INTAKE/ELIGIBILITY REVIEW

Welcome to RMC. Thank you for filling out these forms. RMC has 3rd party and grant funders who require that we ask these questions of all our program participants. In addition, knowing this information about you helps us to ensure that you get the best possible care, and that we make you aware of all our programs and services you are eligible for. Rest assured that all of this information is stored securely in our electronic databases and is protected according to all privacy laws, including HIPAA. We appreciate you taking the time to help us get to know you and your individual needs. If you have questions please let staff know.

Personal Information

Date completed: _____

Preferred Full Name
Full Legal Name
Gender Pronoun(s)
☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Their ☐ Ze/Hir/Hirs ☐ Other pronouns

Social Security Number	**Date of Birth**
- - (*N/A if you don't have one*)	/ /

Housing type (*please check all that apply*):	☐ Rent/Own ☐ Temporary (living with friends or family) ☐ Unstable			
Street Address	**City**	**State**	**Zip**	**County**
Mailing address, if different	**City**	**State**	**Zip**	
Home Phone Number	**Cell Number**		**Email Address**	
- -	- -		@	
Sex Assigned at Birth	☐ Male ☐ Female			

Gender Identity (*please check all that apply*):
☐ Male ☐ Female ☐ Intersex ☐ Gender expansive ☐ Transgender Male/Trans Man/FTM ☐ Transgender Female/Trans Woman/MTF ☐ Another category: _____

Ethnicity/Race (*please check all that apply*):	
☐ White/Caucasian ☐ Black, Afro-Caribbean, or African American ☐ Middle Eastern or Arab American ☐ Native American or Alaskan Native ☐ Latinx or Hispanic American (*please specify*): ☐ Mexican, Mexican-American, Chicano(a) ☐ Puerto Rican ☐ Cuban ☐ Another Hispanic origin	☐ Asian (*please specify*): ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Another Asian origin ☐ Native Hawaiian or Other Pacific Islander (*please specify*): ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Another Pacific Islander origin ☐ Another category:_____

Primary Language	
Preferred spoken language	Interpreter Needed? ☐ Yes ☐ No
Preferred written language	

Sexual Orientation	
☐ Heterosexual ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Asexual ☐ Pansexual ☐ Prefer not to say ☐ Another: _____	
Are you a veteran:	☐ Yes ☐ No
When you have to learn something new, how do you prefer to learn the information?	
☐ Listening to an explanation ☐ Talking with People ☐ Trying to figure it out for yourself ☐ Watching TV ☐ Reading	

Key Contacts

Emergency Contact	Relationship	Phone Number	Aware you are being seen at RMC?
			□ Yes □ No
Primary Care Physician		**Phone Number**	
Pharmacy		**Phone Number**	
HIV/Prevention Specialist		**Phone Number**	
Dentist(s)		**Phone number**	

Annual Income & Household

What is your annual income?	**$**
How many people in your household depend on your income?	

Health Insurance Information

Primary Insurance Type (*please select one of the checkboxes below*):

□ Medicaid □ Medicare Part A/B □ Employer-based □ COBRA □ Marketplace Plan □ Veterans Affairs
□ Indian Health Services (IHS) □ No Insurance/Self Pay □ ADAP □ PHIP/UMR □ Other (write below)

Primary Insurance Name:	

Secondary Insurance Type (*please select one of the checkboxes below if you have secondary insurance*):

□ Medicaid □ Medicare Part A/B □ Employer-based □ COBRA □ Marketplace Plan □ Veterans Affairs
□ Indian Health Services (IHS) □ No Insurance/Self Pay □ ADAP □ PHIP/UMR □ Other (write below)

Secondary Insurance Name:	
Pharmacy Insurance, if different than above:	

Employment (*please check all that apply*):

☐ Retired ☐ Living with a disability ☐ Full-time ☐ Part-time ☐ Temporary/seasonal ☐ Volunteer/Intern

☐ Unemployed ☐ Other: _____

If you are living with HIV please complete Section 2 below. If you are not living with HIV, please skip Section 2 and move on to page 5.

