Health Corporation, Division of HIV & STD Programs, Olive View Medical Center, Pathways, Project Angel Food, South Bay Family Healthcare Center, Spectrum, St. Mary Medical Center CARE Program & Clinics, Tarzana Treatment Center, T.H.E. Clinic, Inc. (To Help Everyone), UCLA Care, Valley Community Clinic, Venice Family Clinic, Watts Healthcare, City of West Hollywood

To release, receive, and share information regarding services, and to share information through the mail, telephone, fax, or electronic computer mail, etc., regarding my HIV test results; HIV status; physical, mental or financial condition; or services received related to my need for current or future assistance at the above agencies.

This consent is valid from the date it is signed and may be revoked at any time by signing under the cancellation statement below or by verbally informing the agency holding this original form. I understand that I may add other specific agencies and individuals to this form by listing them and signing below.

X ________________________________ ______ / ______ / _______ _____ / ______ / ________

Signature of Client Date (DD/MM/YY) Consent Valid Through (DD/MM/YY)

I wish to **add** the following specific individuals, agencies, and/or physicians to this Consent to Release Medical Information:

____

X ____ __________ / ____ ______ / _________

Signature of Client Date (DD/MM/YY)

I wish to **cancel** this Consent to Release Medical Information.

X ____ / ____/ ______ / _________

Signature of Client Date (DD/MM/YY)

CASEWATCH MILLENIUM CONSENT FORM

I, ____ (print full name), wish to register with Ryan White Program/Casewatch Millennium (R) in order to receive services funded by the Ryan White Program or the Department of Public Health, Division of HIV and STD Programs (DBSP). During registration I will be asked to provide information about myself including my name, race, gender, birthdate, 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, 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. 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/Millennium system unless I provide my specific, informed consent for such a disclosure. A list of Ryan White Program/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 without my consent, except as allowed by law.

By initialing the “I AGREE and UNDERSTAND” line 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 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 information 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/Millennium agencies.

By signing this form I acknowledge that I have been offered a copy of this consent form, and that I 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 years from the date I signed this form.

____

Signature of Client or Parent/Guardian of Minor

____

Date

For Local Health Care Agency Use Only

____ ______________________________

Administered by Agency Name

____ ______________________________

Signature Date

APLA Health

PATIENT AND CLIENT BILL OF RIGHTS AND RESPONSIBILITIES

The purpose of this Patient and Client Bill of Rights is to help enable clients act on their own behalf and in partnership with their providers to obtain the best possible HIV/AIDS care and treatment. This Bill of Rights and Responsibilities comes from the hearts of people living with HIV/AIDS in the diverse communities of Los Angeles County. As someone newly entering or currently accessing care, treatment, or support services for HIV/AIDS, you have the right to:

A. Respectful Treatment

1. Receive considerate, respectful, professional, confidential, and timely care in a safe, client-centered environment without bias.
2. Receive equal and unbiased care in accordance with federal and state law.
3. Receive information about the qualifications of your providers, particularly about their experience managing and treating HIV/AIDS or related conditions.
4. Be informed of the names and work phone numbers of the physicians, nurses, and other staff members responsible for your care.
5. Receive safe accommodations for protection of personal property while receiving care and services.
6. Receive services that are culturally and linguistically appropriate, including having full explanations of all services and treatment options provided clearly in your own language and dialect.
7. Look at your medical records and receive copies of them upon your request (reasonable agency policies including reasonable fee for photocopying may apply).
8. When special needs arise, extended visiting hours by family, partner, or friends during inpatient treatment, recognizing that there may be limits imposed for valid reasons by the hospital, hospice, or other inpatient institution.

B. Competent, High-quality Care

1. Have your care provided by competent, qualified professionals who follow HIV treatment standards as set forth by the Federal Public Health Service Guidelines, the Centers for Disease Control and Prevention (CDC), the California Department of Health Services, and the County of Los Angeles.
2. Have access to these professionals at convenient times and locations.
3. Receive appropriate referrals to other medical, mental health, or other care services.

C. Make Treatment Decisions

1. Receive complete and up-to-date information in words you understand about your diagnosis, treatment options, medications (including common side-effects and complications), and prognosis that can reasonably be expected.
2. Participate actively with your provider(s) in discussions about choices and options available for your treatment.
3. Make the final decision about which choice and option is best for you after you have been given all relevant information about these choices and the clear recommendation of your provider.
4. Refuse any and all treatments recommended and be told of the effect not taking the treatment may have on your health, be told of any other potential consequences of your refusal, and be assured that you have the right to change your mind later.

