www.afanlv.org

Dear Consumer,

Welcome to Aid for AIDS of Nevada!

We are pleased to welcome you as a prospective client. We will work with you as you begin to make changes that will improve your life. Please remember our mission is to assist and guide you through your process in accessing the services that will enhance your life. Together we will work for a successful outcome. Please take a moment to **read carefully** this documentation as it contains important information about your services with us and do not hesitate to ask any questions you may have.

If you have any concerns, please ask your Case Manager, Social Worker or any other member of our staff. All of us are happy to assist you.

Sincerely,

Management and staff of Aid for AIDS of Nevada

Aid for AIDS of Nevada
Confidential Client Information

____/____/____

Today's Date | Last Name | First Name | Middle Name

_______-_______-_______ ____/____/____

Social Security Number | Date of Birth | Birth Place (*City*) | (*State*)

Gender (*please check one*) ☐Male ☐Female ☐Transgender (male to female) ☐Transgender (female to male) ☐Unknown

Please check the following: ☐Single ☐Married ☐Divorced ☐Widowed ☐Domestic Partner ☐Other

Home Address | Apt. # | City | State | Zip

***Note**: Please provide us with mailing address if it is different than home address*

Mailing Address | Apt. # | City | State | Zip

May we contact you by mail at this address? ☐ **Yes, contact via mailing address** ☐ **No**

Telephone(s) (______)________________ Home (______)________________ Cellular (______)________________ Work

Emergency Contact: ***Please provide us with a working number for your emergency contact and advise them that they are on the list to be contacted by us in the event of an emergency***

Name | Phone Number | Relationship

Address | Apt. # | City | State | Zip

May AFAN Staff contact you or leave a message on your voice mail / answering machine? ☐ Yes ☐ No

If yes, please specify: ☐Cellular ☐ Home ☐ Work ☐ Other ______________________

RACE

☐ WHITE
☐ AMERICAN INDIAN /ALASKAN NATIVE
☐ HAWAIIAN / PACIFIC ISLANDER
☐ BLACK OR AFRICAN AMERICAN
☐ ASIAN
☐ OTHER / TWO OR MORE ______________________ *(Please Specify)*

Ethnicity:

☐ Mexican ☐ Puerto Rican ☐ Cuban
☐ Central American ☐ South American ☐ Other ______________

Who is your primary insurance provider?

☐Medicaid/AHCCCS
☐Medicare
☐No Insurance
☐Other, please specify:__________
☐Other public (e.g. Champus, VA)
☐Private Insurance
☐Unknown

Other Insurance (if any):

☐Medicaid/AHCCCS
☐Medicare
☐No Insurance
☐Other, please specify:__________
☐Other public (e.g. Champus, VA)
☐Private Insurance
☐Unknown

Have you ever served in the military? ☐ Yes ☐ No **If yes, please list your dates of services:** __________to__________

What is your primary source of transportation? ☐Own a car ☐Public Transportation ☐Friends/Relatives ☐Walking

If you drive, what vehicle do you drive? *(This question is for security purposes **only**)*

Make______________Model__________________Year_____________License Plate number__________________

Aid for AIDS of Nevada
Consumer Rights and Responsibilities

These are universal rights for all clients attending any and all programs at our organization. Please take the time to read them. As the client of AFAN, your rights include but are not limited to the following:

