Foothill AIDS Project

Dear Client,

Welcome and thank you for your interest in Foothill AIDS Project's Case Management program and other services. We are here to serve persons affected by HIV/AIDS who live in the far San Gabriel Valley in Los Angeles County and the western part of San Bernardino County.

Enclosed is a packet of registration forms for you to complete. Please return them to the office as soon as possible. If you need assistance with completing these forms please call the office Monday through Friday between 9 a.m. and 5 p.m.

Foothill AIDS Project offers a variety of services including case management, mental health support, food programs, housing assistance, transportation to medical appointments, public benefits counseling, treatment advocacy, family support and referrals for medical care, home health services, and substance abuse programs, HIV/AIDS health education and risk reduction.

If you have any questions or need more information concerning the registration packet, or any of Foothill AIDS Project's services, please contact the Claremont office at (909) 482-2066 and the San Bernardino office at (909) 884-2722

Sincerely,

Maritza Tona
Executive Director

Enclosures: Registration Packet

Foothill AIDS Project

SERVICES REQUESTED & NEW CLIENT APPOINTMENT CHECKLIST

Intake/Orientation Date:_____

Services requested:
Foothill AIDS Project and other community resources may be able to assist you with the following services. Please check the services you are interested in. We understand that your needs may change in the future.

_____ Case Management - Ongoing assistance with information, referrals, and coordination of services.

_____ Mental Health – Individual adult, child, couple, family counseling, and support groups.

_____Adult Groups – parent empowerment, women support, heterosexual support and or other.

_____Family Support – child or adolescent groups, emotional support, recreational, educational support.

_____ Food Programs - Referrals to food banks and home delivered meals.

_____ Insurance Counseling - Private health and disability benefits.

_____ Legal Assistance - Wills, powers of attorney, discrimination.

_____ Medical and Dental Care - Referrals to health care providers, dentist, and home health care.

_____ Public Benefits Counseling - County, State, and Federal programs.

_____ Transportation - Transportation to medical appointments, case management, & food appointments.

_____ Treatment Advocacy - Information about HIV disease and medical treatments.

_____ Substance Abuse Treatment - Counseling, treatment.

_____ Child and respite care

_____ Move-in, Rent and utilities assistance

_____HIV/AIDS Health Education, Risk Reduction-individual and family

_____ Other: _____

What services are you currently receiving through other providers?

_____

_____

_____

_____
Client Signature

Foothill AIDS Project

New Client Appointment Checklist

Your first appointment with a case manager will take 60-90 minutes. Please bring the following items to your appointment:

- ✓ A valid photo identification card
- ✓ Medical insurance card (i.e. Medi-Cal, Medicare, private insurance)
- ✓ Proof of your current income (or your parent or guardian's) dated within the last three months such as bank statement, copy of check, Social Security award letter.
- ✓ Any document which shows your (or your parent or guardian's) current address such as utility bill, bank statement.
- ✓ Verification of diagnosis

Foothill AIDS Project

CLIENT REGISTRATION FORM

HIV RISK FACTORS:

[ ] Blood Transfusion
[ ] Homosexual/Bisexual Contact
[ ] Intravenous (IV) Drug Use
[ ] Homosexual/Bisexual Contact & IV Drug Use
[ ] Heterosexual Contact
[ ] Hemophilia
[ ] HIV+ Parent
[ ] Perinatal Transmission

CURRENT DIAGNOSIS:

[ ] HIV+ No Symptoms
[ ] HIV+ Symptomatic
[ ] AIDS
[ ] No HIV

THOSE THAT APPLY:

[ ] Deaf/Hard of Hearing
[ ] Physically Challenged
[ ] Blind/Partially Sighted
[ ] Homeless

I am requesting assistance from Foothill AIDS Project, and hereby certify that the information I have provided is true and correct.

