



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 #:

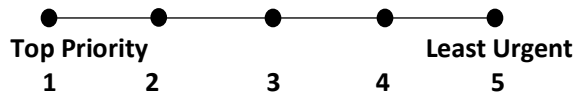
Preferred Language:

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.



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)



* 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

| <i>For Staff Receiving Referral Only</i> | |
|---|-------|
| Referral Received by: | Date: |
| Contacted referring source on (enter date): Additional Information Received: | |
| Forwarded to: | Date: |



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): | | |
| <input type="checkbox"/> Proof of HIV+ status | <input type="checkbox"/> Proof of Residency | <input type="checkbox"/> Proof of Income |
| Requested Assistance Frequency (select one): | <input type="checkbox"/> Ongoing assistance Anticipated duration of need: <input type="checkbox"/> One-time assistance | |
| Please indicate type of assistance needed (may select more than one): | | |
| <input type="checkbox"/> Taxi Ride* *Must include justification (attach medical provider justification if destination is accessible by bus) | | |
| <input type="checkbox"/> Bus Pass <input type="checkbox"/> Gas Card | | |
| Has the client applied for, or been enrolled in, any other transportation programs? | | |
| <input type="checkbox"/> Yes * <input type="checkbox"/> No <input type="checkbox"/> Don't Know | | |
| * If yes, please select type of transportation program: | | |
| <input type="checkbox"/> Medicaid Transportation (MAS) ↳ MAS Status: <input type="checkbox"/> Pending <input type="checkbox"/> Approved <input checked="" type="checkbox"/> Denied | | |
| <input type="checkbox"/> Other: ↳ Other Status: <input type="checkbox"/> Pending <input type="checkbox"/> Approved <input type="checkbox"/> Denied | | |
| <p>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.</p> | | |
| Qualified Provider Types: | | |
| <input type="checkbox"/> - Medical appointment (including dental, pharmacy); | | |
| <input type="checkbox"/> - Mental health counseling appointment with a licensed provider (including individual, family, couples and group); | | |
| <input type="checkbox"/> - Substance abuse treatment (not inclusive of NA/AA) | | |
| <input type="checkbox"/> - Treatment adherence services | | |
| <input type="checkbox"/> - Legal services (does not include probation or parole) | | |
| <input type="checkbox"/> - Case management services | | |
| <input type="checkbox"/> - Nutrition Education Programs Services (not congregate meals; stand-alone food distribution/pantries if not enrolled in education) | | |
| <input type="checkbox"/> - Entitlements/DSS Social Services | | |
| <input type="checkbox"/> - 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: |
| <input type="checkbox"/> HIV Verification included* <input type="checkbox"/> Income Verification included* <input type="checkbox"/> Residency Verification included* | |

*Required documentation all HIV-specific program referrals