1. The consumer has the right to be involved in and make decisions about your plan of care prior to the start of and during the course of treatment.
2. The consumer has the right to renegotiate your care plan at any time
3. The consumer has the right to give informed consent before undergoing any healthcare procedure or receiving any social service.
4. The consumer may change your mind after refusing or consenting to services without affecting ongoing care.
5. The consumer has the right to be informed of the program's rules of your conduct at the facility
6. The consumer has the right to access all available services pending eligibility
7. The consumer has the right to be treated, at all times, with respect and courtesy within a setting that provides the highest degree of privacy possible
8. The consumer has the right to freedom from discrimination related to age, ethnicity, national origin, gender, gender identity, disability, religion, sexual orientation, values and beliefs, marital status, medical condition and any other arbitrary reasons
9. The consumer has the right to full access to information from the health care providers about current FDA approved or other proven HIV/AIDS treatments. The consumer has the right to full access to information from all service providers about HIV related social and support services. Any biases or conflict of interest the healthcare provider may have shall be disclosed.
10. Consumers must be advised of the risk and benefits of any proposed treatment considered to be experimental in nature. The provider will discuss the alternative or complimentary treatments and may make recommendations
11. The consumer has the right to know the identities, titles, specialties and affiliations of all health and social service providers, as well as anyone else invol.ved in the consumer's care
12. The consumer has the right to know about health or social services organizational rules and regulations that are pertinent to the care or type of care a client receives
13. The consumer has the right to have information shared in a way that is easily understood and sensitive to each consumer's background, culture and ethnicity
14. The consumer has the right to refuse to participate in any care/service without affecting ongoing care
15. The consumer has the right to identify an advocate such as family member or other person to support the consumer by notifying the relevant service provider
16. The consumer has the right to have advance directives, such as living will, Healthcare Proxy or Durable Power of Attorney for health and social services.
17. The consumer has the right to inspect and receive an explanation of healthcare bills or proposed changes, regardless or payment sources
18. The consumer has the right to receive needed referral and support with payment problems.
19. The consumer has the right to confidentiality and access to treatment records and communications relate to his or her case.
20. The consumer has the right to open and honest discussion in all dealings with health or social service providers
21. When a transfer for care/service for any reason is needed, the consumer shall be informed of all possible options.
22. A provider may not initiate transfer of the consumer's case to another provider or facilitate unless a complete explanation of the need for the transfer and alternatives to transfer are provided to the consumer. The new provider or facility must be notified of the transfer
23. The consumer has the right to receive timely notification of program changes affecting eligibility.
24. If deemed ineligible, the consumer has the right to pursue the Ryan White Part A eligibility appeals process.

Aid for AIDS of Nevada
Consumer Rights and Responsibilities

25. The consumer has the right to file a written grievance without fear of pressure, retaliation, or interruption of services

26. The consumer has the right to receive a written response to a grievance in a timely manner

27. The consumer has the right to express his or her satisfaction or dissatisfaction with any Ryan White Part A Service Provider

28. The consumer has the right to grieve actions, decisions of facility staff that you believe are inappropriate, including but not limited to actions, and decisions that you believe violate your rights as a client. The facility is obligated to develop a grievance procedure for timely resolution of complaints from clients. The facility has a procedure in a place where the Client Grievance Form shall be immediately available to you at the front desk. You have the right to freedom from retribution or other adverse consequences as the product of filing a grievance. Clients have the right to register grievances about his/her services, the administration of rules, regulations, disciplinary measures, sanctions, and modifications of rights to the appropriate Department Supervisor. The department supervisor thoroughly researches the client's claims, as presented in the completed Client Grievance Form. The department supervisor presents his/her findings to the Associate Director. The Associate Director formulates a course of action, with consideration of the findings from the supervisory staff. The Associate Director presents a recommended course of action to the Executive Director, along with the research compiled by the supervisory staff and the completed Client Grievance Form. The Executive Director decides the suitable final course of action. The Associate Director shall notify the Executive Director within 3 working days of any notice of appeal that he has received. The Associate Director shall provide the Executive Director with all documents related to the appeal, including the Client Grievance Form, any incident reports, any related correspondence and any other relevant document pertaining to the appeal. The client is notified, in writing, within forty-five (45) days of the Executive Director's decision and the course of action taken. If the client still does not feel that his/her grievance has been resolved, he/she has the right to present his/her case to the Ryan White Part A, B or HOPWA depending under which program you are receiving services. **For Ryan White Part A Program**, complaints related to a problem encountered while accessing services, please bring your complaint/grievance to the attention of the appropriate person at that agency and follow the grievance procedure. Upon your request you will be provided with: An agency grievance form in triplicate, A pre-addressed and pre-stamped envelope addressed to the agency's Executive Director, A pre-addressed and pre-stamped envelope addressed to the Las Vegas Part A Grants Administrator. After receipt of your written compliant/grievance, you will be contacted by the Ryan White Part A Grantee to discuss your concerns.

