Being Alive!

For Office Use: Input
- o Database
- o Email
- o Program
- o Therapy
- o WeHo

MEMBER INTAKE FORM

Date: _____ How Did You Hear About Us? _____ What is your immediate concern?_____

Name: Last: _____ First: _____ M.I: _____ Birth Date: _____/_____/_____

Primary Phone: (____) _____ Does this number receive text messages? Y N May we text you? Y N

Address: _____ Apt:_____ City: _____ State: _____ Zip: _____

May we send you mail at this address? YES NO May we identify ourselves on a voice message? YES NO

Email:_____ May we email you? YES NO

For appointment reminders, what is your preferred method of contact (circle one): PHONE EMAIL TEXT

Do you work, rent, go to school, own property, or are homeless in West Hollywood? YES NO

If YES, Employer Name and Address: _____

Please provide verification of West Hollywood affiliation.

Gender Identity: Male Female Transgender (please specify FTM MTF) Gender at birth: Male Female

Are your sexual partners primarily (mark all that apply): Men Women Transgender Non-Binary Other_____

Race/Ethnicity: _____ Primary Language: _____ Family/ Household Size: _____

Annual Income: _____ Occupation/ Source of Income: _____ Dependent Children: _____

HIV Status: HIV Negative HIV +/no symptoms HIV +/ with symptoms AIDS /no symptoms AIDS / with symptoms

Date of your first HIV Diagnosis: ____/____/____ Viral load _____ as of_____ CD4 _____ as of _____

How did you contract HIV: Sexual Contact_____ IV Drug Use_____ Other _____

If HIV Negative, what was the date of last HIV Test (if HIV-) _____ If HIV-, are you currently on PrEP? YES NO

Are you in a sero-discordant relationship (HIV+ and HIV-)? YES NO

Rate yourself at managing your own healthcare: Excellent Good Fair Poor

What (if anything) is keeping you from managing your healthcare? _____

Where do you access medical care? _____ What is your provider's name? _____

Which is your pharmacy?_____ What are your HIV Meds? _____

What type of medical insurance do you have? _____

If on HIV Meds, do you take them as prescribed? Always Sometimes Rarely Never N/A

If HIV- and on PrEP, do you take it as prescribed? Always Sometimes Rarely Never N/A

Do you need more knowledge or understanding about HIV/AIDS? YES NO

Do you need help in setting up a better adherence plan? YES NO Do you need Peer Support? YES NO

Substance Use History: Yes, within past year Yes, not within past year No History Decline to state

Are you currently in treatment for substance use? YES NO If yes, where? _____

Are you currently in treatment for mental health issues? YES NO If yes, where? _____

Do you have any current risk behaviors? Unprotected Sex Crystal Meth Use IV Drug use None

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Please check the outside services listed below that you may need referrals to:

_____ Housing _____ Transportation _____ Legal _____ Food Banks _____ Medical/ Dental Resources

_____ Case Mgmt. (Benefits) _____ Mental Health Counseling _____ Drug/ Alcohol Mgmt. _____ Other

Emergency Contact

Name, Last: _____ First: _____ Phone: (_____) _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Is this person aware of your HIV Status? YES NO

By signing below, I authorize Being Alive to release/share information with other like agencies regarding services I've received, my HIV status, finances, and physical/mental conditions for purposes of assistance in gaining services related to my needs. This information may be shared through mail, by telephone/fax, or electronic computer mail. I understand that I may revoke this consent at any time, by contacting Being Alive in person, by phone or in writing. (A list of these other agencies will be provided to me upon request, and I may add other specific agencies to this consent. I have been given the HIV/AIDS Patient's Bill of Rights/Responsibilities and been made aware of the Grievance Procedures.)

X_____ _____

Member Signature Date

X_____ _____

Staff Signature Date

Office Use:
Necessary paperwork for eligibility: Proof of residency: ____ Proof of Diagnosis: ____ Proof of WeHo Qualification _____

Please mark the services in which you are interested:

_____ **Wellness Center**
Being Alive offers a variety of alternative & holistic practices that will complement the drug therapies that most people take to reach and maintain an undetectable viral load. The program includes therapies such as Chiropractic, Acupuncture, Reiki, Massage and more.

_____ **Dignity Plus (Psychotherapy)**
This ground breaking Mental Health program will pair you with a Master's level Psychotherapy Trainee or Associate. They offer individual, group, couples, family, and short term crisis counseling implementing a variety of therapeutic modalities. There is no predetermined limit on the number of sessions offered.

