Clayton County Health District-Ryan White
Client Information Sheet

GEORGIA DEPARTMENT OF PUBLIC HEALTH
Clayton County Health District

Please Print When Completing This Form

Appointment: _____ Walk-in: _____ Stand-by: _____ (Check One)

Date: _____ Reason for Visit: _____

Other health problems today?

_____

Last Name: _____ First Name: _____
(Client's Name)

Maiden Name: _____ Middle Name: _____

Are you a United States citizen? [ ] Yes [ ] No Do you smoke? [ ] Yes [ ] No

Date of Birth _____ Age _____ Social Security Number_____

Gender (at birth): _____ Gender Identity: _____ Race: _____

Marital Status: _____ Years of Education: _____

Street Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____ County: _____

Mailing Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____ County: _____

Email address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact Name: _____ Emergency Contact Number: _____

Parent/Guardian Name (if patient is a minor): _____

Name of Employer/School: _____

Name & Phone Number of Primary Care Physician: _____

Allergies: _____ Reaction: _____

_____ Reaction: _____

_____ _____
Client Signature Date

Clayton County Health District-Ryan White

Declaration and Insurance Verification

Some programs offer reduced fees based on income. To apply for a reduced fee, please provide the following information (Family Planning, STD, & Health Checks for Children):

Number of family members in the household: _____

Total family income: $ _____ [ ] Week [ ] Month [ ] Year

Self-Declared Income: _____
(Family Planning or STD only)

OR

Proof of Income: [ ] Pay Stub [ ] W2 [ ] Social Security Verification [ ] Other (explain) _____

Do you have health insurance? [ ] Yes [ ] No

Client has health insurance coverage with the following: (Check ALL that apply)

- ☐ Medicaid
- ☐ Wellcare
- ☐ Peachstate
- ☐ Amerigroup
- ☐ Medicare
- ☐ Private Insurance _____
  Name of Insurance Provider
- ☐ Patient does not have health insurance

Client does not have health insurance due to the following: (Check all exclusions that apply)

- ☐ I am a Native American receiving healthcare services through the Indian health service or tribunal organization.
- ☐ I am in a period of exclusion under my health insurance plan.
- ☐ I have exhausted my lifetime limits under my insurance plan.
- ☐ I have limited scope coverage such as dental, vision, long term care or coverage for specific illnesses, not including family planning and/or breast and cervical cancer screening.
- ☐ I have health insurance via a self-insured company that does not provide coverage for family planning and/or cervical cancer screening.

I verify that the information I have given above is current and accurate. I understand that I may be asked to provide written proof of any insurance exclusion as indicated above. I understand that qualifying for any special discounted fees will be based upon the information regarding my income and number of dependents as listed above. I understand that if I have insurance or fail to disclose insurance information, I will be held responsible for payment of services provided.

My signature below indicates that I have either read or had read to me the above regulations. I had an opportunity to ask questions and understand the guidelines as listed above.

_____ _____
Client Signature Date

OFFICE USE ONLY: Income Verified, Self-Declared at _____%

_____ _____
CCHD Witness (Employee) Date

Notice of Privacy Policies for Clayton County Health District
Signature Page

- ☐ I have had an opportunity to read/or request the Notice of Health Information practices from Clayton County Health District.
- ☐ I prefer to limit the disclosure of my health information and desire to speak with the Clayton County Health District Privacy Officer.

_____ _____

Signature Date

If signed by someone other than the client, please state relationship to client.

_____

I _____ gave the Notice of Health Information Practices to
(EMPLOYEE NAME)

_____ on _____ and he/she
(CLIENT NAME) (DATE)

refused to sign the acknowledgement receipt.

FINANCIAL RESOURCES

1. Client Information

Name: _____
Last First MI

Address: _____
Street Address City State Zip County

Phone Number: _____ Social Security # _____

Date of Birth: _____ Race: _____ White _____ Black _____ Other

Marital Status: _____ Single _____ Married _____ Widowed _____ Separated

U.S. Citizen: [ ] Yes [ ] No GA Resident: [ ] Yes [ ] No _____ Years _____ Months

2. Insurance Information

Medicaid	Yes	No	Pending
Medicare Part A	Yes	No	Pending
Medicare Part B	Yes	No	Pending
Private Health Insurance	Yes	No	Pending

If Private Insurance:

Name of Company: _____

Policy/Group Number: _____

Any other benefit programs? _____

3. **Household Members** (Include parents if client is a minor)

Name	Age	Relation to Client	Gross Income per Month	Source

4. **Client Expenses**

Source of Debt	Yes	No	Amount
Rent/Mortgage			
Utilities			
Telephone			
Car Payment/Car Insurance			
Health/Life Insurance			
Hospital Bills			
Doctor Bills			
Child Support/Alimony			
Other			
Other			

Total Monthly Expenses $_____

NOTE: Income includes wages, rental income from apartments or boarders, child support, alimony, pensions, etc. Attach a paycheck stub for the last four weeks, most recent W-2, or notarized statement from employer verifying income. If applicable, attach statements of child support payments, public assistance award letter, Social Security Income letter, and form from unemployment check, etc. If no income is listed, explain how living expenses are met.

