FAP
FOOTHILL
AIDS PROJECT

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fax (909) 482-2070

362 Orange Show Lane
San Bernadino, CA 92408
(909) 884-2722
fax (909) 884-2732

www.fapinfo.org

Dear Client,

Welcome and thank you for your interest in Foothill AIDS Project's Case Management program and other services. We are here to serve persons affected by HIV/AIDS who live in the far San Gabriel Valley in Los Angeles County and the western part of San Bernardino County.

Enclosed is a packet of registration forms for you to complete. Please return them to the office as soon as possible. If you need assistance with completing these forms please call the office Monday through Friday between 9 a.m. and 5 p.m.

Foothill AIDS Project offers a variety of services including case management, mental health support, food programs, housing assistance, transportation to medical appointments, public benefits counseling, treatment advocacy, family support and referrals for medical care, home health services, and substance abuse programs.

If you have any questions or need more information concerning the registration packet, or any of Foothill AIDS Project's services, please contact the office at (909) 482-2066.

Sincerely,

Maritza Tona

Executive Director

Enclosures: Registration Packet

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NEW CLIENT APPOINTMENT ✓CHECKLIST

Please bring the following items to your appointment:

✓A valid photo identification card

✓Medical insurance card *(i.e. Medi-Cal, Medicare, private insurance)*

✓Proof of your current income *(or your parent or guardian's)* dated within the last three months such as bank statement, copy of check, Social Security award letter.

✓Any document which shows your *(or your parent or guardian's)* current address such as utility bill, bank statement.

✓Verification of diagnosis

Your first appointment with a case manager will take 60-90 minutes.

INTAKE/ORIENTATION DATE:_____

SERVICES REQUESTED

Foothill AIDS Project and other community resources may be able to assist you with the following services. Please check the services you are interested in. We understand that your needs may change in the future.

- ○ Case Management - Ongoing assistance with information, referrals, and coordination of services.
- ○ Mental Health – Individual adult, child, couple, family counseling, and support groups.
- ○ Adult Groups – parent empowerment, women support, heterosexual support and or other.
- ○ Family Support – child or adolescent groups, emotional support, recreational, educational support.
- ○ Food Programs - Referrals to food banks and home delivered meals.
- ○ Insurance Counseling - Private health and disability benefits.
- ○ Legal Assistance - Wills, powers of attorney, discrimination.
- ○ Medical Care - Referrals to health care providers, dentist, and home health care.
- ○ Public Benefits Counseling - County, State, and Federal programs.
- ○ Transportation - Transportation to medical appointments, case management, & food appointments.
- ○ Treatment Advocacy - Information about HIV disease and medical treatments.
- ○ Substance Abuse Concerns - Counseling, treatment.
- ○ Child and respite care
- ○ Move-in and utilities assistance
- ○ Alternative Therapies
- ○ Other: _____
  _____
- ○ What services are you currently receiving through other providers? _____
  _____

CLIENT REGISTRATION FORM

HIV RISK FACTORS

- ○ Blood Transfusion
- ○ Homosexual/Bisexual Contact
- ○ Intravenous (IV) Drug Use
- ○ Homosexual/Bisexual Contact & IV Drug Use
- ○ Heterosexual Contact
- ○ Hemophilia
- ○ HIV+ Parent

CURRENT DIAGNOSIS

- ○ HIV+ No Symptoms
- ○ HIV+ Symptomatic
- ○ AIDS
- ○ No HIV

THOSE THAT APPLY

- ○ Perinatal Transmission
- ○ Deaf/Hard of Hearing
- ○ Physically Challenged
- ○ Blind/Partially Sighted
- ○ Homeless

I am requesting assistance from Foothill AIDS Project, and hereby certify that the information I have provided is true and correct.

_____ _____/_____/_____
SIGNATURE OF CLIENT *(Parent's or guardian's if under 18 years of age)* DATE

_____ _____/_____/_____
CASE MANAGER/FAMILY SUPPORT SPECIALIST DATE

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NEW CLIENT REGISTRATION FORM

CLIENT INFORMATION

Name _____ ❑Male ❑Female Date of Birth _____/_____/_____

Address _____ Place of Birth/Country _____ Religion _____

City _____ Zip Code _____ State _____ Phone ( )_____-_____

May we send you mail with agency logo? ❑Yes ❑No May we leave phone messages? ❑Yes ❑No

Person(s) we may leave message with?: _____

Social Security # _____-_____-_____ Marital Status ❑ Married ❑ Single ❑ Living with Partner

Ethnicity _____ Primary Language _____ Other Languages _____

Last Grade Completed in School _____ Mother's Maiden Name _____

Do you have children? ❑ Yes ❑No Names & Ages of Children _____

How many people live with you? _____

EMERGENCY INFORMATION

Name _____

Address _____

City _____

Phone _____

Relationship _____

Does this person know you are HIV+? ❑YES ❑NO

Name _____

Address _____

City _____

Phone _____

Relationship _____

Does this person know you are HIV+? ❑YES ❑NO

INCOME & EMPLOYMENT

Occupation _____ Employer _____

Are you interested in job re-training placement? ❑Yes ❑No Monthly income _____

WORK INSURANCE
- ❑ Full time
- ❑ Part time
- ❑ Temporary medical disability
- ❑ Permanent medical disability
- ❑ Unemployed
- ❑ Retired
- ❑ Student/dependent

BENEFITS RECEIVED
- ❑ State Disability Insurance
- ❑ Social Security Disability
- ❑ General Relief
- ❑ AFDC/Cal Works
- ❑ VA benefits
- ❑ Private Disability Insurance
- ❑ Other

HEALTH
- ❑ Medi-Cal
- ❑ Medicare
- ❑ Group Insurance
- ❑ Individual insurance policy
- ❑ HMO
- ❑ None/Self Pay

MEDICAL CARE

Medical Provider _____ Phone ( ) _____-_____

Address _____ City _____ State _____ Zip _____