Ryan White Part A Administrator Clark County Social Service 2820 W. Charleston Blvd Ste. B15 Las Vegas, NV 89102 Phone (702) 455-1071	Ryan White Planning Council Office 2820 W. Charleston Blvd Ste. B15 Las Vegas, NV 89102 Phone (702) 455-7255
HOPWA City of Las Vegas, 400 Stewart Ave. Las Vegas NV, 89101 Phone (702) 229-2330	

29. You have the right to receive a copy of the signed version of this form should you request it.

I, ______________________________ have read and understand the above terms.
(Please print your name here)

Client Signature ______________________________ Date______________

Staff Signature ______________________________ Date ______________

Consumer Responsibilities

AFAN strives to deliver quality services to all its eligible clients and offers a comfortable/safe environment in which to obtain services. Please take a moment to read the following information regarding your enrollment at AFAN and/or its programs. At the end, please print your name, date and sign at the bottom of the page. If you have any questions about this form, please ask your social worker, case manager or eligibility specialist for clarification. Thank you!

a. AFAN's clients are expected to act in a manner that is respectful to other clients and their needs, as well as agency staff and agency's property.

b. Understand that providing falsified or fraudulent information in order to obtain services is against the law and will not be tolerated.

c. Sexual harassment/misconduct towards AFAN staff, volunteers, and/or clients is not tolerated.

d. AFAN prohibits any possession, selling, distribution of any elicit controlled substance, prescription medication and or alcohol in the premises.

e. Theft or selling of food vouchers, bus passes, nutritional supplements, prevention materials or other AFAN distributed materials/property is not tolerated.

f. Vandalism of AFAN property or the property/venue of any AFAN hosted event is against the law and will not be tolerated by AFAN.

g. AFAN does not tolerate physical or verbal threats against other clients, volunteers, or staff on AFAN premises, supporter premises, property, and events having to do with AFAN.

h. AFAN Does not allow possession of any weapons used to intimidate or physically threaten clients, volunteers, or staff on AFAN's property, or AFAN hosted events, (weapons are defined as any object which could be used in a manner to threaten bodily harm).

i. Threats and/or incidences of assault, theft or abusive behavior towards our staff, volunteers and/or clients are not tolerated.

If a client does not act accordingly, or becomes agitated or aggressive to the point that staff or clients feel threatened, AFAN staff may ask the client to leave the premises. AFAN does not engage in physical or chemical restraint, but clients refusing to leave the premises after being asked to will be removed by law enforcement officials. Engaging in any of the activities described above may result in the suspension, alteration or termination of services/privileges at AFAN.

Any clients, staff, volunteers, or visitors who encounter and/or witness the above incidences of misconduct must complete an AFAN incident report (available in the AFAN main office). Once the incident report is completed, it will be processed by the departmental supervisor and reviewed by the Executive Director to determine appropriate actions.

I, ____ have read and understand the above terms.
(Please print your name here)

Client Signature ____ Date______________

Staff Signature ____ Date ______________

Aid for AIDS of Nevada
Purpose of This Privacy Notice

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, initiate payment, or conduct health care operations, and for other purposes that are permitted or required by law.

Clark County reserves the right to make changes in the Notice of Privacy Practices. The Notice describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that identifies you and relates to your past, present or future physical or mental health or condition and related health care services.

Our Pledge Regarding Medical Information: We understand that your medical and health related information is personal, and we are committed to protecting it. A record of the care and services you receive at Clark County is created and maintained at Clark County. This notice applies to those records of your care received and maintained by Clark County. We are required by law to:

- Make sure that medical information that identifies you is kept private
- Provide you this notice describing our legal duties and privacy practices regarding your medical information
- Follow the terms of the notice that is currently in effect. We may change the terms of our notice at any time without advance notice to you. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may obtain a copy by contacting Clark County's HIPAA Compliance Office at (702) 383-3854. The current version of the Notice may also be found on Clark County's website at: http://www.co.clark.nv.us/

Who Will Follow This Notice: This notice describes the privacy policies of Clark County and that of:

