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| **Section I: Applicant’s Information** | | |
| Legal First Name: | Legal Last Name: | Middle Initial: | |
| Date of Birth: | Social Security Number: (optional) | | |

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| **Section II: Household Information** | | | | |  |  |  |
| Live alone Live with others (complete below) Homeless  Shelter \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Correction Release \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| **Household Member’s Name** | **Date of Birth/Age** | **Relationship** | **Sex at Birth**  **(Male, Female)** | **Current Gender**  **(Male, Female, Trans Male to Female Trans Female to Male, Trans Other, Unknown)** | **Race**  **(White, Black or African American, Asian, Native Hawaiian/Pacific Islander, American Indian or Alaska Native, Other)** | **Ethnicity**  **(Hispanic or Latino, Non-Hispanic or Latino)** | **Hispanic Subgroup**  **(Mexican, Mexican American, Chicano/a, Puerto Rican, Cuban, Another Hispanic, Latino, or Spanish origin write in name)** |
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| **Only complete if needing to Self-Declare Residency** | |
| I understand self-declaration is only permitted when I do not have a fixed address or have attempted but cannot obtain third-party proof of current residency. I understand that any misrepresentation of information or failure to disclose information requested on this form may disqualify me from participation in the Program and may be grounds for termination of assistance. It is unlawful to provide false information to the government when applying for federal public benefit programs per the Program Fraud Civil Remedies Act. I certify that the above information is true and correct. I also understand that it is my responsibility to report all changes to my household composition or income and provide documentation of such to my case manager within ten (10) business days.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Signature Date | |
| **Section III. Medical Information** |
| **Labs:** |
| **Have you been screened for Tuberculosis since HIV diagnosis: DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes  No  Not Medically Indicated  Unknown |
| **Have you been screened/tested for Syphilis during the calendar year: DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes  No  Not Medically Indicated |
| **Have you been screened for Hepatitis B: DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Yes  No  Not Medically Indicated  Unknown |
| **Have you been screened for Hepatitis C: DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Yes  No  Not Medically Indicated  Unknown  **Have you ever been treated for Hepatitis C: DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes  No  Not Medically Indicated  Unknown  **Are you considering treatment:**  Yes  No  Unknown |
| **Have you received any immunizations:** |
| Hepatitis A  Hepatitis B  Influenza  Human Papillomavirus (HPV)  Pneumococcal Conjugate Vaccine (PCV13)  Pneumococcal Polysaccharide Vaccine (PPSV23)  Tdap (Tetanus, Diphtheria, Pertussis)  Immunization Start Date (for Hepatitis A/B): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Immunization End Date (for Hepatitis A/B): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Medications:** |
| Are you currently taking HIV medications? Yes No  Medication Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  What type of medication (check all that apply):  ART  OI-Prophylaxis  OI-Treatment  Other  Hepatitis B  Hepatitis C  Influenza  HPV  Medication Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Medication End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  What pharmacy do you use for your HIV medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Exposure Category:** | |
| Men who have sex with men | Injection drug use |
| Heterosexual contact | Recipient of blood transfusion, blood components, or tissue |
| Perinatal transmission | Unknown |