

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

**Remember to enter the client information into RWISE the same day the services is being provided.**

**ADMINISTRATIVE INFORMATION (required)**

RWise ID (if applicable)		Type of visit during which eligibility information was collected	<input type="checkbox"/> In person
HIVE ID (if applicable)			<input type="checkbox"/> Virtual
Moved to Indiana in past 90 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Newly diagnosed with HIV in past 90 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**APPLICANT INFORMATION (required)**

Legal First Name		Preferred First Name	
Legal Last Name		Preferred Last Name	
Legal Middle Name		Preferred Middle Name	
Date of birth (MM/DD/YYYY)		Preferred pronoun	<input type="checkbox"/> He/him <input type="checkbox"/> They/their <input type="checkbox"/> She/her <input type="checkbox"/> Other
Current self-reported gender identity	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	<input type="checkbox"/> Transgender – male to female <input type="checkbox"/> Transgender – female to male <input type="checkbox"/> Transgender – other	Sex at birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined to answer
In what language would the applicant prefer to receive information about health and services?		<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:	
Legal United States resident (includes Visa, Green Card) <b>Note:</b> United States residency is not a requirement for all service categories, but is required for health insurance enrollment through selected health insurance carriers.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Does applicant have a Social Security Number (SSN) or Individual Tax Payer Identification Number (ITIN) <b>Note:</b> SSN is not used for eligibility determination.			<input type="checkbox"/> Yes, please include:  <input type="checkbox"/> No
Housing status	<input type="checkbox"/> Stable/permanent <input type="checkbox"/> Temporary <input type="checkbox"/> Unstable Housing status date collected (MM/DD/YYYY):		
Current home address (address at where the individual sleeps most often) <b>Note:</b> PO Box is not acceptable to establish residency.	Street Address including apartment number:		
	City:		
	State:		
	ZIP code:		



**NEW APPLICANTS ONLY**

**DEMOGRAPHIC INFORMATION**

<p>Ethnicity (choose <u>one</u>)</p>	<input type="checkbox"/> Hispanic/Latino/a (Choose all that apply in list below) <input type="checkbox"/> Mexican, Mexican American or Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other Hispanic, Latino/a or Spanish origin <input type="checkbox"/> Declined to answer <input type="checkbox"/> Non-Hispanic/Latino/a <input type="checkbox"/> Declined to answer
<p>Race (choose <u>all</u> that apply)</p>	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian (choose all that apply in list below) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Declined to answer <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander (choose all that apply in list below) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined to answer <input type="checkbox"/> White <input type="checkbox"/> No race reported <input type="checkbox"/> Declined to answer

**DIAGNOSIS INFORMATION**

<p>HIV/AIDS Status</p> <p><b>Note:</b> once an HIV indeterminate infant client is confirmed to be HIV negative, he/she must be reclassified as an HIV negative (affected) client.</p>	<input type="checkbox"/> HIV positive, not AIDS Diagnosis Date (MM/DD/YYYY): <input type="checkbox"/> If this date is estimated, check here <input type="checkbox"/> HIV positive, AIDS status unknown Diagnosis Date (MM/DD/YYYY): <input type="checkbox"/> If this date is estimated, check here <input type="checkbox"/> CDC-defined AIDS Diagnosis Date (MM/DD/YYYY): <input type="checkbox"/> If this date is estimated, check here <input type="checkbox"/> HIV indeterminate (infants less than 2 years only) <input type="checkbox"/> HIV negative (affected)
<p>HIV risk factor at time of HIV diagnosis (choose all that apply)</p>	<input type="checkbox"/> Male to Male Sexual Contact (MSM) <input type="checkbox"/> Injection Drug Use (IDU) <input type="checkbox"/> Hemophilia/coagulation disorder <input type="checkbox"/> Heterosexual Contact <input type="checkbox"/> Receipt of blood transfusion <input type="checkbox"/> Perinatal Transmission <input type="checkbox"/> Risk factor not reported or not identified