By signing this statement, I verify that the above information is correct to the best of my knowledge.

_____ _____

Client's Signature Date

_____ _____

Witness (Name and Title of CCHD Employee) Date

Clayton County Health District

Ryan White Sliding Scale Fee Application Form

Client Name: _____ Date: _____

Name of wage earners in the household:

_____

_____

_____

_____

Billing Address: _____

City: _____ State: _____ Zip: _____

Driver's License #: _____ SS#: _____

Number of Family Members: _____

Combined Annual Income: _____

Documents provided by client to prove income:

_____

_____

The Clayton County Health District staff member has explained to be my financial responsibility. My percentage of discount from Clayton County Health District's full fee is _____% based on my current income and family size. My 6-month period of eligibility starts on _____. I will need to be re-determined for this program on the 6-month anniversary date which is _____. I understand I must bring in more current documentation at that point.

_____ _____

Client Signature Date

_____ _____

CCHD Representative Signature Date

CCHD Ryan White

Sliding Scale Fee Policy
Notice to Clients

This practice serves all patients regardless of ability to pay. Discounts for essential services are offered depending upon the family size and income.

Please bring proof of income with you to each visit.

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Política de tarifas de escala móvil
Aviso a los pacientes

Esta práctica sirve a todos los pacientes independientemente de su capacidad de pago. Se ofrecen descuentos por servicios esenciales dependiendo del tamaño de la familia y los ingresos.

Por favor, traiga un comprobante de ingresos con usted a cada visita.

Name: _____ Date: _____

IN THE LAST THREE (3) MONTHS, HAVE YOU EXPERIENCED:	YES	NO	COMMENTS
Weight Loss			
Weakness /Fatigue			
Fever, chills, night sweats			
Lymph node enlargement			
Mouth infections of any kind			
Painful or bleeding gums			
Long-lasting sores on lips			
Visual disturbances			
Cough			
Shortness of breath			
Loss of appetite			
Painful or difficulty swallowing			
Nausea/vomiting			
Abdominal distention (abdominal bloating)			
Diarrhea			
Rectal or anal problems			
Hepatitis A, B, C, or jaundice			
Intestinal parasites			
Unusual bleeding or bruising			
Headache			
Difficulty concentrating			
Confusion			
Change in mental ability			
Seizures			
Depression			
Numbness/tingling			
Shingles (herpes zoster)			
Any new rash or skin discoloration			
Any skin problems that worry you			
PAST HISTORY			
Do you have any chronic illnesses?			
Have you ever had surgery?			
Have you ever received a blood transfusion?			
Are you taking any medications now?			

Infectious Disease Control
Client Information Sheet

I am HIV+ [ ] YES [ ] NO Approximate Date of Test _____

I was infected through: (Check all that apply)

- ☐ Homosexual Contact
- ☐ Hemophilia Treatment
- ☐ Heterosexual Contract
- ☐ IV Drug Use
- ☐ Blood Transfusion
- ☐ Congenitally (infants only)
- ☐ Other

Physician's Name: _____ Phone Number: _____

Preferred Hospital: _____ Phone Number: _____

Have you been on any HIV medications? [ ] YES [ ] NO

1st Combination

1. _____
2. _____
3. _____

2nd Combination

1. _____
2. _____
3. _____

3rd Combination

1. _____
2. _____
3. _____

4th Combination

1. _____
2. _____
3. _____

GEORGIA DEPARTMENT OF PUBLIC HEALTH
Clayton County Health District

Client Name	
Date of Birth	
Medical Records #	**SSN #**

AUTHORIZATION TO RELEASE INFORMATION

I hereby request and authorize: _____
(Name of Person/Agency Requesting Information)

_____
(Address)

to obtain from: _____
(Name of Person/Agency Requesting Information)

_____
(Address)

The following type(s) of information from my records (and any specific portion thereof).

_____

_____

for the purpose of: _____

_____

*I understand that the federal Privacy Rule (HIPAA) does not protect the privacy of information if re-disclosed, and therefore request that all information obtained from this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for benefits, treatment, or payment is not conditioned upon my provision of this authorization. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for: (**PLEASE CHECK ONE**)*

- ☐ *Ninety (90) days unless I specify an earlier expiration date here: _____*
- ☐ *One (1) year*
- ☐ *The period necessary to complete all transactions on matters related to services provided to me.*

I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.

