## INDIANA ALL PARTS: INITIAL AND RE-ENTRY CHECKLIST (OPTIONAL)

## Remember to enter the client information into RWISE the <u>same day</u> the services is being provided.

ADMINISTRATIVE INFORMATION (required)								
RWise ID (if applicable)			Type of visit during which eligibility				☐ In person	
HIVe ID (if applicat	ole)		information was collected				□ Virtual	
Moved to Indiana in	n □ Yes		Newly diagnosed with HIV in past 90				☐ Yes	
past 90 days?	□ No		days?			□ No		
,								
APPLICANT INFORMATION (required)								
Legal First Name			Preferred First Na	ame				
Legal Last Name			Preferred Last Name					
Legal Middle Name	•		Preferred Middle Name					
Date of birth			Preferred pronoun		☐ He/him		☐ They/their	
(MM/DD/YYYY)					□ She	her/	☐ Other	
Current self-	□ Male	☐ Transgender –	male to female			□ Male		
reported gender	☐ Female	<ul><li>□ Female</li><li>□ Transgender – female to male</li><li>□ Unknown</li><li>□ Transgender – other</li></ul>		female to male Sex at		☐ Fema	ıle	
identity	☐ Unknown				☐ Declined to answer		ned to answer	
In what language w	rould the applicant	nrefer to receive	□ English					
In what language would the applicant prefer to receive information about health and services?			□ Spanish					
			☐ Other:		T			
Legal United States resident (includes Visa, Green Card)								
Note: United State	s rosidonov is not	roquiroment for all co				□ Yes		
<b>Note:</b> United States residency is not a requirement for all se required for health insurance enrollment through selected he								
•		Number (SSN) or Indi						
Identification Numb			☐ Yes, please include:					
			□ No					
Note: SSN is not used for eligibility determination.								
Housing status	Stable/permanent   Temporary   Unstable							
_	ousing status date collected (MM/DD/YYYY):							
Current home address (address at Street Address including apartment number:								
where the individual sleeps most		<b>A</b> 11						
often)		City:						
Note: PO Box is not acceptable to		State:						
establish residency.		ZIP code:						

Can the applicant receive hard copy mail at			☐ Yes	Are the home address and mailing address the	☐ Yes				
this address?		□ No	same?	□ No					
Current mailing address (if different		PO Box/Street Address:							
than home addre	ss)	City:							
		State:							
Note: PO Box is		ZIP code:							
mailing purposes									
Preferred method of contact		☐ Phone:							
(choose all that apply)		Can a message be left? ☐ Yes ☐ No							
		□ Email:							
		□ Other:							
	ALT	TERNATE (	CONTACT	INFORMATION (required)					
	Name:								
	Phone number:								
Client alternate	Does this person	Does this person know applicant's HIV status?							
contact	□ Yes								
	□ No								
	Agency:								
Non-Medical	Name:								
Case Manager	Phone number:								
	E-mail address:								
	Clinic name:								
Doctor	Name: Phone number:								
		STAT	EMENT OF	FACT (optional)					
Please describe a	any/all information th	at may be	difficult to ca	apture with the application alone.					

## **NEW APPLICANTS ONLY**

		DEMOGRAPHIC INFORMA	TION			
	☐ H belov	ispanic/Latino/a (Choose all that apply in l	list	□ Non-Hispanic/Latino/a		
Ethnicity (choose <u>one</u> )	<ul> <li>□ Mexican, Mexican American or Chicano/a</li> <li>□ Declined to answer</li> <li>□ Puerto Rican</li> <li>□ Cuban</li> <li>□ Other Hispanic, Latino/a or Spanish origin</li> <li>□ Declined to answer</li> </ul>					
	□ A	merican Indian or Alaskan Native	<ul> <li>□ Native Hawaiian or Pacific Islander (choose all that apply in list below)</li> </ul>			
Race (choose <u>all</u> that apply)	☐ Asian (choose all that apply in list below) ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese			<ul> <li>□ Native Hawaiian</li> <li>□ Guamanian or Chamorro</li> <li>□ Samoan</li> <li>□ Other Pacific Islander</li> <li>□ Declined to answer</li> </ul>		
(enesse <u>un</u> that apply)		<ul><li>☐ Korean</li><li>☐ Vietnamese</li></ul>	☐ White			
	☐ Other Asian ☐ Declined to answer		☐ No race reported			
		lack or African American	☐ Declined to answer			
		DIA CNOCIC INFORMATIO	ON!			
HIV/AIDS Status		DIAGNOSIS INFORMATIO				
TIIV/AIDS Status		☐ HIV positive, not AIDS		CDC-defined AIDS		
Note: once an HIV indeterminate infant client is confirmed to be HIV negative, he/she must be reclassified as an HIV negative (affected) client.		Diagnosis Date (MM/DD/YYYY):		Diagnosis Date (MM/DD/YYYY):		
		☐ If this date is estimated, check here		☐ If this date is estimated, check here		
		☐ HIV positive, AIDS status unknown Diagnosis Date (MM/DD/YYYY):		HIV indeterminate (infants less than 2		
				years only)		
				HIV negative (affected)		
		☐ If this date is estimated, check here				
HIV risk factor at time of HIV diagnosis (choose all that apply)		V ☐ Male to Male Sexual Contact (MSM) ☐ Injection Drug Use (IDU) ☐ Hemophilia/coagulation disorder ☐ Heterosexual Contact		Receipt of blood transfusion Perinatal Transmission		
				☐ Risk factor not reported or not identified		