Intake / Annual Eligibility Review

Confidential - this form must be saved on a secure network accessible only by Ryan White funded staff

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Community Services at community.services@odhsoha.oregon.gov or 503-975-4642 (voice/text). We accept all relay calls.

☐ Initial Intake Date completed: _____

☐ Annual Review Date completed: _____

Social Security number: _____ Age: ____ Birth Date: _____

Personal information

Legal last name: _____ M.I.: _____

Legal first name: _____

Other names used: _____

Pronoun:

☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Their ☐ Ze/Hir/Hirs

☐ Other: _____

Street address (if homeless, complete Homeless or Residency Affidavit):

_____

City: _____ State: _____ Zip: _____

Ok to receive mail? Enter in CAREWare ☐ Yes ☐ No

Mailing address (if different):

_____

City: _____ State: _____ Zip: _____

Ok to receive mail? Enter in CAREWare ☐ Yes ☐ No

Home phone number: _____

Ok to leave message? ☐ Yes ☐ No

Cell phone number: _____

Ok to leave message? ☐ Yes ☐ No

Ok to send text message? ☐ Yes ☐ No

Message phone number: _____

Ok to leave message? ☐ Yes ☐ No

Message phone name and relationship: _____

Current ROI on file?[1] ☐ Yes ☐ No

Email: _____

Ok to send email message? ☐ Yes ☐ No

If no contact through phone, mail, state plan for eligibility review:

_____

Key contacts

Emergency contact: _____

Relationship: _____ Phone number: _____

Aware of HIV status? ☐ Yes ☐ No

Ok to leave message? ☐ Yes ☐ No

1 On ROI specify what type of information can be shared

Do you have a payee? ☐ Yes ☐ No

If yes, payee name: _____

Relationship: _____ Phone number: _____

ROI obtained? ☐ Yes ☐ No

Primary care physician: _____

Clinic name: _____

Phone number: _____

Pharmacist: _____ Phone number: _____

HIV specialist: _____

Clinic name: _____

Phone number: _____

Dentist: _____ Phone number: _____

Clinic name: _____

Sex assigned at birth? ☐ Male ☐ Female

Gender identification:

☐ Male ☐ Female ☐ Transgender (Male to Female)

☐ Transgender (Female to Male) ☐ Other: _____

Ethnicity and race:

☐ Hispanic or Latino ☐ Non-Hispanic or Latino

☐ White or Caucasian ☐ Black or African American ☐ Asian

☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native

☐ Other (specify): _____

If Hispanic or Latino:

☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Cuban

☐ Other Hispanic origin

If Asian:

☐ Asian-Indian ☐ Chinese ☐ Filipino ☐ Japanese

☐ Korean ☐ Vietnamese ☐ Other Asian origin

If Native Hawaiian or Pacific Islander:

☐ Native Hawaian ☐ 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)

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

HIV diagnosis date: _____

Documentation presented. Check one:

- ☐ 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 manfacturers;
  2. The rapid test used for confirmatory testing has an equivalent sensitivity

Verification of identify

Required only at intake. Client must provide one of the following:

☐ Driver license ☐ Tribal ID ☐ State ID Card
☐ Social Security card ☐ Citizenship/naturalization ☐ Student ID
☐ Military ID ☐ Passport ☐ Birth certificate ☐ Learner's permit
☐ Student Visa ☐ Temporary license

☐ List other official documents[2]: _____

2 See "Support Service Guide" for additional allowable documents.

Medical insurance (enter in CAREWare Annual Tab)

☐ Health Exchange ☐ Qualified Health Plan (QHP)

Metal level (check one)

☐ Bronze ☐ Silver ☐ Gold ☐ Platinum

☐ Medicare (mark all that apply):

- ☐ Part A
- ☐ Part B
- ☐ Part D:
  - ☐ Advantage Plan
  - ☐ Low income subsidy
  - ☐ Qualified Medicare beneficiary

☐ Oregon Health Plan (OHP) - (Medicaid)

- ☐ OHP number: _____
- ☐ Coordinated Care Organization (CCO): _____
- ☐ OHP Open Card
- ☐ Dual Eligible Managed Care Organization (MCO): _____
- ☐ Citizen Alien Waived Emergent Medical (CAWEM)

☐ Private

- ☐ Purchased outside the exchange
- ☐ Group policy (through employer or spouse/parent employer)
- ☐ COBRA (end date): _____

☐ Other public

- ☐ VA benefits number: _____
- ☐ Indian Health Services

☐ No insurance

☐ Referred to case manager to complete CAREAssist application

Comments:

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 ☐ Public-funded or Health Department ☐ Private practice