_____ _____/_____/_____

SIGNATURE OF CLIENT (Parent's or guardian's if under 18 years of age) **DATE**

_____ _____/_____/_____

CASE MANAGER/FAMILY SUPPORT SPECIALIST **DATE**

Foothill AIDS Project

NEW CLIENT REGISTRATION FORM

CLIENT INFORMATION

Name: _____ [ ] Male [ ] Female [ ] Transgender [ ] male to female [ ] female to male

Date of Birth: _____/_____/_____ Place of Birth/Country: _____Religion: _____

Address: _____

City: _____ Zip Code:_____State: _____ Phone: ( )_____-_____

May we send you mail with agency logo? [ ] Yes [ ] No May we leave phone messages? [ ] Yes [ ] No
Person(s) we may leave message with?: _____

Social Security #: _____-_____-_____Marital Status: □ Married □ Single □ Living with Partner

Ethnicity: _____Primary Language: _____ Other Languages: _____

Last Grade Completed in School: _____Mother's Maiden Name: _____

Do you have children? [ ] Yes [ ] No Names & Ages of Children:_____
_____How many people live with you? _____

EMERGENCY INFORMATION

Name:	Name:
Address:	Address:
City:	City:
Telephone:	Telephone:
Relationship	Relationship:
Does this person know you are HIV+? □ Yes □ No	**Does this person know you are HIV+? □ Yes □ No**

INCOME & EMPLOYMENT:

Occupation: _____ Employer: _____

Are you interested in job re-training placement? [ ] Yes [ ] No Monthly income: $ _____

WORK
[ ] Full time
[ ] Part time
[ ] Temporary medical disability
[ ] Permanent medical disability
[ ] Unemployed
[ ] Retired
[ ] Student/dependent

BENEFITS RECEIVED
[ ] State Disability Insurance
[ ] Social Security Disability
[ ] General Relief
[ ] AFDC/Cal Works
[ ] VA benefits
[ ] Private Disability Insurance
[ ] Other

HEALTH INSURANCE
[ ] Medi-Cal
[ ] Medicare
[ ] Group Insurance
[ ] Individual insurance policy
[ ] HMO
[ ] None/Self Pay

MEDICAL CARE

Medical Provider: _____Phone #: ( ) _____-_____

Address: _____City: _____State: _____Zip _____

Foothill AIDS Project

CLIENT RIGHTS AND RESPONSIBILITIES
CASE MANAGEMENT

I understand that as a client of FAP I have certain rights and responsibilities as defined below:

CLIENT RIGHTS:

1. The right to be given a fair and comprehensive assessment of the client's health functional, psychosocial and cognitive ability.

2. The right to have access to needed health and social services without discrimination to age, gender, national origin, physical or mental disability, race, religion, or sexual orientation.

3. The right to be notified of any changes in services, including termination of service or discharge from the program.

4. The right to withdraw from case management program at any time the client is dissatisfied with the case management service being provided.

5. The right to be treated with dignity and respect.

6. The right to a grievance procedure in the event the client feels that their rights have been violated, has perceived discrimination and/or feels a representative of FAP has said or done something in an inappropriate manner.

CLIENT RESPONSIBILTIES:

Clients are expected to assume specified responsibilities to ensure that the client actively participates in his/her actions that do not infringe upon the rights of other clients or upon the rights and responsibilities of FAP.

I understand that as a client I have certain responsibilities as defined below:

1. It is my responsibility to provide written proof of my HIV status and/or AIDS-related diagnosis to FAP as a condition of receiving services.

2. It is my responsibility to work with staff and volunteers in creating a safe environment on the Foothill AIDS project premises. This includes:

    - ♦ Maintaining appropriate behavior while on the premises.

    - ♦ Refraining from verbal abuse, verbal threats of physical violence and actual violence directed toward staff, volunteers or clients. Clients whose behavior is inappropriate or who abuses/misuses agency property may be dis-enrolled for up to one year. Clients will not be eligible for any FAP services during that one-year suspension.

    - ♦ Abstaining from the use of illicit drugs or alcohol on the premises.