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5. Be informed about and afforded the opportunity to participate in any appropriate clinical research studies for which you are eligible.
6. Refuse to participate in research without prejudice or penalty of any sort.
7. Refuse any offered services or end participation in any program without bias or impact on your care.
8. Be informed of the procedures at the agency or institution for resolving misunderstandings, making complaints, or filing grievances.
9. Receive a response to any complaint or grievance within 30 days of filing it.
10. Be informed of independent ombudsman or advocacy services outside the agency to help you resolve problems or grievances (see phone number at bottom of this form), including how to access a federal complaint center within the Center for Medicare and Medicaid Services (CMS).

D. Confidentiality and Privacy

1. Receive a copy of your agency's Notice of Privacy Policies and Procedures. Your agency will ask you to acknowledge receipt of this document.
2. Keep your HIV status confidential or anonymous with respect to HIV counseling and testing services. Have information explained to you about confidentiality policies and under what conditions, if any, information about HIV care services may be released.
3. Request restricted access to specific sections of your medical records.
4. Authorize or withdraw requests for your medical record from anyone else besides your health care providers and for billing purposes.
5. Question information in your medical chart and make a written request to change specific documented information. Your physician has the right to accept or refuse your request with an explanation.

E. Billing Information and Assistance

1. Receive complete information and explanation in advance of all charges that may be incurred for receiving care, treatment, and services as well as payment policies of your provider.
2. Receive information on any programs to help you pay and assistance in accessing such assistance and any other benefits for which you may be eligible.

F. Patient/Client Responsibilities

In order to help your provider give you and other clients the care to which you are entitled, you also have the responsibility to:

1. Participate in the development and implementation of your individual treatment or service plan to the extent that you are able.
2. Provide your providers, to the best of your knowledge, accurate and complete information about your current and past health and illness, medications and other treatment and services you are receiving, since all of these may affect your care. Communicate promptly in the future any changes or new developments.
3. Communicate to your provider whenever you do not understand and information you are given.
4. Follow the treatment plan you have agreed to and/or accept the consequences of not following the recommended course of treatment or of using other treatments.
5. Keep your appointments and commitments at this agency or inform the agency promptly if you cannot do so.

6. Keep your provider or main contact informed about how to reach you confidentially by phone, mail, or other means.
7. Follow the agency's rules and regulations concerning patient/client care and conduct.
8. Be considerate of your providers and fellow clients/patients and treat them with the respect you yourself expect.
9. The use of profanity or abusive or hostile language; threats, violence or intimidation; carrying weapons of any sort; theft or vandalism; intoxication or use of illegal drugs; and sexual harassment or misconduct is strictly prohibited.
10. Maintain the confidentiality of everyone else receiving care or services at the agency by never mentioning to anyone who you see here or casually speaking to other clients not already know to you if you see them elsewhere.

For More Help or Information

Your first step in getting more information or resolving any complaints or grievances should be to speak with your provider or a designated client services representative or patient or treatment advocate at the agency. If this does not resolve any problem in a reasonable time span, or if serious concerns or issues that arise that you feel you need to speak about with someone outside the agency, you may call the number below for confidential, independent information and assistance.

For patient and complaints/grievances call (800) 260-8787
8:00 am – 5:00 pm
Monday-Friday

APLA Health

CLIENT GRIEVANCE PROCEDURES

Policy

APLA Health has established a Client Bill of Rights to ensure that clients are treated with respect and are provided the highest possible quality of services. The grievance policy has been adopted for a client to utilize if he/she feels one of his/her rights, as defined in the Client Bill of Rights, was violated or if he/she has a specific grievance that needs to be addressed.

Procedures

1. If a client has a grievance with a program or with the staff of a program, the client should first try to resolve the matter with the supervisor or program manager.
2. If resolution is not achieved after speaking with the supervisor or the program manager, then the client should contact the division director.
3. The supervisor, program manager, and division director will listen to the information about the incident and will attempt to mediate the grievance.
4. Any grievance that is the result of a dispute over a written service agreement between a client and a manager of a specific program will be examined by the division director to determine if the service agreement was fair, and if the service agreement was in fact violated by the client.
5. If the matter cannot be mediated, it will be turned over to the division director for final resolution.
6. Grievances will receive prompt attention. Every effort will be made by all appropriate staff to address and resolve grievances within ten (10) working days.
7. If you believe your grievance has not been resolved, you may contact the Los Angeles Division of HIV and STD Programs at 1.800.260.8787.