☐ Emergency room ☐ Hospital outpatient

☐ Other: _____

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

1. Name: _____
   Relationship: _____
   Spouse, or Legal Dependent? ☐ Yes ☐ No Age: _____
   Aware of HIV status? ◯ Yes ◯ No
   Release of Information (ROI) needed? (if aware of status = yes): ☐ Yes ☐ No
2. Name: _____
   Relationship: _____
   Spouse, or Legal Dependent? ☐ Yes ☐ No Age: _____
   Aware of HIV status? ◯ Yes ◯ No
   Release of Information (ROI) needed? (if aware of status = yes): ☐ Yes ☐ No
3. Name: _____
   Relationship: _____
   Spouse, or Legal Dependent? ☐ Yes ☐ No Age: _____
   Aware of HIV status? ◯ Yes ◯ No
   Release of Information (ROI) needed? (if aware of status = yes): ☐ Yes ☐ No
4. Name: _____
   Relationship: _____
   Spouse, or Legal Dependent? ☐ Yes ☐ No Age: _____
   Aware of HIV status? ◯ Yes ◯ No
   Release of Information (ROI) needed? (if aware of status = yes): ☐ Yes ☐ No
5. Name: _____
   Relationship: _____
   Spouse, or Legal Dependent? ☐ Yes ☐ No Age: _____
   Aware of HIV status? ◯ Yes ◯ No
   Release of Information (ROI) needed? (if aware of status = yes): ☐ Yes ☐ No

Family size (client + spouse + legal dependents[3]) Enter in CAREWare: _____

Federal poverty level listed in CAREWare: _____

3 Unmarried partner living with client who share a biological/adopted child in household are counted in family size and income

Verification of income

☐ **Current CAREAssist client**. If copy of CAREAssist Eligibility Verification (CEV) form is attached, **do not** complete verification of income or "Income Affidavit" below (update information from CEV in CAREWare)

☐ **Not a CAREAssist client**: Complete the income section below. Required documentation must be in the client record

Income Section

Type of income (check all that apply per Support Service Guide)	Person(s) receiving income	Monthly gross income	Annual gross income	Required documentation (see Support Services Guide for more detail)
☐ No source of income				☐ Client no income: complete the "Income Affidavit"
Other Household Income: ☐ Spouse, or Partner living with client with a shared legal child; ☐ Legal Dependent income				☐ See below required documentation based on type of income and list type:
☐ Work income (wages, tips, commissions, bonuses)				☐ 2 Months current, **consecutive** paystubs or earnings statements for **all** jobs

Type of income (check all that apply per Support Service Guide)	Person(s) receiving income	Monthly gross income	Annual gross income	Required documentation (see Support Services Guide for more detail)
☐ Self-employment income				☐ Most recent federal tax return, including Schedule C (if filed) **AND** ☐ Previous 6 months banks statements **OR** if not available: ☐ Business records for 6 months prior to enrollment/ recertification.
Social Security: ☐ Retirement ☐ SSDI ☐ Survivers benefits ☐ SSI				☐ Annual benefit award letter
☐ Private/Employer Pension or retirement income (not Social Security)				☐ Annual benefit award letter/ statement
☐ Unemployment benefits				☐ Compensations stubs
Employer Disability benefits: ☐ Short Term (STD) ☐ Long Term (LTD)				☐ Compensation stubs **OR** ☐ Benefit award letter/statement

Type of income (check all that apply per Support Service Guide)	Person(s) receiving income	Monthly gross income	Annual gross income	Required documentation (see Support Services Guide for more detail)
☐ Veterans benefits	_____	_____	_____	☐ Annual benefit award letter
☐ Stocks, bonds, cash dividends, trust, investment income, royalties	_____	_____	_____	☐ Documentation from financial institution showing income received, values, terms and conditions
☐ Alimony ☐ Child support (received on a periodic or predictable basis)	_____	_____	_____	☐ Benefit award letter/statement **OR** ☐ Official document showing amount received regularly
☐ Rental income	_____	_____	_____	☐ Most recent federal tax return, including Schedule E (if filled) **AND** ☐ Previous 3 months bank statements
☐ Other: _____	_____	_____	_____	☐ Document: _____
Total:		Monthly: _____	Enter in CW Annual: _____	

Verification of Residency

- ☐ **Current CAREAssist client**. If copy of CAREAssist Eligibility Verification (CEV) form is attached, **do not** complete varification of residency or "Homeless/ Residency Affidavit" (update residential address from CEV in CAREWare)
- ☐ **Not a CAREAssist client**: **Client must provide** one of the **unexpired documents** below, which must include client's full legal name and match residential address on this form (update address in CAREWare)
- ☐ Client is homeless- Complete Residency Affidavit
- ☐ Client does not have proof of residency and is not on CAREAssist- Complete Residency Affidavit
- ☐ Oregon State driver license, Tribal ID or Oregon State ID
- ☐ Utility bill (including cell phone)
- ☐ Lease, rental mortage or mortage agreement/document
- ☐ Current property tax document
- ☐ Current Oregon Voter Registration card
- ☐ Letter from lease holding roommate[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 Affair documents
- ☐ Oregon vehicle title or registration card
- ☐ Approved letter from Oregon State Hospital, homeless shelter, transitional service provider or halfway house

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.

☐ 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, mortage document, closing paperwork, a statement for a retirement account, etc

☐ 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

Signatures

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