APLA Health

Housing Support Services Registration Form

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

APLA Health

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
   - ☐ Female
   - ☐ Transgender Male to 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

APLA Health

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
☐ Medi-Cal with share cost
☐ Medicare
☐ Both Medi-Cal and Medicare
☐ HMO/PPO
☐ Private
☐ VA and/or other government benefits
☐ Other (please specify)_____
☐ None

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

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	☐ Yes	☐ No	$
Please specify source:_____			

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)? _____

17. Marital Status (check all that applies)

- ☐ Single
- ☐ Partnered/not legally married
- ☐ Separated/Divorced
- ☐ Widowed _____years
- ☐ Married/Domestic partnership _____ years ☐ Male partner ☐ Female partner ☐ Transgender male to 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 (_____)_____-_____

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.

Client Consent for Electronic Communication (Email and Text Messaging)

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY. YOUR SIGNATURE BELOW INDICATES YOUR UNDERSTANDING OF THIS INFORMATION AND YOUR ACCEPTANCE OF THE RISKS AND TERMS OUTLINED BELOW.

You have requested that Alliance for Housing and Healing communicate with you via unencrypted emails and text messaging ("Electronic Communication"). You must be aware that there is no guarantee of privacy when sending information by these methods. If you decide not to sign this form, Alliance for Housing and Healing will not communicate with you via email or text messaging but your enrollment, eligibility for assistance or other service operations will not be affected. If you decide that you'd like to communicate with your Alliance for Housing and Healing staff via email or text messaging, you should consider the following risks before signing this consent form.

Client Information

Client Name: _____ Date of Birth (MM/DD/YYYY): _____

Email Address: _____

Cell Phone Number: _____

My consent for electronic communication is not effective until I receive and respond appropriately to a test message from Alliance for Housing and Healing**.**

Please select the security question you want to use for identify verification the first time we receive a message from you, and provide us with your answer below:

- Last four digits of my Social Security number: _____
- My mother's maiden name: _____
- My pet's name: _____

Risks of Using Email and Text Messaging for Electronic Communication

- Email and text messages:
  - can be copied, circulated, forwarded, and stored in electronic files;
  - can be broadcast worldwide immediately, whether accidentally or intentionally, and received by many unintended recipients;
  - are easier to falsify than handwritten or signed documents;
  - can be intercepted, altered, forwarded, or used without written authorization or detection;
  - may not be answered in the time frame expected by the sender.
- Backup copies of email and text messages may exist even after all participants have deleted their own copies;
- Employers and online services may have a right to archive and inspect emails transmitted through their systems;
- Passwords providing access to email and cell phones can be stolen and misused, or host systems can be compromised, leading to unauthorized disclosure of personal information;

Conditions for the Use of Email and Text Messaging with Alliance for Housing and Healing **Staff**

When applicable, Alliance for Housing and Healing may use and disclose protected health information ("PHI") as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") in accordance with HIPAA and related regulations. Alliance for Housing and Healing will use reasonable means to protect the confidentiality of PHI and other client information sent and received through email and text messaging. However, because of the risks outlined above, Alliance for Housing and Healing cannot guarantee the security and confidentiality of email and text-based communications, and will not be liable for improper disclosure of confidential information that is not caused by Alliance for Housing and Healing intentional misconduct.

It is also important to understand that the purpose of email and text-based communication is to facilitate communication with Alliance for Housing and Healing. It is not intended to substitute for face-to-face meetings and/or personal conversations with Alliance for Housing and Healing.

By signing this consent form, I agree to and acknowledge the following:

- I am an established client of Alliance for Housing and Healing;
- I consent to receive email and/or text messages as specified in this form, including messages that Alliance for Housing and Healing may send to me using automated dialing systems or other automated means. Message and data rates may apply.
- I have read and understand Alliance for Housing and Healing Conditions for the Use of Email and Text Messaging with Alliance for Housing and Healing staff;
- Alliance for Housing and Healing will read and respond to email communications as promptly as reasonably possible; however, a specific turnaround time is not guaranteed. Thus, I will not use email or text messaging for time-sensitive matters;
- Some or all information sent or received via email or text messaging may concern my diagnosis and/or other health-related information. It may be made part of my record or forwarded internally to other Alliance for Housing and Healing staff as necessary for the use in providing services or other business-related activities. Electronic information will not, however, be forwarded to independent third parties without my prior written consent, except as authorized or required by law.
- Communication via email and text is not secure, and therefore, Alliance for Housing and Healing cannot guarantee the confidentiality of electronic PHI and other client information. I understand that it is my responsibility to protect passwords to my email and other accounts. I also understand that Alliance for Housing and Healing and its representatives are not liable for breaches of confidentiality related to email or text messages caused by any third party or myself;
- I may, at any time, revoke my consent for email and text communications;

Client Acknowledgement and Agreement

I hereby acknowledge that I have read and fully understand the information provided in this Client Consent Form for Electronic Communication (Email and Text Messaging). I understand the risks associated with using email and text messaging to communicate with Alliance for Housing and Healing staff. By signing below, I am consenting to participate in Electronic Communication with Alliance for Housing and Healing staff.