    - ♦ Abstaining from bringing weapons of any kind on the premises.

CLIENT RIGHT & RESPONSIBILITIES

It is my responsibility to be informed. If I do not understand a treatment or services I will ask staff for a simpler explanation. It is my responsibility to let FAP staff know if I speak, read and/or understand a language other then English.

3. It is my responsibilities to keep appointments and to notify FAP 24 hours in advance should I need to cancel and/or rescheduled an appointment.

4. It is my responsibility to assess whether services provided are meeting my needs and if they are not, to discuss my concerns with my case manager and/or ask for appropriate referrals.

5. It is my responsibility to participate actively in decisions regarding my care.

I have read and understand my rights and responsibilities as a client of Foothill AIDS Project. I understand that Foothill AIDS Project reserves the right to terminate or suspend services if I do not fulfill my responsibilities as a client.

_____ _____/_____/_____

Client's Signature (parent or guardian's if under 18 yr.) **Date**

_____ _____/_____/_____

Case Manager/Family Support Specialist **Date**

Foothill AIDS Project

CONSENT TO PARTICIPATE

Client: _____ Date of Birth: _____

Social Security #: _____-_____ - _____ ARIES#: _____

Foothill AIDS Project provides support services with HIV/AIDS. The support services provided include, but are not limited to, case management, crisis intervention counseling, family support, health education, food pantry, transportation services, benefits information, CARE-HIPP and Medi-Cal enrollment.

All services provided by Foothill AIDS Project are confidential and no personal identifying information will be released without prior written consent of the individual. We acknowledge that during times of crisis and exacerbation of symptoms, written consent may be difficult to obtain. Under these circumstances, verbal consent will always be obtained prior to releasing information to sources identified by the case manager and client as important to the resolution of the crisis. Every effort will be made to follow-up with the client to obtain written consent. There may be an exchange of information directly related to your case between client services and volunteer staff of Foothill AIDS Project who are directly involved in your case. Individuals my request that copies of their records be sent to a physician, mental health provider, social service agency or health care facility.

In accordance with the law, the staff at Foothill AIDS Project is mandated to report to the appropriate authorities information regarding:

1. Any person who is in danger of hurting themselves or others.
2. Any reasonable suspicion that any child, elder or dependent adult has been abused or neglected.
3. Any reasonable suspicion that any person has been the victim of domestic violence.

Participation in the services provided by Foothill AIDS Project is voluntary. Clients may choose to stop receiving services at any time.

I have read the above, understand its content and agree to the conditions stipulated therein. I voluntarily agree to participate in the activities and programs of Foothill AIDS Project.

_____ _____/_____/_____

Client's Signature (parent or guardian's if under 18 yrs) **Date**

_____ _____/_____/_____

Case Manager/Family Support Specialist **Date**

I voluntarily withdraw from the services at Foothill AIDS Project. I understand that I may, in the future, receive services from Foothill AIDS Project if I request them.

_____ _____/_____/_____

Client's Signature (Parent's or guardian's if under 18 years of age) **Date**

_____ _____/_____/_____

Case Manager/Family Support Specialist **Date**

Foothill AIDS Project

PHYSICIANS DIAGNOSIS FORM
(To be completed by Medical Provider/Dr.)

Patient's Name _____ DOB _____

Social Security # _____ Sex: [ ] Male [ ] Female [ ] Other

MEDICAL INFORMATION: (Please answer all questions completely)

Diagnosis: [ ] HIV+ Symptomatic [ ] HIV+ Non Symptomatic [ ] AIDS

HIV Risk Factors: [ ] Unprotected Sex [ ] Hemophilia [ ] IV Drug Use

Please Comment: _____

CD4 Count: _____ CD4 Percentage _____ %Date: _____ Viral Load Date: _____

Date of Last TB test _____ Result: [ ] Negative [ ] Positive mm CXR Date/Results _____

Patient Receives: [ ] LTBI Treatment [ ] Active TB Treatment [ ] No Treatment [ ] Non- Compliant
(Latent TB Infection)

