Legal Services Referral/Intake Checklist

- 2019 Rainbow Health Legal Intake or Referral Form
- Data Practices Notice for Clients
- Client Bill of Rights
- Grievance Procedure form
- Rainbow Health Legal Services Consent Form
- Authorization to Exchange Information (Housing Access Services) form
- No Income Statement

Rainbow Health

Legal Intake/Referral Form

Date: _____

DEMOGRAPHICS (Required for all Clients)

_____ _____ _____ _____

LEGAL First Name **Middle Name** **Last Name** **Birth Date (MM/DD/YYYY)**

Preferred Name: _____ **Gender assigned at birth:** ☐ male ☐ female

Current Gender:

- ☐ male
- ☐ female
- ☐ transgender male
- ☐ transgender female
- ☐ non-binary
- ☐ Other _____

Sexual Orientation:

- ☐ Bisexual
- ☐ Gay
- ☐ Heterosexual
- ☐ Lesbian
- ☐ Refused
- ☐ Other

Pronouns:

- ☐ he/him/his
- ☐ she/her/hers
- ☐ they/them/theirs
- ☐ other: _____

Race: (All identified with**):**

- ☐ American Indian
- ☐ Alaska Native
- ☐ Asian
- ☐ African American/Black
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ White
- ☐ Refused

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Born in MN? ☐ Yes ☐ No *If no: date moved to* MN _____ *(MM/DD/YYYY)* *Moved From* _____

Citizenship (Country): _____ **Country of Origin (if not born in USA):** _____

HOUSING/ADDRESS/CONTACT (Required for all Clients)

Housing Type: ☐ Stable/Permanent ☐ ***Temporary ☐ ***Unstable

_____

Street Address **City** **State** **Zip Code** **County**

➢ **OK to send mail?:** ☐ Yes ☐ No

_____ ☐ ☐ ☐ ☐ _____

Phone (type- cell, home, etc.) **Call OK** **Text OK** **MAP OK** **Name & # only** **Email** (if okay to email from MAP)

***Have you moved at least two (2) times in the last 60 days? ☐ Yes ☐ No

***Are you housed in a Transitional Housing Program or a Program with supportive Services? ☐ Yes ☐ No

Are you currently in a lease? ☐ Yes ☐ No

FINANCIAL (Required for all Clients) – *VERIFICATION NEEDED*

Legal Household size: _____ (Client + total number of people **legally** dependent on client's income.)

Total Monthly Income- MDH: $_____ Source(s): _____

*Employment, SSDI, SSI, GA, food stamps, etc

Monthly income of *other adult and/or legal dependents* (spouse or child): $_____

Relationship to client _____ Source(s): _____

HIV STATUS (Required for Clients Living with HIV) – *VERIFICATION NEEDED*

Is this client living with HIV?

☐ Yes ☐ No ☐ Unknown

If Yes, Date of HIV diagnosis: _____ (MM/DD/YYYY) *check if estimate* ☐

Does the client have an AIDS Diagnosis?

☐ Yes ☐ No ☐ Unknown

If Yes, Date of AIDS diagnosis: ☐ N/A _____(MM/DD/YYYY) *check if estimate* ☐

How was the client exposed to HIV?

☐ Male to Male sex ☐ Hemophilia ☐ Occupational Exposure
☐ Male to Female sex ☐ Blood recipient ☐ Other (_____)
☐ Injection Drug Use ☐ Perinatal ☐ Unknown

What is the client's HIV Specialty Clinic? _____ Name of client's HIV Doctor: _____

When did client last see an HIV Doctor? _____ (MM/DD/YYYY)

FOR INTERNAL PROCESSING: If client has not seen a doctor within 6 months of QC, document referral in Provide

Does client have an HIV Case Manager ☐YES ☐NO Name/agency: _____

Does client need translation services ☐YES ☐NO Language: _____

Is the client active on AIDS Drug Assistance/HH? ☐ Yes ☐ No If no refer: _____

HEALTH (Required for all Clients – IMPORTANT TO COMPLETE FOR SOCIAL SECURITY DISABILITY ASSISTANCE)

Does client have any current physical health concerns? ***(If YES, what are the diagnosis; is the client receiving care for physical health concerns; and do the physical health concerns limit activities of daily living or ability to work)***

Does client have any current mental health concerns? ***(If YES, what are the Diagnosis; is the client receiving care for mental health concerns; and do the mental health concerns limit activities of daily living or ability to work)***

Does client have any current chemical health concerns? ***(If YES, what are the diagnosis; is the client receiving care for physical health concerns; and do the physical health concerns limit activities of daily living or ability to work)***

INSURANCE (Required for all Clients) – *VERIFICATION NEEDED*

What is the client's current insurance? **(Check all that apply)**

☐ Medicare A/B

☐ Medicare D ☐ Medicaid/MA ☐ Private
☐ Medicare D Low Income Subsidy/Extra Help ☐ MN Care ☐ Other: _____
☐ VA/Tricare ☐ No insurance

SUMMARY OF LEGAL NEEDS (Required for all Clients) – *SUBMIT ANY RELATED DOCUMENTS*

Which of the following legal issues does client need to address?