Client Signature: _____

Date: _____

Expiration

Unless revoked below in writing, this Authorization will expire upon the later of the following events: (1) one year after the date of my signature; or (2) the date on which my services are terminated with Alliance for Housing and Healing.

Right to Revoke

I request that Alliance for Housing and Healing no longer use the above email address and/or cell phone number to communicate with me electronically.

By signing below, I am revoking my previous consent above.

_____

Client Name (Head of Household) *Signature* *Date (MM/DD/YYYY)*

_____ *(Ct's Initials) Client Received Copy*

AFFIDAVIT of BANK ACCOUNT and ASSETS

This form should be completed by the HOPWA applicant, but applies to the entire household.

I, _____, am applying for assistance through a Los Angeles Housing Department (LAHD) federally funded program. HUD regulations require verification of all financial information for participating households, including income, bank accounts, and assets. Annual income includes amounts derived from assets for all household members. Assets are any items of value that may be turned into cash. There is no asset limitation for participation in this program.

Please check all that apply to your household:

- ☐ I/we have one or more bank savings account(s)
- ☐ I/we have one or more bank checking account(s)
- ☐ No household member has a bank account

Please check off if you or any adult in your household currently have any of the following assets:

- ☐ Cash held in Savings and Checking accounts, Safe Deposit Boxes
- ☐ Certificates of Deposit, Mutual Funds, Stocks, Bonds
- ☐ Cash Value of Whole or Universal Life Insurance
- ☐ Annuities, Revocable Trust
- ☐ Collections held as an investment: Gems, Jewelry, Coin Collections
- ☐ Employer Pensions and Retirement
- ☐ Individual Retirement Accounts (IRA), Keogh accounts
- ☐ Cash, this includes but not limited to saving cash at home under a mattress, coffee can, etc. *(Although this is does not produce income, it is a thing of value that could be used to the benefit of the household member. Some programs require that households "spend down" assets before they can participate)*

An asset does not include the following: Clothing, cars, wedding ring or other jewelry not held as an investment, furniture, interests in Indian trust land, term life insurance policies, equity in cooperative unit, assets that are par of an active business, assets that are not accessible.

Please check off if you or any adult in your household do not have any assets:

- ☐ No assets

I understand that any misrepresentation of information or failure to disclose information requested on this form may disqualify me from participation in this LAHD federally funded program, and may be grounds for termination of assistance. WARNING: It is unlawful to provide false information to the government when applying for federal public benefit programs per the Program Fraud Civil Remedies Act of 1986, 31 U.S.C. §§ 3801-3812.

I certify that the above information is true and correct. I also understand that it is my responsibility to report all changes in my household composition or income in writing within ten (10) business days of such change.

_____	_____	_____
Client Name	**Client Signature**	**Date**
_____	_____	_____
Provider Name	**Provider Signature**	**Date**

Self-Certification of Income or Zero Income

This form should be completed by the HOPWA applicant, but applies to the entire household.

I,_____ am applying for assistance through a Los Angeles Housing Department (LAHD) federally funded program.

I understand that HUD regulations require gross income documentation for all household members 18 years of age and older. (Documentation must be complete and cover a full month (30 days) preceding the eligibility certification or recertification). I understand that this form is used to declare zero income or to document household income for which I cannot obtain third party documentation.

Income includes, but is not limited to:

- Gross wages, salaries, overtime pay, commissions, fees, tips, bonuses, and other compensation for personal services.
- Net income from operation of a business or from rental or real personal property.
- Interest, dividends, and other net income of any kind for real personal property.
- Amounts derived from assets for all household members.
- Full amount of periodic payments received from Social Security, annuities, insurance policies, retirement funds, pensions, disability/death benefits, and other similar types of periodic receipts except as provided in line 14 of Annual Income Exclusions.
- Payments in lieu of earnings, such as unemployment and disability compensation, worker's compensation, and severance pay except as provided in line 3 of Annual Income Exclusions.
- Temporary Assistance for Needy Families (TANF), including amounts designated for shelter and utilities. Alimony, child support payments, and regular contributions from organizations or from persons not residing in the dwelling. All regular pay, special pay, and allowances of a member of the Armed Forces except as provided in line 7 of Annual Income Exclusions.

Zero Income

☐ I hereby certify that **no one** in my household has received any income in the last 30 days. I/we do not expect to receive any income in the near future. I will notify my provider immediately if I/we do receive any income from any source.

Self-Certification of Income

☐ I hereby certify that I and/or an adult household member received the following income in the last 30 days, but **cannot obtain** third party verification. I understand that third-party verification is the preferred method of confirming income, but is unavailable because:_____

Income Source:_____ Pay Frequency_____ Date of Receipt_____

Income Source:_____ Pay Frequency_____ Date of Receipt_____

Income Source:_____ Pay Frequency_____ Date of Receipt_____

I understand self-certification of income is only permitted when I have zero income or attempted but cannot obtain third party proof of income. I understand that any misrepresentation of information or failure to disclose information requested on this form may form may disqualify me from participation in this LAHD federally funded program, and may be grounds for termination of assistance. WARNING: It is unlawful to provide false information to the government when applying for federal public benefit programs per the Program Fraud Civil Remedies Act of 1986, 31 U.S.C. §§ 3801-3812. It is unlawful to provide false information to the government when applying for federal public benefit programs per the Program Fraud Civil Remedies Act. I agree to report any changes in income to my housing case manager immediately.

