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Client ID:_____

## WNCAP Syringe Services Community Navigation Intake

Date:___/___/_____

Legal Name:_____ Preferred Name:_____

Gender Identity:_____ DOB:___/___/_____

Primary Phone:_____ Secondary Phone:_____

VM Permission: Y / N | Text: Y / N VM Permission: Y / N | Text: Y / N

Email:_____

County of Residence:_____ Address:_____

Employed: Yes / No _____

Emergency Contact:_____ Phone:_____

Relation:_____ May we contact this person if we cannot reach you: Yes / No

## Initial STD Screening

Date:___/___/_____

HIV: Reactive / Nonreactive /Self Reported Care Coordination: Yes / No

HCV: Reactive / Nonreactive /Self Reported Refused Testing ☐

Confirmatory Test Notes:

_____

_____

_____

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Client ID:_____

| | |
|---|---|
| Insured: Yes / No | Insurance Provider: _____ |
| Insurance ID: _____ | Deductible: _____ |
| Co-Pay: _____ | |

**Services/ Referrals Provided**

- ▫ Safer Injection Supplies
- ▫ MAT / MOUD
- ▫ Recovery Support
- ▫ Behavioral Healthcare
- ▫ Medical Healthcare
- ▫ Safer Use Guidance
- ▫ Sexual Health Items
- ▫ Wound Care Education
- ▫ ID Assistance
- ▫ Unemployment Benefit Assistance
- ▫ Employment Assistance
- ▫ PreP
- ▫ HCV Care
- ▫ WNCAP MCM
- ▫ Overdose Response Training
- ▫ Overdose Reversal Kit
- ▫ Program Enrollment
- ▫ Bad Date Referral
- ▫ Health Insurance/ Medicaid Enrollment
- ▫ Food/ Nutrition Assistance
- ▫ Legal Referral
- ▫ Other (Please include notes)

**Intake Notes/ Action Plan:**

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Client ID:_____

# HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

**I. My Authorization**

I authorize the following using or disclosing party:

Western North Carolina AIDS Project (WNCAP)

**to use or disclose the following health information.**

☐ - All of my health information

☐ - My health information relating to the following treatment or condition:

_____

☐ - My health information covering the period from _____ (date) to _____ (date)

☐ - Other: _____

**The above party may disclose this health information to the following recipient:**

Organizations deemed necessary for the requested resources and/ or treatment.

**The purpose of this authorization is (check all that apply):**

☐ - At my request

☐ - Other: _____

**This authorization ends:**

☐ - On (date)_____

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Client ID:_____

☐ - When I or WNCAP terminates my relationship as a client.

**II. My Rights**

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

**Signature of Patient**: _____

Date: _____

**If the patient is a minor or unable to sign, please complete the following:**

☐ - Patient is a minor: _____ years of age

☐ - Patient is unable to sign because: _____

**Signature of Authorized Representative**: _____

Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:

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Client ID:_____

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____

**III. Additional Consent for Certain Conditions**

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

**Signature of Patient or Authorized Representative**: _____

Date: _____ Time: _____

**IV. Additional Consent for HIV/AIDS**

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

**Signature of Patient or Authorized Representative**: _____

Date: _____ Time: _____

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Client ID:_____

Date: _____

Transportation Agreement

**TRANSPORTATION POLICY**

- All transports must be arranged at least 24 hours in advance unless otherwise approved by the HRed Coordinator
- Transports are only meant for medical, legal, and/or resources.
- Only one enrolled client can be in the vehicle at a time.
- No emergency room transportation can be provided.
- Transportation is limited to a reasonable area of distance from Community Naavigator's base office
- Absolutely no substances or weapons are to be in the vehicle, brought by the client or CN. This is to ensure the safety of both the client and CN.

