Alliance for Positive Health Referral Form

Date of Referral: Check here if urgent referral: ☐

Client Information

Name: DOB:

Street Address: City/Town:

Zip Code: Phone Number(s):

Email:

How to contact client (select all that apply):

☐ OK to contact by phone

☐ OK to email

☐ Use discretion

☐ OK to text

☐ OK to leave message

Is the client HIV positive? ☐ Yes ☐ No ☐ Don't Know (if yes, please include verification)

Client Gender at Birth: Client Gender Identity:

Client Sexual Orientation:

Does client have Medicaid? ☐ Yes ☐ No ☐ Don't Know Medicaid #:

Does client have Medicare? ☐ Yes ☐ No ☐ Don't Know Medicare #:

Does client have other insurance? ☐ Yes ☐ No ☐ Don't Know Insurance #:

Preferred Language: Translation Required: ☐ Yes ☐ No

Please provide a detailed narrative of why you are referring the client and what services s/he needs. Please indicate whether specific program referrals have been discussed with the client. Include information on medical treatment, housing, entitlements, legal, substance use, prevention, mental health, etc.

alliance
for positive health

Please select up to five services for referral, ranking the services in order of importance/appropriateness/urgency for the client. ***(see Program Services List for more information)***

Top Priority — **Least Urgent**

1 2 3 4 5

* Indicates only for people living with HIV

- Care/Case Management
- Food4Life *
- Health Insurance Access Program (HIAP)
- HIV Testing
- STI Testing
- HCV Testing
- Housing Retention Services *
- Housing Financial Assistance * (complete ***FAR Short Form***)
- Link2Care
- Link2PrEP
- Health Education*
- S.E.L.F. Women's Group
- Ryan White Medical Transportation*

☐ HIV Verification included* ☐ Income Verification included* ☐ Residency Verification included*

*Required documentation all HIV-specific program referrals

Yes, I have attached a Release of Information: ☐

Referred by: Organization:

Email Address: Phone # :

FAX referrals to: 518-427-8184 or email to: referrals@alliancefph.org

Questions? Call 518-434-4686

For Staff Receiving Referral Only		
Referral Received by:		Date:
Contacted referring source on (enter date): Additional Information Received:		
Forwarded to:		Date:

alliance
for positive health

Transportation Services Program Referral

** ONLY COMPLETE THIS FORM IF YOU ARE MAKING A REFERRAL TO WHITE MEDICAL TRANSPORTATION*
*** For clients already enrolled with the Alliance for Positive Health, this form can be a stand-alone document*

Eligibility (please attach):

☐ Proof of HIV+ status | ☐ Proof of Residency | ☐ Proof of Income

Requested Assistance Frequency (select one):
☐ Ongoing assistance
Anticipated duration of need:
☐ One-time assistance

Please indicate type of assistance needed (may select more than one):
☐ Taxi Ride*
*Must include justification (attach medical provider justification if destination is accessible by bus)
☐ Bus Pass
☐ Gas Card

Has the client applied for, or been enrolled in, any other transportation programs?
☐ Yes * ☐ No ☐ Don't Know

* If yes, please select type of transportation program:

☐ Medicaid Transportation (MAS)
→ MAS Status: ☐ Pending ☐ Approved ☒ Denied

☐ Other:
→ Other Status: ☐ Pending ☐ Approved ☐ Denied

IMPORTANT: The items below indicate the <u>only types of qualifying appointments</u> for White Medical Transportation. Please indicate below all medical providers regularly visited by the client as well as other qualified providers. Complete page 4 and attach applicable releases if available.

Qualified Provider Types:

☐- Medical appointment (including dental, pharmacy);
☐- Mental health counseling appointment with a licensed provider (including individual, family, couples and group);
☐- Substance abuse treatment (not inclusive of NA/AA)
☐- Treatment adherence services
☐- Legal services (does not include probation or parole)
☐- Case management services
☐- Nutrition Education Programs Services (not congregate meals; stand-alone food distribution/pantries if not enrolled in education)
☐- Entitlements/DSS Social Services
☐- Housing (apartment searches are not allowable)

Providers for which the Client May Use White Medical Transportation

*** ONLY COMPLETE THIS FORM IF YOU ARE MAKING A REFERRAL TO WHITE MEDICAL TRANSPORTATION**

**Please attach any applicable releases if available*

Provider Name and Address	Release of Information with Alliance for Positive Health? Y/N
	Choose one:
	Choose one:
	Choose one:
	Choose one:
	Choose one:
	Choose one:
	Choose one:
	Choose one:
	Choose one:
	Choose one:
	Choose one:

☐ HIV Verification included* ☐ Income Verification included* ☐ Residency Verification included*

*Required documentation all HIV-specific program referrals