|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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

|  |
| --- |
|  |

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)