_____ _____
(Signature of Client) (Date)

_____ _____
(Signature of Witness/CCHD Staff) (Date)

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

_____ _____
(Signature of Client) (Date of Withdrawal)

Ryan White Part B Program
Private Insurance Enrollment Screening Form

Client Name _____ Client ID# _____

Employee Name _____

Enrollment Screening

Y	N	N/A	
☐	☐	☐	**Client was informed about other health insurance options.** Date of Encounter: _____
☐	☐	☐	**Client was referred to a Health Insurance Marketplace Enrollment Assistance location in their area.** Date of Encounter: _____
☐	☐	☐	**Is the client eligible for insurance through the Health Insurance Marketplace?** If no, is the client's income at or below 99% FPL? Yes [ ] No [ ] (If yes, proof of income required. If no, please explain below). Date of Encounter: _____
			Does the client have a certificate of exemption? Yes [ ] No [ ] (If yes, copy of exemption required. If no, please explain below.
☐	☐	☐	**Client will be enrolled or re-certified into Ryan White Part B/ADAP.** If yes, and the client is eligible for a health insurance plan, please explain why in the Notes section. If no, and the client has an income at or below 99% FPL or has a certificate of exemption, please explain why in the Notes section. Date of Encounter: _____

Notes

_____ _____

Client Signature Date

_____ _____

CCHD Representative Date

Clayton County Health District
Ryan White Clinic
Client Agreement Policy

1. **ELIGIBILITY**
   Any person residing in Clayton County who is HIV positive is eligible for services. Clients outside this area will be considered on individual request. All new patients who present to the clinic requesting HIV services must present one of the following documents: Positive HIV test results, Viral Load, or CD4 report.

   The Clayton County Health District 3-3 does not refuse services based on sex, age, religion, race, economic status, sexual orientation, or mode of transmission.

2. **SERVICES**
   - Case management: all clients are assessed, and care plans established.
   - Social services
   - Mental Health/Substance abuse counseling referrals, when needed.
   - Nutritional evaluation and counseling
   - Medical services: all eligible clients will have a medical evaluation
   - Financial assistance for labs, medication, and doctor's visit, per Ryan White guidelines of policy and procedures.
   - Housing assistance
   - Peer and client education
   - Outreach opportunities/community involvement

3. **CLIENT'S RIGHTS & RESPONSIBILITIES**
   This statement of Client's Rights and Responsibilities is designed to enable clients to act on their own behalf and in partnership with Clayton County Health District-Ryan White Staff to obtain the best possible HIV/AIDS care and treatment. Clients newly entering or currently accessing care, treatment, or support services for HIV/AIDS have the following rights and responsibilities.

   Client's Rights
   a. Clients have the right to be informed of the services the Ryan White Clinic provides how to obtain such services, and the reason for services not being provided.
   b. Clients have the right to choose whether to apply for assistance through this program.
   c. Clients have the right to receive the services needed; these my or may not include all the services desired.
   d. Clients have the right to receive considerate, dignified, and respectful care and treatment by all CCHD personnel.
   e. Clients have the right to refuse service or to terminate participation without recrimination.
   f. Clients have the right to expect the agency will maintain confidentiality of all information in charts and records pertaining to the services received, except as otherwise required by law (unless it involves suicide, homicide, abuse of a child or incapacitated adult or specific danger to others). This does not apply to statistical data, which may be required by funding agencies.

   Client's Responsibilities

   a. Clients are responsible for bringing proof of income to every medical assessment visit.
   b. Clients are responsible for making and keeping appointments for medical assessments every 3 months.
   c. Clients are responsible for notifying the CCHD-Ryan White staff in advance if they must cancel an appointment. After 3 failed appointments, client will be contacted to discuss barrier to care.
   d. Clients are responsible for providing, to the best of their knowledge, accurate and complete information about current and past health and illness, medications, and other treatment and services affecting their care.
   e. Clients are responsible for informing the clinic or staff of any hospital admission or visit to the emergency room.
   f. Clients are responsible for keeping appointments and commitments at this agency or inform the agency promptly if you cannot do so.
   g. Clients are responsible for following the agency's rules and regulations regarding patient/client care and conduct.
   h. Clients are responsible for being considerate of and respectful to the staff and fellow clients.