_____ **Activities & Events**
Being Alive offers social events and other activities designed to bring people out of isolation and find support and friendships with others living with HIV & AIDS. In addition to weekly activities such as ceramics, acting and writing workshops, field trips to area attractions are offered several times a year. Past field trips have included The Getty, Huntington Gardens, Norton Simon Museum, Doheny Beach, and Point Fermin Lighthouse. Concert tickets for Disney Hall, Hollywood Bowl, LA Ballet and other venues are also offered throughout the year.

_____ **Support Groups/Classes**
Being Alive hosts nightly support groups including: "Strength Within" for HIV+ Women; a fun and educational group to remove stigma from sex called "Shameless," "Wise Guys" for long-term survivors, "Positively New" for those newly diagnosed with HIV, an open group called "Friday Night Light", and an AA group. Groups are open to anyone and their friends/family, and are subject to change based on the needs of the community. Classes are frequently offered with topics ranging from apartment gardening, cooking on a budget, advanced planning, immigration, and more.

_____ **Medical Updates/ Treatment Education**
Learn current information on medical breakthroughs, clinical trials, drug interactions, new treatment options, etc. at monthly presentations from HIV experts, clinicians, researchers, and other guest speakers. These updates include a complementary meal.

_____ **Prevention / Get Real / PeP/PrEP Workshops**
Group & individual risk reduction counseling sessions that enhance personal strategies to improve life skills are offered at Being Alive. Topics frequently discussed include HIV/STD transmission, disclosure, reducing substance misuse, sex, dating, & relationships. The Group workshops also present information and referrals for PrEP and PEP. Incentives are provided for attending all 3 weekly sessions, and a light lunch is included at group presentations.

_____ **Care Management**
Staff members are able to help clients get linked to medical care including PrEP treatment, find resources for food, shelter, and clothing, and general support for those finding difficulty navigating the services available to the community.

_____ **Advocacy/Outreach**
Opportunities exist throughout the year to help with outreach at events, informing people about reducing risk for STI and HIV transmission, proper condom usage, and general information to help others have a healthy approach to intimacy and sex. Additionally, clients can choose to participate in events to raise awareness about HIV, community needs, and available services.

CLIENT RIGHTS AND RESPONSIBILITITES

AS A CLIENT, I HAVE THE RIGHT TO:

1. Receive considerate and respectful care in a safe environment.
2. Expect that all aspects of care are managed in a confidential and professional manner.
3. Receive complete and current information.
4. Request a second opinion
5. Participate actively in establishing a productive Client Service Plan.
6. Refuse treatment, be told to what effect this may have on my health, and be informed of other potential consequences of refusal.
7. Know by name my Counselor and other Staff Members.
8. Privacy during counseling

AS A CLIENT, I HAVE THE RESONSIBILITY TO:

1. Observe the Being Alive Code of Conduct.
2. Respect the rights of others, including Staff Members, to a safe environment free of violence or threat of violence.
3. Maintaining the confidentiality of those being served.
4. Provide complete and accurate information to my Counselor.
5. Keep appointments, and if unable to do so, provide 24 hours' notice of the cancellation

GRIEVANCES

If a Client has a grievance of disagrees with a Staff Member and is not able to resolve the issue with their own immediate Manager, they make take advantage of the grievance procedure outlined below:

1. Discuss the problem with the Manager, who should do their best to resolve the matter
2. If you feel that the problem has not been resolved then the Program Manager should arrange a meeting with the Executive Director who will listen to all sides of the matter and will help to try to find a solution. After reviewing the matters in dispute, the Executive Director will make a decision which will be final and binding for all parties.
3. The Client will have the right to discontinue services at any time.

Client: _____ Date: _____

Being Alive Client Code of Conduct

Being Alive is a community-based organization dedicated to providing a continuum of care for people infected with and affected by HIV. Participation in the organization's programs is subject to the observance of the organization's rules and procedures. *The activities outlined below are strictly prohibited.* Any participant or staff member who violates this Code is subject to discipline, up to and including removal from the program.

- Abusive language towards a staff member, volunteer, providers, or another participant.
- Possession or use of alcoholic beverages or illegal drugs on Being Alive's property or reporting to the program while under the influence of drugs or alcohol.
- Bringing onto Being Alive's property dangerous or unauthorized materials such as explosives, firearms, weapons or other similar items.
- Discourtesy or rudeness to a fellow participant, staff member, provider, or volunteer.
- Verbal, physical or visual harassment of another participant, staff member, provider, or volunteer.
- Actual or threatened violence toward any individual or group.
- Conduct endangering the life, safety, health or well-being of others.
- Failure to follow any agency policy or procedure.
- Bullying or taking unfair advantage of any participant.
- Failing to cooperate with staff members, facilitators, or providers.
- Smoking or use of tobacco or tobacco-related products including marijuana and e-cigarettes in and within 100 ft. of Being Alive property.
- Loitering.
- Causing unreasonable disturbance.
- Leaving children or pets unattended at any time while at the clinic.
- ANY other behavior(s) that could jeopardize the safety of Being Alive, its community relations, affiliates, business reputation, and safety standards, as specified by staff.