Section 2:

Risk Factors

How do you think you got HIV?	
☐ Man who have sex with men	☐ Received a blood transfusion
☐ Health-care or occupational exposure	☐ Heterosexual
☐ Hemophilia/coagulation disorder	☐ Prefer not to say
☐ Injecting Drugs	☐ Other:
☐ Contracted HIV as an infant	_____

When were you first diagnosed with HIV?	(Month) _____ (Year)_____ (*estimate if necessary*)
Have you ever been told by your doctor or a laboratory that you have AIDS? ☐ Yes ☐ No ☐ Not sure *If yes, please estimate month and year you were diagnosed:* (Month) _____ (Year)_____	

Income Sources

Sources	**Household Member's Name**	**Amount**	**Month/Year**	
AND		$	/	Per
Food Stamps/SNAP		$	/	Per
Employment PT/FT		$	/	Per
S.S.I./S.S.D.I		$	/	Per
Disability		$	/	Per
Unemployment		$	/	Per
VA Benefits		$	/	Per
Foster Care		$	/	Per
Disabled Family Member		$	/	Per
Educational Assistance		$	/	Per
Child Support		$	/	Per
Military		$	/	Per
Pension		$	/	Per
Business Income		$	/	Per
Other Income		$	/	Per
Zero Income	*If you do not have any income, please fill out the "No Income Affidavit" on page 4*			
	Total Gross Income	$	Per/	

If you <u>do not have income,</u> please complete the affidavit below:

No Income Affidavit
I declare that I and my family have no income. I (we) get food, housing and clothing the following ways:
I understand that I must tell Rocky Mountain CARES about any changes as part of my six month eligibility review. If I lie or do not give complete information, my eligibility for Ryan White-funded services may be denied. _____ _____ Client (or legal guardian) signature Today's date

If you <u>do not have stable housing,</u> please complete the affidavit below:

Unstable Housing Affidavit
I currently have unstable housing, do not have a fixed address and/or do not have proof of address. I am living in the city of _____. I most often stay at the following locations: _____ I am supported by:
I am a resident within Colorado. All statements regarding my housing status are true. I understand that if I lie or do not give complete information, my eligibility for Ryan White-funded services may be denied. _____ _____ Client (or legal guardian) signature Today's date

Assignment of Benefits Form

AIDS Resource Center of Wisconsin
d/b/a Rocky Mountain CARES

Patient/Client's Full Name: _____

I hereby authorize payment directly to the AIDS Resource Center of Wisconsin/Rocky Mountain CARES of the benefits otherwise payable to me.

_____ _____
Signature (Insured Person) Date

My signature is valid for one year from the above date, unless revoked by me at an earlier date.

The AIDS Resource Center of Wisconsin/Rocky Mountain CARES, as well as its mental health staff, are authorized to provide any insurance company(ies), claim administrator(s), and consulting health-care professionals the information concerning diagnosis and dates of service. This information will be used for the purpose of evaluating and administering claims for benefits.

This authorization is valid for the term of coverage of the policy or contract.

I know I have a right to receive a copy of this authorization upon request and agree that a photographic copy of the authorization is as valid as the original.

_____ _____
Signature (Insured Person) Date

Communication Preference Request & Confidentiality (Form PR-3A)

Patient/Client's Full Name: _____ **Today's Date:** _____

Date of Birth: _____ **Last 4 Social Security#:** _____

AIDS Resource Center of Wisconsin/Rocky Mountain CARES is committed to protecting the privacy of your protected health information (PHI). Communications containing your PHI might remind you of an upcoming appointment or they might include more detailed confidential information. Please use this form to let us know how and where you would like to receive communications from us.

On this form mark a box for:

1. Each method you request we use for communication of your protected health information
2. Any method you do not want us to use for communication of your protected health information

You may also request in writing another reasonable method of communication that is not listed.

U.S. Mail

- ☐ Yes, send mail to this address_____.
- ☐ NO, DO NOT send paper mail

By selecting "Yes" above I understand there may be risks including, but not limited to, others receiving and opening my mail or delivery to the wrong address.

Telephone

Home# _(_____)_____

- ☐ Yes, call and leave a message
- ☐ Yes, call but DO NOT leave a message
- ☐ NO, DO NOT CALL

By selecting "Yes" above I understand there may be risks including, but not limited to, the call being answered by someone other than me or messages being accessed by someone other than me.

