The Rainbow Health staff member conducting the intake session has provided me with the following documents:

☐ Rainbow Health Client Bill of Rights ☐ Rainbow Health Grievance Policy ☐ Rainbow Health Data Practices Notice

I have also completed the following documents:

☐ HERR Community Education Event Consent ☐ Authorization to Exchange Information

Client Information

Legal FIRST name	**Legal MIDDLE name**	**Legal LAST name**	Preferred name

Birth Date (MM/DD/YYYY)	**Gender at birth:** ☐ male ☐ female **Current Gender:** ☐ male ☐ female ☐ transgender, male to female ☐ transgender, female to male
Housing type: ☐ stable/permanent ☐ temporary ☐ unstable	**Date moved to MN (MM/DD/YYY)** or ☐ **born in Minnesota**

Street address line 1:	**City:**	**State:**
Street address line 2 (unit or apartment):	**County:**	**Zip code:**
Primary phone:	**Secondary phone:**	
Email address:		

Rainbow Health Contact Permission Opt-In Selections

Mail - ok to send mail?	**Primary phone - msg type:**	**Secondary phone - msg type:**	**Email – ok to send email?**
☐ yes ☐ no ☐ JustUS Health name logo OK ☐ return address only – no name ☐ DO NOT USE RETURN ADDRESS	☐ agency & staff name with return phone number ☐ staff name & return phone number ONLY ☐ staff name, no phone ONLY ☐ NO MESSAGES	☐ agency & staff name with return phone number ☐ staff name & return phone number ONLY ☐ staff name, no phone ONLY ☐ NO MESSAGES	☐ yes ☐ no

Demographic Information

Citizenship (country):	**Race** (select all identified with)**:**	**Sexual Orientation:**
	☐ American Indian ☐ Alaska Native ☐ Asian ☐ African American/Black ☐ Native Hawaiian ☐ Pacific Islander ☐ White	☐ Bisexual ☐ Gay ☐ Heterosexual ☐ Lesbian ☐ Refused ☐ Unknown
Country of Origin:	**Ethnicity:** ☐ Hispanic/Latino ☐ not Hispanic/Latino	**Veteran:** ☐ Yes ☐ No

Financial and Insurance Information

Legal household size: (client + total number of people **legally** dependent on client's income)	**Total monthly income – MDH:**	**Income Source:**	**Other income from spouse or adult child:**
		☐ SSDI ☐ SSI ☐ Govt. Assistance ☐ Food stamps/WIC ☐ Private employer ☐ Self/other	☐ Yes ☐ No **Relationship & source:**

Insurance (check all that apply)**:**

☐ Medicare A/B ☐ Medicare D ☐ Medicare D Low Income Subsidy/Extra Help ☐ Medicaid/Medical Assistance (MA)
☐ MN Care ☐ Veterans Assistance (VA)/Tricare ☐ Private Employer/Marketplace ☐ Other ☐ No Insurance

HEALTH EDUCATION & RISK REDUCTION INTAKE

General Health Information

When was the last time you have seen an HIV doctor?

Month: _____.

Year: _____.

Date of HIV Diagnosis:

MM	DD	YYYY

☐ this date is an estimate

Date of AIDS Diagnosis:

MM	DD	YYYY

☐ this date is an estimate

☐ not applicable / no AIDS diagnosis

Exposure categories

☐ M/M sex ☐ M/F sex
☐ IV drug use ☐ Hemophilia
☐ Blood recipient
☐ Perinatal
☐ Occupational Exposure
☐ Other _____.
☐ Unknown

Mental Health Information

Have you ever been diagnosed with a mental health concern?

☐ None ☐ Depression
☐ Bipolar Disorder
☐ Anxiety ☐ PTSD
☐ Other:_____

Over the last two weeks have you experienced any of the following:

☐ feeling down, depressed, or hopeless
☐ feeling like you want to hurt yourself or others
☐ changes in sleep patterns
☐ changes in eating habits
☐ difficulties with concentration or completing tasks
☐ feeling fidgety or unable to relax
☐ lack of interest or pleasure in doing things you previously enjoyed

Are you currently seeing a mental health provider? (counselor, therapist, psychologist, psychiatrist, etc.)

☐ Yes ☐ No

Miscellaneous Information

Do you require and interpreter in order to participate in support groups or events?

☐ Yes ☐ No

If yes, what language is needed:

Special accommodations:

Do you require any special accommodations (wheelchair access, etc.)?

_____.

Do you have any special food needs (hallal, allergies, vegetarian, vegan, etc.)?

_____.

Childcare needs:

There may be a limited stipend for childcare arrangements. Details will be confirmed by the program facilitator. Children are not allowed at any time during support group sessions.

Number of children living with client: _____.

Ages of children:

1) _____.
2) _____.
3) _____.
4) _____.

Transportation:

We may be able to provide transportation assistance for Educational Sessions and Support Groups, but this is not guaranteed.

Will you need transportation assistance to attend these activities?

☐ Yes ☐ No

During your intake interview, a Rainbow Health staff member will review the agency programs and services with you. If you are interested in or need follow-up on any of the services explained, you may select from the list below.

I would like more information from Rainbow Health on the following topics:

☐ Case Management
☐ Insurance
☐ Housing
☐ Medical Care
☐ Transportation
☐ Other (explain below)
☐ Chemical Health
☐ Emergency Financial Assistance
☐ Mental Health
☐ Food Resources

Other: _____

Client Signature_____

(Or indicate completed via phone with date & time)

Staff Member Checking Form_____