

Maricopa County
Ryan White Part A
New Client Information

Date: _____ Agency: _____

Name: _____

Eligibility Address: _____ City/St/Zip: _____

Eligibility County: Maricopa Pinal Date of Birth: _____ Gender: M / F Other: _____

Race/Ethnicity: Check all that apply

<input type="checkbox"/> Hispanic		
<input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Other
<input type="checkbox"/> Black or African-American	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian or Pacific Islander

Risk Factors: Check all that apply

<input type="checkbox"/> Male who has sex with male(s)	<input type="checkbox"/> Heterosexual contact	<input type="checkbox"/> Receipt of transfusion of blood, blood components, or tissue
<input type="checkbox"/> Injected drug use	<input type="checkbox"/> Perinatal transmission	<input type="checkbox"/> Other _____
<input type="checkbox"/> Hemophilia/coagulation disorder		

HIV Related Diagnosis:

Diagnosis	Date of 1 st Diagnosis	State of Diagnosis
<input type="checkbox"/> HIV+		<input type="checkbox"/> In Arizona <input type="checkbox"/> Other State
<input type="checkbox"/> Aids		<input type="checkbox"/> In Arizona <input type="checkbox"/> Other State
<input type="checkbox"/> HIV- /Affected/ Undetermined		<input type="checkbox"/> In Arizona <input type="checkbox"/> Other State
<input type="checkbox"/> Never Tested		

HIV Related Treatment Status:

Primary Care Physician: _____ Date of Last Visit: _____
Current Medications: _____

Clinical Review	Test Date	Results
CD4 Count		
Viral Load		

Primary Source of Medical Insurance:

<input type="checkbox"/> Private	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid (AHCCCS)
<input type="checkbox"/> Other Public	<input type="checkbox"/> No Insurance	<input type="checkbox"/> Other: _____

Primary HIV Medical Care is Received at:

<input type="checkbox"/> Public funded clinic	<input type="checkbox"/> Private Practice Physician	<input type="checkbox"/> Hospital Outpatient Center
<input type="checkbox"/> Emergency Room	<input type="checkbox"/> No primary source of care	<input type="checkbox"/> Other: _____

Housing/Living Arrangement:

<input type="checkbox"/> Permanent Housing	<input type="checkbox"/> Institution
<input type="checkbox"/> Non-Permanent Housing	<input type="checkbox"/> Other

Household Information:

Household Size: _____	Annual Household Income: _____
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Contact Information:

Mailing Address (If Different than above): _____
City/St/Zip: _____ Phone Number(s): _____
Emergency Contact(s), Name and phone number(s): _____