I have read and I understand Being Alive's Code of Conduct. I agree to abide by the rules described above and understand that I may be removed as a participant if I violate any of these rules.

Signature _____ Date _____

Staff Member _____ Date _____

CONSENT TO RELEASE MEDICAL INFORMATION

This consent is applicable for all clients receiving Being Alive services.

Your health and medical information is considered sensitive and private and is afforded protection under the law. Being Alive will make every effort to keep all client records secure. However, as a client of Being Alive there are circumstances that will require the exchange of information about me through phone, faxing, e-mailing, and mailing.

I understand that Being Alive will represent me in these exchanges, and that Being Alive cannot be held responsible if any person becomes aware that I am a client at Being Alive.

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 Being Alive for the purpose of verification of diagnosis and/or providing or referring for medical treatment, housing benefits, dental care, and other related services. 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), AIDS Project Los Angeles (APLA), Alliance for Housing and Healing, Asian Pacific AIDS Intervention Team, Andrew Escajeda Clinic, ALTAMED Health Service Corp, Automated Case Management Systems (ACMS), Children's Hospital, Division of Adolescent Medicine, Bienestar, Cedars Sinai, Center at Blessed Sacrament, Central City Clinic, City of Long Beach -AIDS Program, East Valley Community Health Center, Coordinated Entry System, EI Proyecto del Barrio, Foothill AIDS Project, Greater Los Angeles Council on Deafness, Harbor/UCLA Medical Center, High Desert Health System, Hubert Humphrey, Housing Authority City of Los Angeles, JWCH Institute, Inc., Kaiser Permanente, LAC-USC (Sp21, 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, SABAN Community Clinic, 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)

Outreach and Risk Assessment (Site ID #15039001/Agency ID #1503)

Location: _____ **Date:** _____ **Time:** _____ am/pm

What country were you born in? _____ **Residence Zip Code:** _____

What is your gender identity?

☐ Male ☐ Female

☐ Transgender (please specify: ____ FTM ____ MTF

Gender at birth:

☐ Male

☐ Female

What is your race? (mark all that apply)

☐ Black / African American ☐ Hispanic / Latino(a) ☐ White

☐ American Indian / Alaskan Native ☐ Native Hawaiian / Pacific Islander ☐ Asian

☐ Don't know ☐ Other race, specify: _____

☐ Decline / Refuse to answer

Who are your sex partners? (mark all that apply)

☐ Men ☐ Transgender ☐ Non-Binary

☐ Women ☐ Other, specify: _____

Do you have any current risk behaviors?

☐ Sharing needles ☐ Skipping/missing HIV medicine doses

☐ Crystal meth use ☐ Any other drug use

☐ Unprotected sex without PrEP ☐ None

Are you HIV positive? ☐Yes ☐No ☐Do not know

i. If yes, are you in treatment? ☐Yes ☐No ☐Decline/Refused to answer

ii. If HIV negative, or you do not know, have you been testing? ☐Yes ☐No When? _____

Have you exchanged sex for money or drugs? ☐Yes ☐No ☐Decline/Refused to answer

Were you incarcerated in the last 12 months? ☐Yes ☐No ☐Decline/Refused to answer

Are you homeless, living outdoors? ☐Yes ☐No ☐Unable or refused to answer

☐ Homeless, staying in a shelter or transitional housing where other services are provided

☐ Homeless, sleeping in a car or temporary indoor situation without additional services

☐ Homeless, but cannot or will not give more detail

First Name: _____ **Last Initial:** _____ **Phone Number:** _____

Email Address: _____ **Date of Birth:** _____ **Completion Time:** _____ am/pm

THANK YOU!

Referred to: _____

Linked Referral

Site ID: 15039001/Agency ID: 1503

Client's Name: _____ Client's DOB: _____

Date of Referral: _____ Staff's Name: _____

Referral to (check all that apply):

- O Get Real-HNS
- O Medical Services
- O Substance Abuse Services
- O Mental Health Services
- O Legal Services
- O Food Banks/Hot Meal Programs
- O DMV Vouchers
- O Get Real-IDG
- O STI Screening/Testing
- O Housing/HOPWA
- O Support Groups
- O CDPH Programs (ADAP/HIPP)
- O Clothing Vouchers
- O Partner Services
- O Wellness Programs (Acupuncture, Chiropractor, Reiki, Sculptra, Self-Hypnosis)

Notes:

Linked Referral Verified: O Yes O No

Name of Agency Verified: _____

Staff's Signature: _____ Date: _____

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