- Any health care professional authorized to enter information into your medical record retained by Clark County
- Civil Division of the District Attorney's Office
- Audit Department
- Purchasing
- Board of County Commissioners
- Department of Juvenile Justice Services
- Clark County Employee Assistance Program
- Information Technology Department
- Comptroller
- County Manager's Office

How We May Use And Disclose Medical Information About You:
The following categories describe ways that we use and disclose medical information. Examples of each category are included. Not every use or disclosure in each category is listed; however, all of the ways we are permitted to use and disclose information falls into one of these categories:

For Treatment: We may use medical information about you to provide, coordinate, or manage your medical treatment or services. We may disclose medical information about you to other physicians or health care providers who are or will be involved in taking care of you. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Your protected health information may also be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to provide treatment.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at a Clark County facility may be billed to and paid by an insurance company, you, or a third party. For example, obtaining approval for a hospital stay may require that we disclose your relevant protected health information to the health plan to obtain approval for the hospital admission.

For Healthcare Operations: We may use or disclose your protected health information to support the business activities of Clark County. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical staff, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at a Clark County facility. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for Clark County. Whenever an arrangement between Clark County and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms to protect the privacy of your protected health information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, your name and address may be used to send you a newsletter about our medical facilities and the services we offer. You may contact Clark County's HIPAA Compliance Office to request that we do not send these materials to you.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization
Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician, our medical staff, or our employees have taken action that relies on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object
We may use and disclose your protected health information in the instances described below. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or are not able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a family member, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your acknowledgement of receipt of the Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object
We may use or disclose your protected health information in the certain situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child or elder abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to track products and to report adverse events, product defects, product problems, and/or biologic product deviations. We may also disclose your protected health information as required by the Food and Drug Administration to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request or other lawful legal process.

Law Enforcement: We may disclose protected health information according to any and all applicable legal requirements for law enforcement purposes. These law enforcement purposes include (1) legal processes and disclosures otherwise required by law, (2) limited information requests for identification and location purposes, (3) information pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) criminal offenses occurring on the premises of Clark County, and (6) a medical emergency (not on the premises) when it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, for use in determining cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Sale or Closure of the Practice: In the event that a Clark County medical facility is sold or acquired by another entity, your protected health information will be disclosed to that group or entity.

Required Uses and Disclosures: Under the law, we must make a list of disclosures available to you upon request and to the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996.

YOUR RIGHTS: Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information: You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and Clark County use for making decisions. Under federal law, you may not inspect or copy the following records:

- Psychotherapy notes;
- Information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and
- Protected health information that is subject to law that prohibits access to those records. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to appeal the decision. Please contact Clark County's HIPAA Compliance Office if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information.
You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Clark County is not required to agree to a restriction. If Clark County believes it is in your best interest to permit the use and disclosure of your protected health information, it will not be restricted. If Clark County does agree to the restriction request, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your caregiver. You may request a restriction by contacting and discussing the issue with Clark County's Privacy Officer.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.
We will attempt to accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to Clark County's HIPAA Compliance Office.

You may have the right to have your physician amend your protected health information.
You may request an amendment of your protected health information in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request, you have the right to file a statement of disagreement with us. In this instance we may prepare a rebuttal to your statement that will be filed in your medical record along with your statement. We will also provide you with a copy of any such rebuttal. Please contact Clark County's HIPAA Compliance Office if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we made, if any, of your protected health information.
This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, in accordance with your authorization, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request up to a six-year history of disclosures. The right to receive this information is subject to certain exceptions, restrictions and limitations. You may receive a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

COMPLAINTS: You may complain to us or to the Secretary of Health and Human Services (HHS) if you believe your privacy rights have been violated by us.

