|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Initial intake  | Date completed:    /    /      | [ ]  Annual review | Date completed:    /    /      |
| Social Security number:     -    -      | Age:       | DOB:    /    /      |
| Personal information | County: |       |
| **Legal last name** | **Legal first name** | **Middle initial** | **Other names used** |
|       |       |       |       |
| **Pro-Noun** |
| [ ]  She/Her/Her [ ]  He/Him/His [ ]  They/Them/Their [ ]  Ze/Hir/Hirs [ ]  Other:       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Street address** *(if homeless, complete affidavit on page 5)* | **City** | **State** | **ZIP** | **O.K. to receive mail?**Enter in CAREWare |
|       |       |       |       | [ ]  No [ ]  Yes |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Mailing address, if different** | **City** | **State** | **ZIP** | **O.K. to receive mail?**Enter in CAREWare |
|       |       |       |       | [ ]  No [ ]  Yes |
|  |  |  |  |   |

|  |  |  |  |
| --- | --- | --- | --- |
| **Home phone number** | **O.K. to leave message?** | **Cell phone number** | **O.K. to leave message?**[ ]  No [ ]  Yes |
|     -     -       | [ ]  No [ ]  Yes |     -     -       | **O.K. to send text message?**[ ]  No [ ]  Yes |
| **Message phone number** | **O.K. to leave message?** | **Message phone name and relationship:** | **Current ROI on file?\*** |
|     -     -       | [ ]  No [ ]  Yes |       | [ ]  No [ ]  Yes |
| **Email address** | **O.K. to send email message?** | **If no contact through phone, mail or email, state plan for eligibility review:** |
|       | [ ]  No [ ]  Yes  |       |
| **Key contacts** |
| **Emergency contact** | **Relationship** | **Phone number** | **Aware of HIV status**[ ]  |
|       |       |     -     -       | **O.K. to leave message?**[ ]  No [ ]  Yes |
|

|  |
| --- |
| **Do you have a payee?** [ ]  No [ ]  Yes**If yes, payee name**:       |

 | **Relationship**      | **Phone number**    -     -       | **ROI obtained?**  [ ]  No [ ]  Yes |
| **Primary care physician** | **Phone number** | **Pharmacist**  | **Phone number** |
|      Clinic Name:       |     -     -       |      Clinic Name:       |     -     -       |
| **HIV specialist** | **Phone number** | **Dentist** | **Phone number** |
|      Clinic Name:       |     -     -       |      Clinic Name:       |     -     -       |
|  |
| **Sex assigned at birth:** | [ ]  Male [ ]  Female | **Gender identification:** | [ ]  Male [ ]  Female [ ]  Transgender (M → F)[ ]  Transgender (F → M) [ ]  Other:       |
| **Ethnicity** **and race** | [ ]  Hispanic or Latino**1** [ ]  Non-Hispanic or Latino [ ]  White or Caucasian [ ]  Black or African American [ ]  Native Hawaiian or Pacific Islander**3** [ ]  Asian**2**  [ ]  American Indian or Alaska Native [ ]  Other *(Specify)*:        |
| 1 If Hispanic or Latino:  [ ]  Mexican, Mexican American, Chicano/a [ ]  Puerto Rican [ ]  Cuban [ ]  Other Hispanic origin |
| 2 If Asian:  [ ]  Asian Indian [ ]  Chinese [ ]  Filipino [ ]  Japanese [ ]  Korean [ ]  Vietnamese [ ]  Other Asian origin |
| 3 If Native Hawaiian or Pacific Islander:  [ ]  Native Hawaiian [ ]  Guamanian or Chomoro [ ]  Samoan [ ]  Other Pacific Islander |
| **Primary language**:       (enter in CAREWare) |
| **Let us know if you need:**[ ]  An interpreter. Language I speak: [ ]  English [ ]  Spanish [ ]  Other (*specify*):      [ ]  A sign language interpreter[ ]  Written materials translated (*what language*): [ ]  English [ ]  Spanish [ ]  Other (*specify*):      [ ]  Materials in**:** [ ]  Audio tape [ ]  Large print [ ]  Braille [ ]  Computer disk [ ]  Oral presentation |