Cell#__(_____)_____

- ☐ Yes, call and leave a message
- ☐ Yes, call but DO NOT leave a message
- ☐ NO, DO NOT CALL

Text

- ☐ Yes, Communicate with me by unencrypted TEXT MESSAGE to the Cell# listed above
- ☐ NO, DO NOT COMMUNICATE WITH ME BY TEXT MESSAGE

By selecting "Yes" above I understand there may be risks including, but not limited to, the call or phone message being received by someone other than me or unencrypted text messages being accessed by a third party.

Email:_____

- ☐ Yes, communicate by unencrypted email to the address I list above
- ☐ NO, DO NOT communicate by email

By selecting "Yes" above I agree to receive email from an arcw.org or rockymountaincares.org address. I also understand there may be risks utilizing unencrypted email including, but not limited to, access to the email by a third party.

Signature:_____. I select the method(s) of communication of personal health information chosen above and understand any and all risks.

Consent for Services

AIDS Resource Center of Wisconsin
d/b/a Rocky Mountain CARES

Patient/Client's Full Name: _____ **Today's Date:** _____

I, _____, do hereby voluntarily consent to services which may include, but not necessarily be limited to a, physical assessment, blood tests and urine analysis, mental health screening, screening and treatment of sexually transmitted diseases, and information and referral by the ARCW/RMC Medical Center, its agents, and employees. I hereby give consent for diagnosis and/or care and treatment.

I understand that my ARCW/RMC Medical Center records and all records of whatever nature or kind in the ARCW/RMC Medical Center will be treated as Protected Health Information as defined by the Health Insurance Portability and Accountability Act (HIPAA). And such records shall be confidential as defined by the Health Insurance Portability and Accountability Act (HIPAA) and the ARCW/RMC Release of Information policy and procedure. Further, I understand that ARCW/RMC Medical Center staff are required to report certain communicable diseases to the Colorado Department of Health and Environment (CDPHE).

Patient/Client Signature	Date
Parent/Guardian Signature (*when appropriate*)	Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

AIDS Resource Center of Wisconsin
d/b/a Rocky Mountain CARES

(Office staff only)
Patient's Full Name: _____ Date: _____

By signing this form, you acknowledge that ARCW/RMC has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations.

Check all that are true:

- ☐ **I have received ARCW/RMC's Privacy Notice**
- ☐ **ARCW/RMC has given me the chance to discuss my concerns and questions about the privacy of my health information.**

_____
Patient/Client Signature

ARCW/RMC staff should complete if Acknowledgement Form is not signed:

1. Does patient have a copy of the Notice? □ Yes □ No

2. Please explain why the patient was unable to sign an acknowledgement form and ARCW/RMC's efforts in trying to obtain the patient's signature:

_____

_____

_____

Rights and Responsibilities

AIDS Resource Center of Wisconsin
d/b/a Rocky Mountain CARES

(To be translated or read aloud to client/patient if they are unable to read or understand this document)

Service Rights: Each patient/client receiving services from AIDS Resource Center of Wisconsin (ARCW)/Rocky Mountain CARES (RMC) has the following rights:

- To be fully informed, as evidenced by the patient's/client's written acknowledgment at the time of enrollment and during the course of services, of these rights and responsibilities;
- To be fully informed, at the time of admission and during the course of service, of the services available at this agency;
- To voice opinions, concerns, or complaints, and recommend changes in policies and services, through appropriate staff;
- To file a grievance which will be responded to according to ARCW/RMC Grievance Procedures.