Client Name	Client 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.

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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

HOPWA Program Participation Agreement

Must be completed with initial/annual eligibility certification

HOPWA Eligibility

- At least one of your household members must be living with HIV.
- Household annual gross income cannot exceed 80% of area median income.
- Must be living in Los Angeles County

People with HIV/AIDS Rights and Responsibilities

- Receive considerate, respectful, professional, confidential and timely care in a safe client-centered environment without bias in accordance with federal, State and local laws.
- Receive services that are culturally and linguistically appropriate.
- Receive complete and up-to-date information in words you understand regarding your housing services.
- Participate actively with your provider(s) in discussions about choices and housing options available.
- 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.
- To be informed of the terms and expectations of your housing and any consequences for refusing to comply with them.
- Refuse any offered services or end participation in any program without bias.
- Be informed and provided a copy of the agency's grievance policy and procedures.
- To have your records and communications kept confidential.
- Collaborate with your provider to develop and comply with a comprehensive housing plan, with the ultimate goal to achieve or maintain permanent sustainable housing.
- Provide, to the best of your knowledge, accurate and complete information.
- To report all changes in income, residency, or household composition to your provider immediately.
- Communicate to your provider whenever you do not understand information you are given
- Follow the individual housing plan you have agreed to or accept the consequences of failing the recommended course of options related to your housing.
- Keep your appointments and commitments at this agency or inform the agency promptly if you cannot do so.
- Keep your provider(s) informed about how to reach you confidentially by phone, mail or other means.
- To be informed and follow the agency's rules, regulations and policies and procedures and any consequences for refusing to comply with them.

Participation Acknowledgement

I hereby state that I have read and understand the HOPWA Program Participation Agreement. I understand that my household must meet basic eligibility requirements to be considered for HOPWA program enrollment. I further understand that specific programs may have additional eligibility requirement(s). I understand that financial assistance may vary from one household to another. I understand that services are needs-based and depend on funding availability, agency capacity, and adherence to my housing plan. I agree to work collaboratively with my provider to achieve my housing goals. I understand that non-compliance with the responsibilities listed above may result in termination of HOPWA services.

_____ _____

Client Name Client Signature Date:

_____ _____ _____

Provider Name Provider Signature Date:

Ann Sewill, General Manager
Tricia Keane, Executive Officer

Daniel Huynh, Assistant General Manager
Anna E. Ortega, Assistant General Manager
Luz C. Santiago, Assistant General Manager

City of Los Angeles

Eric Garcetti, Mayor

LOS ANGELES HOUSING DEPARTMENT
1200 West 7th Street, 9th Floor
Los Angeles, CA 90017
Tel: 213.928.9071

housing.lacity.org

HOPWA ECCOVIA CLIENTTRACK SYSTEM CONSENT FORM

I, _____ (*print full name*), agree to register with the Housing Opportunity for Person With AIDS (HOPWA) Program/Eccovia ClientTrack System,which is used to coordinate services funded by the HOPWA Program. During registration I will be asked to provide information about myself including my name, race, gender, birthdate, income, and other demographic data. I will also be asked questions about my HIV status, CD4 cell count, viral load, general physical and mental health, and housing history.

I authorize the Los Angeles Housing Department (LAHD) and other HOPWA funded agencies to release/share information regarding services I have received or requested, my HIV status, or my physical/mental/financial conditions for program reporting, monitoring, statistical analysis, and research activities. A list of HOPWA funded agencies is available upon request. No identifying information will be released, published, or used without my consent, except as allowed by law. No information will be shared outside the network of HOPWA funded agencies of Los Angeles County.

My registration in the HOPWA Program/Bitfocus system does not guarantee services from any agency. Waiting lists or eligibility requirements may exclude me from services at other HOPWA Program. By Signing this form:

- I verify that I reside in Los Angeles County.
- I will provide a letter of diagnosis signed and dated by a physician or certified health care worker that shows that I am HIV positive.
- I will provide my current CD4 count and viral load at enrollment and every 12 months, at minimum.
- I will provide proof of income or complete a zero affidavit form.
- I understand that declining to sign this consent form, or revoking my consent, does not disqualify me from receiving any services for which I am eligible.

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/or in the Bitfocus system, and that this consent form remains in effect for three years from the date I signed this form. I am aware that I reserve the right to revoke consent at any time by submitting written notification to lahd.bitfocus.clarity@lacity.org.

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

For Local HOPWA Agency Use Only (Fill out "Administered by" before discussing the consent form with the client)

_____ _____
Administered by Agency Name

_____ _____
Signature Date

APLA Health

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

APLA Health

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

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)

_____ _____
Signature of Client Date (MM/DD/YY)

_____ _____
Agency Representative (Please Print) Title

_____ _____
Agency Representative Signature Date (MM/DD/YY)

APLA Health

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

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)

APLA Health

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:(____) _____