To file a complaint with Clark County, submit the complaint in writing to:	To file a complaint with HHS, send a letter to:
Clark County/ UMC Privacy Officer or to: Clark County HIPAA Compliance Office 1800 W. Charleston Blvd. P.O. Box 551120 Las Vegas, NV 89102 Las Vegas, NV 89155-1120 You may also call (702) 383-3854 for further information about the complaint process.	Office of Civil Rights U.S. Department of Health and Human Services 50 United Nations Plaza - Room 322 San Francisco, CA 94102 (415) 437-8310; (415) 437-8311 (TDD) ; (415) 437-8329 FAX

We will not retaliate against you for filing a complaint

I, ____ have read and understand the above terms.
(Please print your name here)

Client Signature ____ Date______________

Staff Signature ____ Date ______________

Nutritional Questionnaire

First Name ________________ **Last Name** ____________________ **Date** _________

For each statement below, **mark** the YES column for those that apply to and the NO column for those that do not.

Nutrition Risk Factors: A

1. Without wanting to, you have experienced significant weight loss in the last 6 months...... YES ☐ NO ☐
2. You have been diagnosed with severe dysphagia (difficulty in swallowing) and/or receive your nutrition via a feeding tube.. YES ☐ NO ☐
3. You are on dialysis or get treated for two or more of the following: (circle all that apply) diabetes, renal disease, liver disease/hepatitis, high cholesterol/heart disease, hypertension, cancer, anemia, severe depression.. YES ☐ NO ☐
4. Your CD4 count is currently less than 200.. YES ☐ NO ☐
5. You were recently discharged from the hospital and/or are being treated for an active opportunistic infection.. YES ☐ NO ☐
6. For women: You are pregnant.. YES ☐ NO ☐

Nutrition Risk Factors: B

1. At least one of the following is true:
   Your arms and legs are getting thinner and you can see your veins
   Your belly is getting bigger
   Your neck has a hump
   You have lost your "rear".. YES ☐ NO ☐
2. You get treated for one of the following: diabetes, renal disease, liver disease/hepatitis, high cholesterol/heart disease, hypertension, cancer, anemia, depression........................ YES ☐ NO ☐
3. You have been diagnosed with osteopenia or osteoporosis.. YES ☐ NO ☐
4. You follow a diet regimen for religious, vegetarian or other reasons............................ YES ☐ NO ☐
5. Most days of the week you have a poor appetite (little or no desire to eat).................... YES ☐ NO ☐
6. Most days of the week you do not have adequate, well balanced meals.......................... YES ☐ NO ☐
7. You are lactose intolerant and/or have food allergies.. YES ☐ NO ☐
8. Most days of the week you experience one or more of the following: (circle all that apply) diarrhea, constipation, nausea, vomiting, heartburn, bloating/gas.................................. YES ☐ NO ☐
9. You currently have chewing, swallowing or mouth problems (thrush/dry mouth/sores) that make it hard for you to eat.. YES ☐ NO ☐

For office use only

Notes

Ryan White Parts A, B, C and D in Nevada and the Las Vegas TGA

Consent for Release of Confidential Information

Client's Name: ____

Date of Birth: __________________________ URN: __________________________

I, the undersigned, do hereby authorize any of the agenices listed below who participate in the community-based Ryan White Care Services program in the Las Vegas Transitional Grant Area (TGA) and the State of Nevada to release and/or share information concerning my eligibility, medical record status, and information concerning my HIV screening, diagnosis and treatment. The following agencies/programs authorized are:

- Access to Healthcare
- Action Red
- Aid for AIDS of Nevada (AFAN)
- African-American Community Cultural Education Programs & Trainings (ACCEPT)
- Catalyst RX-Pharmacy Bennefits Manager
- Carson City Health & Human Services
- Community Counseling Center
- Community Outreach Medical Center
- Clark County Social Services
- Golden Rainbow
- North Country Healthcare
- Nevada Disability Advocacy & Law Center (NDALC)
- Northern Nevada HIV Outpatient Program Education (HOPES)
- Nye County Health & Human Services
- Rebuilding All Goals Efficiently, INC. (RAGE)
- Southern Nevada Health District
- University Medical Center-Wellness Center
- University of Nevada School of Medicine-Pediatrics
- University of Nevada School of Medicine-OB Care
- UNLV School of Dental Medicine
- Your Physician:____________________

Information may be released between the above listed agencies throughout the duration of my active enrollment in the Ryan White Care Services program. I may withdraw this consent by notifying, in writing, the Ryan White agency where my eligibility was completed. I understand that my records are protected under federal HIPAA regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent in writing any time, except to the extent that any action has been taken while it is still in force. This consent expires automatically one (1) year from registration or previously signed consent.