**By signing this I certify that I have read and understand the WNCAP Transportation Policy and agree to the limitations and requirements therein.**

**Client Signature:**_____

**Date:**_____

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Client ID:_____

I have participated in the creation of this plan for my care. I understand that I must take responsibility for my plan in order for the plan to succeed. My Community Navigator has explained to me what portions of this plan I am solely responsible for and those that my Community Navigator will assist me with. I agree to do my best to follow all aspects of this plan to the best of my ability and advise my Community Navigator if there are significant changes in my life that would make it necessary to change my action plan. I agree to stay in contact with my Community Navigator to the best of my ability.

Client Signature: _____ Date:_____

Community Navigator Signature:_____ Date:_____

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Client ID:_____ Date:_____

# Community Navigation Notes

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Client ID:_____ Date of creation:

# Prioritized Needs List

| Need | Organization(s) |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |
| 7. | |
| 8. | |
| 9. | |
| 10. | |

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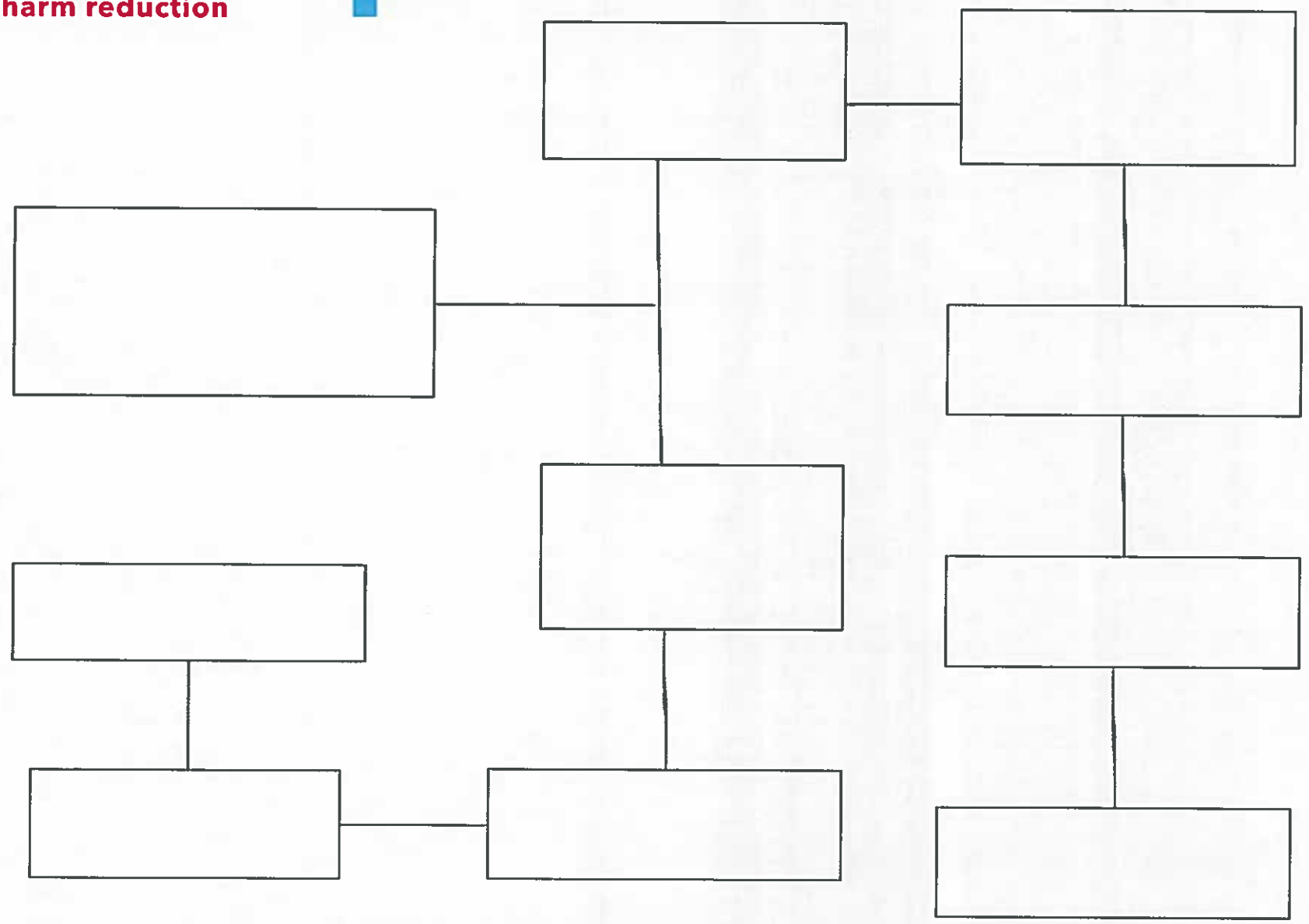
# Action Step Flow Chart