My signature below acknowledges that I have read or been informed and given a copy of the above policy and procedures. I also understand that APLA Health has the right to suspend or terminate services to me if I do not comply with or sign these policies and procedures.

______________________________ Client Name (Please Print)

______________________________ AP#

______________________________ Signature of Client

______________________________ Date (MM/DD/YY)

______________________________ Agency Representative (Please Print)

______________________________ Title

______________________________ Agency Representative Signature

______________________________ Date (MM/DD/YY)

FINANCIAL SCREENING FORM (1 OF 2)

APLA Health receives government funding to provide certain HIV-related services to individuals who can provide documentation that s/he is eligible to receive services. In order that APLA Health complies with its funding source requirements, we are requesting that you provide proof of your monthly income.

Client Name ____ AP# ____________________

Case Manager _______________ Phone _________________ Agency _________________

Type of Income	Monthly Amount
Social Security Disability Insurance (SSDI)	$
Supplemental Security Income (SSI)	$
State Disability Insurance (SDI)	$
General Relief (GR)	$
CalWORKs (TANF)	$
Veterans Benefits (VA)	$
Employment Income (Self-Employment*)	$
Private Disability Insurance	$
Unemployment Insurance (Ul)	$
Retirement/Pension	$
Child Support and/or Alimony	$
Worker's Compensation	$
Food Stamps	$
Support of Family/Friends*	$
Investment Income	$
Other	$
Total Monthly Income	$

*Client must complete Certification of Alternative Income form and provide appropriate documentation.

I hereby certify that the above financial information is accurate and I agree to immediately notify APLA Health of any changes in my monthly income. Further, I understand that failure to provide accurate information may result in suspension or termination of services.

X ________________________________ ______________________

Signature of Client Date (MM/DD/YY)

X ________________________________ ______________________

Financial Screener Date (MM/DD/YY)

FINANCIAL SCREENING FORM (2 OF 2)

CERTIFICATION OF ALTERNATIVE INCOME

Self-Employment:

I, ____ , *am self-employed.*
Print first name Print middle initial Print last name

I have listed my total earnings for the past three (3) months from________ to the present as follows:

Pay Date (DD/MM/YY)	**Type of Work**	**Monthly Income**
		$
		$
		$
	Average Monthly Income	**$**

I hereby certify that the above financial information is accurate and I agree to immediately notify APLA Health of any changes in my monthly income. Further, I understand that failure to provide accurate information may result in suspension or termination of services

X ____ __________/_______ /________
Signature of Client Date (MM/DD/YY)

Have you been denied any public Benefits for which you applied?

Benefit applied for: ____

Date of Denial: _______________ (MM/DD/YY) *Proof of denial required (dated within the last three months).*

Appeal pending: ______________________________

Support from Family or Friends:

Support Provided By_______________________________ Monthly Income $ _____________

Letter of support required

DOCUMENTS ACCEPTED FOR VERIFICATION OF GROSS MONTHLY INCOME

Documents used to verify income cannot be older than three months.

Income Source	Verification Document
Social Security Disability Insurance (SSDI) Supplemental Security Income (SSI)	• Check Stub • Bank Statement (Direct Deposit) • Award Letter • COLA Statement • Social Security Benefit Statement
State Disability Insurance (SDI) Unemployment Insurance (Ul) Workers Compensation	• Check Stub • Award Statement
General Relief (GR) CalWORKS (TANF)	• DPSS Benefit Statement
Veterans Administration Benefits (VA)	• Check Stub • Bank Statement (Direct Deposit) • Award Letter/COLA Statement • VA Benefit Statement
Employment Income	• Payroll Check Stub • W2 or 1099 Tax Form • Tax Return • Letter from Employer • APLA Health Alternative Income Form
Private Disability	• Check Stub • Benefit Verification Statement
Retirement/Pension	• Check Stub • Bank Statement (Direct Deposit) • Benefit Verification Statement
Child Support Alimony	• Check Stub
Support Family & Friends	• Letter of Support
Investment Income	• Tax Records
Cash Assistance Program for Immigrants (CAPI)	• Check Stub or DPSS Benefit Statement • Award Letter/DPSS Benefit Statement