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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 text

☐ OK to email ☐ OK to leave message

☐ Use discretion

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.

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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

Rank - Care/Case Management
Rank - Food4Life*
Rank - Health Insurance Access Program (HIAP)*
Rank - HIV Testing
Rank - STI Testing
Rank - HCV Testing
Rank - Housing Retention Services*

Rank - Housing Financial Assistance* (complete ***FAR Short Form***)
Rank - Link2Care
Rank - Link2PrEP
Rank - Health Education*
Rank - S.E.L.F. Women's Group
Rank - 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:

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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)

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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: Y/N
	Choose one: Y/N
	Choose one: Y/N
	Choose one: Y/N
	Choose one: Y/N
	Choose one: Y/N
	Choose one: Y/N
	Choose one: Y/N
	Choose one: Y/N
	Choose one: Y/N
	Choose one: Y/N
☐ HIV Verification included* ☐ Income Verification included* ☐ Residency Verification included*	

*Required documentation all HIV-specific program referrals