Service and Treatment: Each patient/client enrolled in or receiving relevant ARCW/RMC services has the following rights:

- To be fully informed of available psychosocial and medical interventions; given the opportunity to participate in the planning of interventions; and may refuse interventions recommended by staff;
- To choose a licensed, certified, or registered health care provider as feasible;
- To receive adequate and appropriate professional service within the capacity of the agency and be informed of any limitations of ARCW/RMC services;
- To participate in the development and periodic revision of treatment and service plans.
- To confidential protection of records and to refuse their release to any individual or entity outside the agency, except as required or allowed by law;
- To choose preferred and reasonable methods of communication with ARCW/RMC staff, when reasonable;
- To be free from discrimination based on age, arrest/conviction record, national origin, ethnicity, race, sex, color, gender identity, ancestry, disability, marital status, pregnancy, religion, sexual orientation, or other protected category;
- To be informed of the identity and role of staff responsible for service or care, and the identity and role and status of others involved in interventions;
- To obtain reasonable access to their own health information and request amendment to it, as permitted under applicable law;
- To designate a person(s) who will participate in discussions with providers for medical care, dental care, housing assistance, legal assistance, testing, and case management. Participation in care decisions by persons other than a patient receiving mental health care will be determined by the mental health care provider, as appropriate;
- Upon request, to be informed both orally in writing, in advance of the care being provided, of the charges, including payment for care/service expected from third parties, when possible, and any estimated charges for which the client/patient may be responsible;

- To receive services in a safe, secure, confidential, respectful and accessible environment.
- To receive meaningful access to services and treatment, regardless of limited English proficiency, including oral interpretation and translated vital documents in a language or format understandable to the client/patient
- To receive accessible and reasonable services and treatment regardless of disability.
- To dis-enroll or opt out of any service or program, including the HIV Medical Home.

Patient/Client Responsibilities: Each patient/client receiving services has the following responsibilities:

- To follow the service plan recommended by staff and agreed to by the patient/client. This may include following instructions of affiliated health professionals;
- To inform the service provider immediately if instructions are not understood, or if they cannot be completed;
- To ask about possible results or outcomes, should interventions or instructions not be followed;
- To supply accurate and complete information about conditions, concerns, complaints, and difficulties relating to needs;
- To provide ARCW/RMC staff with information and documentation to assist with program eligibility, such as proof of income, residency and insurance.
- To notify the program staff of any change in status (including address, phone, finances, benefits, health, service needs);
- To notify the program staff of any desire to dis-enroll or opt out from any service or program.
- To follow agency rules and regulations, and to be considerate of the rights, privacy, and property of other patients/clients and of agency staff and volunteers.

I have read and/or have had explained to me these Rights and Responsibilities.
With my signature I am stating that I understand and agree to these service provisions. A signed photocopy of this shall be considered as valid as the original.

Patient/Client Signature	Date
ARCW/RMC Staff Signature	Date
Parent/Guardian Signature (*when appropriate*)	Date

Patient/Client Grievance Policy and Procedure

AIDS Resource Center of Wisconsin
d/b/a Rocky Mountain CARES

PURPOSE

The purpose of the AIDS Resource Center of Wisconsin (ARCW)/Rocky Mountain CARES (RMC) Patient/Client Grievance Procedure is to work to resolve grievances related to ARCW/RMC service delivery. ARCW/RMC will respond to a grievance in a timely and effective manner to assure that conflicts are resolved and consumer service needs are met.

POLICY

Consumers have the right to file a grievance related to ARCW/RMC's health, prevention, and social services. The grievance procedure will assist those who have complaints related to accessing or receiving any ARCW/RMC services.

In filing a grievance, patients/clients are assured that:

☒ there will be no repercussions from ARCW/RMC staff, volunteers, or other service users;
☒ services will continue to be provided to them without interruption or discrimination;
☒ the grievance procedure is confidential;
☒ there is no cost to consumers to file a grievance.

ARCW/RMC will assist the patient/client through the steps of the grievance procedure. A person filing a grievance may be represented by a parent or a legal guardian.

Grievances should be filed within 90 days of the incident or from the time the patient/client learned of the incident. The time limit can be extended for good cause including incarceration, poor health, hospitalization, or other items.

All grievances and steps to resolve them will be documented in the ARCW/RMC Grievance Log maintained by ARCW/RMC's Executive Vice President and Chief Operating Officer. Any ARCW/RMC staff member receiving a completed, signed grievance - either one filled out by the patient/client or an oral grievance written down by a staff person and then signed by the complainant - will forward this information to the Vice President of Operations within 24 hours.