**Diagnosis and Identity** (*Intake only*)

| **Eligibility category** | **Documentation presented** *Copies of all documentation are to be filed with this form and retained by the provider agency.* |
| --- | --- |
| **INITIAL INTAKE ONLY** | **HIV + diagnosis***—*Required only at intake. Check one:HIV diagnosis date:    /    /      | [ ]  Current CAREAssist client (*prior to enrollment with this agency*)[ ]  Lab test *(Viral load, Western Blot, etc.) sent from lab or physician (lab cannot show viral  load as “not detected”)*[ ]  Documentation submitted from the healthcare provider who is providing medical care[ ]  Previously obtained, is in client file[ ]  Documentation of 2 Rapid HIV tests used for preliminary and confirmatory HIV verification meeting the following criteria: 1 – the rapid test kits are produced by different manufacturers;  and 2 – the rapid test used for confirmatory testing has an equivalent sensitivity. |
| **Verification of identity** *—*Required only at intake. Client must provide one of the following: | [ ]  Driver license[ ]  Tribal ID[ ]  State ID Card[ ]  Military ID[ ]  Student ID[ ]  Passport | [ ]  Social Security card[ ]  Citizenship/naturalization[ ]  Student Visa [ ]  Birth certificate[ ]  Learner’s permit or temporary license[ ]  List other official documents[[1]](#footnote-1):       |

### Medical insurance (*enter in CAREWare Annual Tab*)

| **[ ]  Health exchange** | **[ ]  Medicare** *(mark all that apply)* | **[ ]  Oregon Health Plan** (OHP) - *(Medicaid)* |
| --- | --- | --- |
| [ ]  Qualified Health Plan (QHP)**Metal level** *(check one)*:[ ]  Bronze[ ]  Silver[ ]  Gold[ ]  Platinum | [ ]  Part A[ ]  Part B | [ ]  OHP number: |       |
| [ ]  Coordinated Care Organization (CCO) |
| [ ]  Part D: | [ ]  Advantage Plan |       |
| [ ]  Low income subsidy[ ]  Qualified Medicare beneficiary | [ ]  OHP Open Card |
| [ ]  Dual Eligible Managed Care Organization (MCO): |
|       |
| [ ]  Citizen Alien Waived Emergent Medical (CAWEM) |

| **[ ]  Private** | **[ ]  Other public** | **[ ]  No insurance****[ ]  Referred to case manager to complete  CAREAssist application** |
| --- | --- | --- |
| [ ]  Purchased outside the exchange | [ ]  VA benefits number: | **Comments**:       |
| [ ]  Group policy *(through employer or*  *spouse/parent employer)* |       |
| [ ]  Indian Health Services |
| [ ]  COBRA *(end date)*: |    /    /      |
|       |

|  |
| --- |
| **For Health Exchange, Medicare, or Private insurance plans:** |
| Insurance carrier: |       |
| Plan name: |       |
| Policy ID number: |       | Policy group number: |       |
| Primary policy holder’s name: |       | Prescription ID number *(if different)*: |       |

|  |  |
| --- | --- |
| **Medical care:** | [ ]  None [ ]  Publicly-funded or Health Department [ ]  Private practice [ ]  Emergency room |
|  | [ ]  Hospital outpatient [ ]  Other (*specify*): |       |
| **CAREAssist:** | [ ]  No [ ]  Yes CAREAssist number:  |       |
|  | [ ]  If No, date referred to case manager/care  coordinator to complete CAREAssist application:  |       |
| **Dental insurance**: | [ ]  No [ ]  Yes Dental plan information: |       |
|  | [ ]  If No and is on CAREAssist, date referred to case manager/care  coordinator to complete CA supported dental insurance plan: |       |