Please Comment on Patient's Status, (if necessary) _____
_____
_____

Karnofsky Scale Assessment: Please mark the appropriate value)

Stage I	Stage II	Stage III	Stage IV
[ ] 100	[ ] 70	[ ] 40	[ ] 30
[ ] 90	[ ] 60		[ ] 20
[ ] 80	[ ] 50		

Is the patient able to work? [ ] Yes [ ] No Is patient able to use public transportation? [ ] Yes [ ] No

Is the patient medically fit to receive routine dental care and/or oral procedures? [ ] Yes [ ] No

Additional comment, if any
_____
_____

Physician's Name (Please print) _____

Physician's Signature _____

License Number _____ Date _____

Address: _____

Phone Number: _____

Patient's Name: _____ DOB: _____/_____/____ Date: _____/_____/_____

Social Security #: _____-_____-_____ Sex: [ ] Male [ ] Female

Foothill AIDS Project

CONSENT TO RELEASE INFORMATION and INCOME CERTIFICATION

I, _____, certify that: I authorize staff and/or volunteer staff of the following agencies to release/share information regarding services I have received or requested, my HIV status, or my physical, and/or financial condition among those same agencies for the express purpose of receiving or gaining access to services related to my current or future needs:

Agencies:

Aid for AIDS (AFA), AIDS Project Los Angeles (APLA), AIDS Service Center (ASC), AIDS Healthcare Foundation (AHF), Asian Pacific AIDS Intervention Team (APAIT), Bienestar Human Services, Behavioral Health Systems (BHS), Bear Valley Counseling Center, California Department of Corrections (CDC), Catholic Charities, Community Action Partnership, Cedar House Rehabilitation Center, Central City Lutheran Mission (CCLM), Clean N' Sober, City of Pomona, City of Riverside, Creative Living, Department of Social Services (DPSS), Department of Public Health for San Bernardino, Los Angeles and Riverside Counties, Desert AIDS Project (DAP), East Valley Community Health Center, Foothill AIDS Project (FAP), Foothill Family Shelter, Gay & Lesbian Centers for Los Angeles & San Bernardino Counties, HALSA Housing Authority of the City of Los Angeles (HACLA), Housing Authority of the Counties of San Bernardino (HACSB), Los Angeles & Riverside, Inland AIDS Project (IAP), LAC/King Drew Medical Center, Loma Linda University & Medical Center, Minority AIDS Project (MAP), New Image Emergency Shelter, Nu-Start Homes, Office of AIDS Policy and (OAPP), OMNI Trans, Palomares Houses, Pomona Alcohol & Drug Recovery Services Inc, Pomona Inland Valley Council of Churches, Pomona Lodge Motel, Prototypes Women's Center, Project Achieve, Project Angel Food, Project New Hope, South Central Loa Angeles Regional Center, Salvation Army, Social Security Administration, Step One Recovery, Tarzana Treatment Center, Tri-City Mental Health, Town Lodge Motel, UCLA Medical Center.

To release, receive and share information from my records regarding personal information, services I have received, results of my HIV test or status, and my physical, financial and/or mental condition, for the express purpose of receiving or gaining access to services related to my current or future needs.

For housing Purposes, I acknowledge that any assistance given to me by the Central Coordinating Agency (CCA) is at the sole discretion and option of the CCA and those dollar assistance levels and criteria for grants are subject to change without notice to me.

I have indicated that information not be exchanged with any agency listed above by drawing a line through the name of the agency and placing my initials next to the line. I understand that the receiving agency is not permitted to release or disclose information to another person or agency without obtaining an additional "Consent to Release Information".

This consent is valid for one year from date signed and may be revoked at any time by signing the revocation line below or by verbally informing the agency holding this original form. I understand that I may add other specific agencies to this form by listing them and signing below. A photocopy of this form is as valid as the original.