A copy of this authorization legally constitutes an original copy.

____ ____________________
Client's Signature Date

____ ____________________
Parent or Guardian/ Relationship to Client Date

____ ____________________
Witness Date

Las Vegas Eligible Metropolitan Area
Ryan White Care Services

Consent for Release of Confidential Information

Client's Name: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

SSN: ________________ DOB: ____________ UID# ____________

I, the undersigned, do hereby authorize ______________________________
(Releasing Agency or Individual)

____

to release the following information from my records: ______________

____

to: ______________________________
(Name of person, agency, or firm authorized to receive information)

____
(Address)

The information authorized for release may include records that indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus (also known as acquired immune deficiency syndrome (AIDS).

I understand that my records are protected under federal regulations and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I understand that I may revoke this consent, either verbally or in writing, at any time except to the extent that action has been taken in reliance on it.

Information may be released to the above named person/agency until: ______________
(Expiration Date)

______________ (Date) ______________________________ (Signature of Client)

______________ (Date) ______________________________ (Signature of Parent or Guardian)

______________ (Date) ______________________________ (Witness)

Federal Transit Administration
Office of Civil Rights
Complaint Form

Section I

Name:_______________________________________

Address:_____________________________________

Telephone Numbers:

(Home)______________(Work)_________________

Electronic Mail Address:__________________________

Accessible Format Requirements?

Large Print _______ Audio tape _____

TDD ___________ Other______________________________________

The Federal Transit Administration (FTA) Office of Civil Rights is responsible for civil rights compliance and monitoring, which includes ensuring that providers of public transportation properly abide by Title VI of the Civil Rights Act of 1964, Executive Order 12898, "Federal Actions To Address Environmental Justice in Minority Populations and Low Income Populations," and the Department of Transportation's Guidance to Recipients on Special Language Services to Limited English Proficient (LEP) Beneficiaries.

In the FTA complaint investigation process, we analyze the complainant's allegations for possible Title VI and related deficiencies by the transit provider. If deficiencies are identified they are presented to the transit provider and assistance is offered to correct the inadequacies within a predetermined timeframe. FTA also may refer the matter to the U.S. Department of Justice for enforcement.

Section II

Are you filing this complaint on your own behalf?

Yes ____ No ____

[If you answered "yes" to this question, go to Section III.]

If not, please supply the name and relationship of the person for whom you are complaining:

____

Please explain why you have filed for a third party. ______________________________

____

Please confirm that you have obtained the permission of the aggrieved party if you are filing on behalf of a third party.

Yes ____ No ____

Section III

Have you previously filed a Title VI complaint with FTA? Yes____ No___

If yes, what was your FTA Complaint Number? _____________

[Note: This information is needed for administrative purposes; we will assign the same complaint number to the new complaint.]

Have you filed this complaint with any of the following agencies?

Transit Provider _____ Department of Transportation ____

Department of Justice_____ Equal Employment Opportunity Commission _____

Other ____

Have you filed a lawsuit regarding this complaint? Yes_____ No____

If yes, please provide a copy of the complaint form.

[Note: This above information is helpful for administrative tracking purposes. However, if litigation is pending regarding the same issues, we defer to the decision of the court.]

Section IV

Name of public transit provider complaint is against:

____

Contact person: _________________________ Title: _________________________

Telephone number: ____

On separate sheets, please describe your complaint. You should include specific details such as names, dates, times, route numbers, witnesses, and any other information that would assist us in our investigation of your allegations. Please also provide any other documentation that is relevant to this complaint.

Section V

May we release a copy of your complaint to the transit provider?

Yes ____ No ____

May we release your identity to the transit provider?

Yes ____ No ____

Please sign here: ____

Date: ______________

[Note - We cannot accept your complaint without a signature.]

Please mail your completed form to: Title VI Program Coordinator, FTA Office of Civil Rights, East Building, 5th Floor – TCR, 1200 New Jersey Ave., S.E., Washington, D.C. 20590