**Household family members living with you**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Names** | **Relationship** | **Spouse, or Legal Dependent?** | **Age** | **Aware of HIV status** | **Release of Information (ROI) needed? *(if aware of status=yes)*** |
|       |       | [ ]  No [ ]  Yes |       |  [ ]  No [ ]  Yes | [ ]  No [ ]  Yes |
|       |       | [ ]  No [ ]  Yes |       |  [ ]  No [ ]  Yes | [ ]  No [ ]  Yes |
|       |       | [ ]  No [ ]  Yes |       | [ ]  No [ ]  Yes | [ ]  No [ ]  Yes |
|       |       | [ ]  No [ ]  Yes |       | [ ]  No [ ]  Yes | [ ]  No [ ]  Yes |
|       |       | [ ]  No [ ]  Yes |       | [ ]  No [ ]  Yes | [ ]  No [ ]  Yes |
| **Family size *(client + spouse + legal dependents[[2]](#footnote-2))*:***(enter in CAREWare)* | **Federal poverty level listed in CAREWare:**  |

### Verification of income

|  |
| --- |
| **[ ]  Current CAREAssist client**. If a copy of CAREAssist Eligibility Verification (CEV) form is attached, **do not** complete  verification of income or “No Income Affidavit” below (*update information from CEV in CAREWare*)**[ ]  Not a CAREAssist client**: complete the income table below. Required documentation must be in the client record. |

[[3]](#footnote-3)

| **Type of income*****(check all that apply per Support Services Guide)*** | **Person(s) receiving income** | **Monthly gross income** | **Annual gross income** *(multiply monthly income to get annual)* | **Required documentation*****(see Support Services Guide*** ***for more detail)*** |
| --- | --- | --- | --- | --- |
| **[ ]**  No source of income  |       |       | $0.00 | [ ]  Client no income: complete the “No Income  Affidavit” at bottom of form |
| **Other Household income**:[ ]  Spouse, or Partner living  with client with a shared  legal child;[ ]  Legal Dependent income  |       |       | $0.00 | [ ]  See below required documentation based on  type of income and list type:       |
| [ ]  Work income *(wages, tips,  commissions, bonuses)*: |       |       |  $0.00 | [ ]  2 months current, **consecutive** paystubs or earnings statements for **all** jobs |
| [ ]  Self-employment income: |       |       | $0.00 | [ ]  Most recent federal tax return, including  Schedule C *(if filed)* **AND**[ ]  Previous 6 months bank statements **OR**  if not available: [ ]  Business records for 6 months prior to  enrollment/recertification. |
| **Social Security:** [ ]  Retirement [ ]  SSDI[ ]  Survivor’s benefits [ ]  SSI |       |       |  $0.00 | [ ]  Annual benefit award letter |
| [ ]  Private/Employer Pension  or retirement income  *(not Social Security)*: |       |       |  $0.00 | [ ]  Annual benefits award letter/statement |
| [ ]  Unemployment benefits: |       |       | $0.00 | [ ]  Compensations stubs  |
| **Employer Disability benefits:**[ ]  Short Term (STD)[ ]  Long Term (LTD) |       |       | $0.00 | [ ]  Compensation stubs OR[ ]  Benefit award letter/statement |
| [ ]  Veterans benefits: |       |       |  $0.00 | [ ]  Annual benefit award letter |
| [ ]  Stocks, bonds, cash  dividends, trust, investment  income, royalties: |       |       | $0.00 | [ ]  Documentation from financial institution  showing income received, values, terms  and conditions. |
| [ ]  Alimony[ ]  Child support *(received on a periodic or predictable basis)*: |       |       |  $0.00 | [ ]  Benefit award letter/statement **OR** [ ]  Official document showing amount  received regularly. |
| [ ]  Rental income: |       |       |  $0.00 | [ ]  Most recent federal tax return, including  Schedule E *(if filed)* **AND**[ ]  Previous 3 months bank statements |
| [ ]  Other:       |       |       |  $0.00  | [ ]  Document:       |
| **Total:** |  | Monthly = $0.00 | Annual $0.00*(Enter in CW)* |  |