The ARCW/RMC grievance procedure is intended to address issues of merit in a confidential manner. ARCW/RMC reserves the right to reject frivolous or unmeritorious grievances and to reject grievances that are not held in confidence by the consumer, parent, or legal guardian. The decision to reject grievances due to lack of merit or frivolity will be made by the Program Manager or Director. All rejected grievances will be filed, with an explanation for the rejection, in ARCW/RMC's Grievance Log.

PROCEDURE

Patients/Clients can file their complaint with ARCW/RMC staff in writing or verbally. If a grievance is filed verbally, ARCW/RMC staff will put the basis and major points of the complaint in writing and the complainant will then sign the grievance prior to ARCW/RMC proceeding with it.

Step 1: The patient/client will complete the ARCW/RMC Grievance Report Form and present it for discussion to the primary service delivery staff person. Through discussion, resolution of issues will be pursued. If the grievance cannot be resolved through discussion, or if the grievance directly involves the service delivery staff person, proceed to step 2.

Step 2: The patient/client will complete and present the ARCW/RMC Grievance Report Form to the appropriate supervisory staff. The appropriate supervisor will contact the complainant within 5 working days of receipt of the grievance to investigate and discuss the issue of the grievance and attempt resolution. The appropriate supervisor will then respond in writing to the complainant, within 5 working days of the discussion with the complainant, with a strategy to resolve the grievance.

Step 3: The patient/client will complete and present the ARCW/RMC Grievance Report Form to the appropriate Program Manager or Director. The Program Manager/Director will contact the complainant within 5 working days of receipt of the grievance to investigate and discuss the issue of the grievance and attempt resolution. The Program Manager/Director will then respond in writing to the complainant, within 5 working days of the discussion with the complainant, with a strategy to resolve the grievance.

Step 4: If the patient/client is dissatisfied with the response from the Program Manager/Director, or if the complaint specifically involves the Program Manager/Director, the complainant will direct the ARCW Grievance Report Form to the Vice President or Operations. The Vice President of Operations will investigate and address the issue and contact the complainant within 10 working days of receiving the grievance. If a mutual satisfactory resolution is not achieved within this grievance process, ARCW/RMC will consult with the State AIDS/HIV Program for final disposition of the grievance.

I have read and/or have had explained to me the Grievance Procedure.
With my signature I am stating that I understand and agree to these service provisions. A signed photocopy of this shall be considered as valid as the original.

Patient/Client Signature	Date
ARCW/RMC Staff Signature	Date
Parent/Guardian Signature (*when appropriate*)	Date

GRIEVANCE REPORT FORM

AIDS Resource Center of Wisconsin
d/b/a Rocky Mountain CARES
(Patient/Client copy)

Person filing grievance: _____ Date: _____

Staff receiving grievance: _____ Date: _____

Description of grievance: _____

Program(s) involved: _____

Staff/Volunteer(s) involved: _____

Complainant's Signature: _____

Actions taken for resolution: _____

Follow-up needed: _____

Resolution obtained: □ Yes □ No Comments: _____

Grievance appealed to: _____

Note: Use back of this page if more space is needed. Director should attach this form to any applicable written reports and file them permanently in a confidential place

Staff Contacts for Patient/Client Grievances

AIDS Resource Center of Wisconsin
d/b/a Rocky Mountain CARES
(Patient/Client copy)

Step 1 Contacts

Direct service delivery staff (*the staff you directly work with*)

Step 2 Contacts – Denver

Health Services (Medical, Dental, Mental Health)
Caroline Eisenberg, Health Services Administrator 303-802-5271

Social Services (Case Management, Insurance Counseling, Food Pantry)
JC Goodhart, Manager of Client Services 303-802-5259

Prevention Services
JC Goodhart, Manager of Client Services 303-802-5259

Step 3 Contacts - Denver

Health Services
Dr. Ken Greenberg, Medical Director 303-802-8050

Social Services (Case Management, Insurance Counseling, Food Pantry)
Karin Sabey, Vice President of Operations 303-802-5299

Prevention Services
Karin Sabey, Vice President of Operations 303-802-5299

Step 4 Contact
All Services Karin Sabey, Vice President of Operations 303-802-5299