_____ _____

Client's Signature (parent's or guardian's if under 18 years of age) **Date**

_____ _____

Agency Representative **Date**

I wish to add the following agencies to this release:

1. _____ 2. _____ 3. _____

_____ _____

Client's Signature **Date**

I wish to cancel this Release of Information

_____ _____

Client Signature (parent's guardian's if under 18 years of age) **Date**
(Signature of agency representative if canceled by telephone)

Notice of Privacy Practices

Acknowledgement of Receipt

By signing this form, you acknowledge that you have received and read **Foothill AIDS Project's** (FAP) *Notice of Privacy Practices.* **FAP's** *Notice of Privacy Practices* provides information about how **FAP** may use and disclose confidential information about you.

FAP's Notice of Privacy Practices is subject to change. If the notice is changed, you may obtain a copy of the revised notice.

I acknowledge that I have received and read a copy of received Foothill AIDS Project's (FAP) *Notice of Privacy Practices.*

Client Name _____ Date _____

Signature _____Record # _____

If client is under age 18, provide name of parent/guardian, relationship and signature.

Name_____ Relationship _____
(Parent/guardian if client is under age 18)

Signature _____ Date _____

****

INABILITY TO OBTAIN ACKNOWLEGEMENT
(To be completed only if no signature is obtained)

The three attempts noted below are documentation of the reasons it was not possible to obtain the client or his/her parent/guardian's acknowledgement. The documentation shall include the dates of the attempts, the nature of the efforts taken (i.e. letter, telephone call, or other notice) and outcome of the efforts.

1. _____
2. _____
3. _____

(Staff Name & Title)	Signature	Date

Foothill AIDS Project

GRIEVANCE AND COMPLAINT PROCEDURE

Clients who feel they have been discriminated against or who have a complaint about services or an employee's actions may direct their complaint to FAP's administrative staff by completing the *Client Complaint Form*. Clients, who are dissatisfied with FAP's resolution of the matter, may

- For Los Angeles County funded services, contact the Office of AIDS Programs and Policy's Director at 600 South Commonwealth Avenue, 6th Floor, Los Angeles, California 90005.

- For San Bernardino County funded services, contact Ryan White CARE Act & HOPWA Program 8088 Palm Lane, San Bernardino, CA 92415
-
- Individuals dissatisfied with the applicable County's resolution may appeal the matter to the State Department of Health Services' Affirmative Action Division.

I have read the above, understand its content and agree to the requirements stipulated therein.

_____ _____/_____/_____

Client's Signature (Parent's or guardian's if under 18 years of age) **Date**

_____ _____/_____/_____

Case Manager/Family Support Specialist **Date**

Foothill AIDS Project

CLIENT COMPLAINT FORM

Today's Date:_____ **Date of Incident**: _____

Client's Name: _____

Address: _____ **City:** _____

Telephone: Day:_____ **Evening**: _____

Please use the following space to present your complaint, or to describe what you feel is wrong. Please be as specific as you can; date, time, place, names of the staff who were involved, and what happened. When you attempted to resolve your complaint with the staff, what was the response?

How would you like this problem resolved? Please help by focusing on the solution, and be as specific as you can.

Please provide any additional information you think would help to resolve the matter.

Note to client: *Agency policy requires that, before completing this form, you attempt to resolve this matter with the involved staff member. If you are dissatisfied, please complete this form and give it to the Administrative Staff.*

Foothill AIDS Project

EMPLOYEE RESPONSE TO CLIENT COMPLAINT

Today's Date: _____ **Date Complaint Received**: _____

Employee's Name: _____

Agency policy requires first, that client and employee mutually attempt to resolve the matter.

Has the client met with you? Yes:_____No: ___ Date of Meeting: _____

Please describe the event or issue as specifically as possible and address "what", "when", "where", "who". Please provide date, time, the individuals involved, and what client was seeking.

Please provide any additional information you think would help to resolve the matter.

Please provide your recommendations as to how this issue can be resolved. Remember to focus on a solution. Please be as specific as possible.