**Verification of Residency**

|  |
| --- |
| **[ ]  Current CAREAssist client**: if a copy of CAREAssist Eligibility Verification (CEV) form is attached, **do not** complete verification of residency below or “Homeless/Residency Affidavit” below (*update residential address from CEV in CAREWare*).**[ ]  Not a CAREAssist client**: client must provide one of the **unexpired documents** below**,** which mustinclude client’s full legal name and match residential address on this form *(update address in CAREWare)***:** |
| [ ]  Client is homeless– complete “Homeless/Residency affidavit” at bottom of form [ ]  Client does not have proof of residency and is not on CAREAssist – complete “Homeless/Residency affidavit” at bottom of form [ ]  Oregon State driver license, Tribal ID or Oregon State ID[ ]  Utility bill *(including cell phone)*[ ]  Lease, rental, mortgage or moorage agreement/document[ ]  Current property tax document[ ]  Current Oregon Voter Registration card[ ]  Letter from lease holding roommate[[4]](#footnote-4)[ ]  Copy of public assistance/benefits letter /documentation (SSI, SSDI, TANF, etc.)[ ]  Paystubs | [ ]  Court Corrections Proof of Identity[ ]  Homeowner's association statement[ ]  Military/Veteran's Affairs documents[ ]  Oregon vehicle title or registration card[ ]  Any document issued by a financial institution that includes residence address, such as, a bank statement, loan statement, student loan statement, dividend statement, credit card bill, mortgage document, closing paperwork, a statement for a retirement account, etc.;[ ]  Approved letter from Oregon State Hospital, homeless shelter, transitional service provider or halfway house[ ]  Letter on company letterhead from an employer certifying that the client lives at a non-business residence address owned by the business or corporation. |

### Additional comments

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| --- |
|       |

Staff member below is signifying all documentation has been obtained and filed in client chart and/or uploaded in CAREWare before the Intake and/or Eligibility Review is considered complete. CAREWare Annual data and service matches date below.

|  |  |  |
| --- | --- | --- |
|       |  |    /    /      |
| **Staff name and credentials** |  | **Date** |

|  |
| --- |
| **No income affidavit** **Completed by:** [ ]  Client [ ]  Legal guardian  |
| [ ]  I declare that I and my family have no income. I *(we)* get food, housing, and clothing in the following ways:       |
| I understand that I must tell my HIV case manager about any changes as part of the eligibility review. If I provide false, misleading, or incomplete information, my eligibility for Ryan White*–*funded services may be denied. |
|  |
|  |  |    /    /      |
| Client or legal guardian - signature |  | Today’s date *(day/month/year)* |

|  |
| --- |
| **Homeless or Residency affidavit** **Completed by:** [ ]  Client [ ]  Legal guardian |
| [ ]  I am currently homeless [ ]  Do not have a fixed address [ ]  Do not have proof of address  |
| I am living in the city of       |  |
| I most often stay at the following locations:      |  |
| I am a resident of Oregon and all statements regarding my housing status are true. I understand that false or misleading information may result in my benefits ending with the Oregon Health Authority (OHA), HIV Care and Treatment Programs, including CAREAssist. |
|  |
|  |  |    /    /      |
| Client or legal guardian - signature |  | Today’s date *(day/month/year)* |

1. [↑](#footnote-ref-1)
2. 1 See “Client Eligibility” in the Support Services Guide for list of documents [↑](#footnote-ref-2)
3. 2 Unmarried partner living with client who share a biological/adopted child in household are counted in family size and income [↑](#footnote-ref-3)
4. ###  Must include the lease holder's name, address that matches the client's application, relationship to the client and lease  holder's telephone number.

 [↑](#footnote-ref-4)