i. Clients are responsible for refraining from use of profanity, abusive or hostile language; threats, violence or intimidation; carrying weapons of any sort; theft or vandalism; intoxication or use of illegal drugs; sexual harassment and misconduct.
j. Clients are responsible for maintaining the confidentiality of other clients receiving care or services at the agency by respecting their right to privacy and confidential services, and for keeping confidential information they may obtain while at CCHD-Ryan White (such as the identity of other CCHD clients or personal information discussed in groups).
k. Clients are responsible for informing the clinic or staff whenever they do not understand information they are given.
l. English is the primary language of our clinic. If a client does not speak, read, or write English, translation will be made available. If a translator is needed, the clinic staff must be notified 7 days in advance.
m. Clients should be aware that there is a Grievance Policy that can be obtained at the CCHD-Ryan White clinic.
n. Clients have a responsibility to follow through on actions as agreed upon in his/her individual client service plan.

4. INVOLUNTARY SUSPENSION OF SERVICES

When a client engages in behavior which impedes the agency's ability to provide services to that person or other clients, involuntary suspension may be necessary. Clients may be suspended under circumstances where the clients do not cooperate in the context of the CCHD-Ryan White Guidelines.

Reasons for suspension may include but are not limited to the following:

1. Aggressive or abusive behavior toward other clients, volunteers, or staff members.
2. Behavior that infringes on other clients' ability to receive CCHD-Ryan White services.
3. Behavior or mental status that interferes with the CCHD-Ryan White ability to provide services.
4. A medical diagnosis indicating the client is not HIV+ (does not have AIDS) and that no further medical testing is warranted.
5. Inability or unwillingness to follow rules.
6. Failure to keep appointments or follow through with recommendations.

Prior to suspension, whenever possible, appropriate staff will meet with the client and establish a written probationary contract under which the client may continue to receive services.

5. PAYMENT OF SERVICES

The maximum annual cumulative charges to an individual for HIV related services are based on the Federal Poverty Guidelines. Service fees are based client's income, using a sliding scale. Services will not be denied due to client's inability to pay. CCHD-Ryan White does not file Medicaid and Medicare. Clients will be responsible for filing their own private insurance claims.

The client is responsible for keeping up with their charges and letting the CCHD-Ryan White staff know when they have reached their billing percent limit, so they will no longer be charged.

I have read the CCHD-Ryan White Client Agreement Policy and have had my questions answered to my satisfaction. I agree to the policy and desire medical services through Ryan White Program at the Clayton County Health District.

_____ _____

Client Signature Date

_____ _____

Signature of CCHD-Ryan White Representative Date

Clayton County Health District
Ryan White Client Grievance Procedure

1. A client must file his/her complaint in writing to the Ryan White Program Coordinator or representative within ten (10) business days regarding the disagreement or receiving notice that they are no longer enrolled in the program.
    a. The written complaint must state the nature of the concern and the desired resolution.
    b. The complaint is reviewed by HIV/AIDS Consortium members and answered in writing within thirty (30) business days of its receipt, with a copy to the Infectious Disease Coordinator. If further information is needed from the client, then the client has five (5) business days to provide this information. The appeal is then answered within thirty (30) business days after receipt of the information.
    c. Failure to file a written appeal within ten (10) business days of the complaint or removal from the program, or failure to respond to the request for further information within five (5) business days waives the right to appeal.

2. If the client is dissatisfied with the decision in Step 1, he/she may submit the same complaint to the District Health Director within five (5) business days of the receipt of the initial decision.
    a. Step 2 of the complaint must be submitted in writing specifying the nature of the complaint, the outcome desired, and stating hat the first step of the procedure has been followed.
    b. The District Health Director may appoint a review committee. Members of this committee cannot be Case Managers of the Ryan White Program. The committee will notify the client in writing of its decision, with a copy to the Ryan White Program Coordinator, within ten (10) business days of receiving the request to review the decision.
        i. However, if further information is needed from the client, the client has five (5) business days to supply it. The committee reviews this information and notifies the client of its decision within ten (10) business days of receipt of this information, with a copy to the Ryan White Program Coordinator.
        ii. Failure to respond to the request for further information within five (5) business days waives the right to appeal.

3. If the client is dissatisfied with the decision in Step 2, he/she may submit the same complaint to the state level HV/AIDS Care Service Manager in the Prevention Services Section, within five (5) business days of the appellate decision.
    a. Step 3 of the complaint must be submitted in writing specifying the nature of the complaint, the outcome desired, and stating that the second step of the procedure has been followed.

I have read the CCHD-Ryan White Grievance Policy and have had my questions answered to my satisfaction. I agree to the policy and am aware of the steps I must take in order to make a complaint.

_____ _____

Client Signature Date

_____ _____

Signature of CCHD-Ryan White Representative Date