Client ID:_____



# TESTING LOG

Client ID:_____

| Test(s) | Date | Result | Next testing date |
|---|---|---|---|
| | | | |
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# Care Coordination Referral Form

## Patient Referral & Intake

- ☐ AMCHC Dale Fell, Phone: (828) 772-4788, Fax (828) 407-4581
- ☐ Jackson County DHHS, Bridge Counselor, Phone: (828) 586-8994, Fax: (828) 586-3493
- ☐ Mission Infectious Disease Associates, Phone: (828) 213-7660, Fax: (828) 258-9682
- ☐ MAHEC Biltmore, Phone: (828) 257-4730, Fax: (828) 257-4729
- ☐ Other (please specify):_____

**Referral for:**

- ☐ Hepatitis C: ☐ tested by WNCAP or ☐ self-reported
- ☐ PreP ☐ Other:(please specify):_____

**Patient Demographic Information**

**Name:**_____ **DOB:**____/____/_____

**Phone Number:**(____) _____

**Street Address:**_____

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

**Gender:** ☐ Male ☐ Female ☐ Transgender ☐ M2F ☐ F2M

**Race:** ☐ Black ☐ White ☐ Native American ☐ Asian ☐ Pacific Islander ☐ Other:_____

**Ethnicity:** ☐ Hispanic ☐ Non-Hispanic

**Insurance Status:** ☐ Insured ☐ Non-Insured ☐ Unknown

**Type of Insurance (if insured):** ☐ Commercial ☐ Medicaid ☐ Medicare ☐ Both

**Please check any of the below boxes that apply to you with the past 12 months:**

☐ sex w/ male ☐ sex w/ female ☐ injection drug use ☐ sex w/ multiple people

My signature below certifies that I understand the terms of this authorization to release and/or obtain information. I understand my right to confidentiality is protected under federal and state law. I understand the information to be release and/or obtained; purpose for the authorization; length of time the authorization is in effect; to whom the information will be released and/or obtained; and that the information will include, as applicable, records pertaining to HIV/AIDS, alcohol and drug use, and psychiatric status. Re-disclosure of my records by those receiving the above authorized information may be accomplished without my further written authorization. **I also understand that certain information must be released under federal and state law without my consent or authorization.** I acknowledge that his authorization is voluntary and valid. I understand that it is my right to revoke this authorization at any time, except to the extent that action based on this authorization has been taken. I understand that a copy of the authorization is as effective as the original.

I understand that I will be contacted by the Referral Source/Contact Person listed below periodically throughout the treatment process for case management purposes, including treatment adherence check-ins, medication assistance, and/or transportation assistance.

**I understand that this authorization will expire 365 days from the date it is signed unless I have specified a different expiration date or expiration event as follows:**_____

Client/Guardian Signature:_____ Date:____/____/_____

Client Date of Birth:____/____/_____ If Minor, Guardian Relationship:_____

Witness Signature:_____ Date:____/____/_____

**Referral Source:** Organization: **WNCAP** Contact Person: **Taylor Walls**

Phone: **(828) 335-9015** Fax: **(828) 274-4483** Email: twalls@wncap.org