- ☐ Benefits (Not Social Security)
- ☐ Debt
- ☐ Discrimination _____
- ☐ Employment
- ☐ Estate Planning
  - ☐ Health Care Directive
  - ☐ Power of Attorney
  - ☐ Will/Trust
- ☐ Immigration
- ☐ Permanency Planning
- ☐ Privacy
- ☐ Social Security
  - ☐ Getting on Benefits/New Application
  - ☐ Maintaining Benefits
  - ☐ Overpayments
- ☐ Other _____

PLEASE PROVIDE A SUMMARY OF THE NEED FOR A LEGAL SERVICES REFERRAL

(Please include any details and documentation related to the urgency of the matter/deadlines related to the matter)

Name of Referrer or Person completing form: _____ Agency _____

Contact email address: _____ Contact phone #: _____

FOR INTERNAL PROCESING

- ✓ If Client is currently in Provide; confirm address, phone, email, Last HIV Doctor Visit and update with any income changes in the past 6 months.
- ✓ Complete section on HIV STATUS only if client is living with HIV
- ✓ Before you schedule any appointments…
  - *Remind clients to bring current income verification, HIV verification, residency verification and copies of current insurance info (as applicable) to appointment;* ***if we do not already have it.***
  - *Income proofs should include copies of last year's tax forms, W2's and/or bank statements as applicable.*
  - *Failure to provide required proofs will delay linkage to services.*

DATA PRACTICES NOTICE

This notice is given and/or reviewed with all Rainbow Health clients. For the purposes of this document, clients are defined as those persons receiving reportable services including AIDSLine Quick Connect, case management, CLEAR, ARTAS Linkage, Peer Support, transportation, housing services, legal services, benefits counseling, chemical health services, Every Penny Counts Emergency Assistance, Positive Link/HERR Support, PrEP Navigation and other support services.

As a client of Rainbow Health certain laws including the right to privacy protect you. The Minnesota Government Data Practices Act provides you with rights about data obtained from you. The data we collect at Rainbow Health is, in nearly all cases, considered private data, which means you have access to it. Rainbow Health is aware of the sensitive and private nature of much of the information that is shared between clients and Rainbow Health staff. Rainbow Health as an agency, is committed to maintaining and protecting your confidentiality.

Why Rainbow Health Collects Data

- To assess your individual situation and coordinate services for you. These services may be at Rainbow Health or they may be services you receive from other agencies;
- To assess the effectiveness of Rainbow Health's services;
- To verify to funding sources that Rainbow Health is providing services and the outcome of those services;
- To determine your eligibility for services offered by Rainbow Health and other agencies;
- To make appropriate referrals.

Information about you may be exchanged among Rainbow Health staff and volunteers as needed to coordinate services for you. Additionally, client records may be reviewed for the following reasons:

- Supervisors, agency attorneys or consultants to make sure you are receiving the best possible service;

Clients receiving services funded in whole or part through the Ryan White program will have demographic data about them (including: name, date of birth, race, ethnicity, gender, zip code, income level, insurance and housing status, HIV/AIDS diagnosis dates and related medical information) sent to the Minnesota Department of Health (MDH). Additionally, the Minnesota Department of Human Services and Hennepin County Ryan White Program will have access to information sufficient to carry out payment, treatment and operations as specified by the HIV/AIDS Bureau of the U.S. Department of Health & Human Services Health Resource and Service Administration (HRSA). These organizations maintain this information in a confidential manner and do not share your name with any other entities.

Right to Refuse and Consequences of Refusal

You have the right at any time to refuse to share information about yourself with Rainbow Health staff. Generally this will not affect the services you are receiving. However, in some cases, there is the possibility that Rainbow Health will be unable to provide some type of service to you unless we have certain information. Rainbow Health staff will let you know if your refusal to share information will affect the services that can be provided.

Rainbow Health provides information to agencies and government offices that provide funding to Rainbow Health. The Minnesota Department of Health HIV/STD Services Division, federal and state program compliance auditors, the Minnesota Department of Human Services HIV/AIDS Division Programs, Housing and Urban Development (HUD), Hennepin County Adult Services, Hennepin County Public Health and Human Services, the Minnesota Housing Finance Agency and the City of Minneapolis, Centers for Disease Control and other persons or entities authorized by law to collect data may also review client records to monitor the services provided by Rainbow Health. The same law that gives you privacy prohibits these persons or entities from releasing information about you once they have received it.

Rainbow Health staff are mandated reporters meaning there are circumstances when they are required to report suspected child abuse or neglect, threats to others or self, or suspected abuse or neglect of vulnerable adults to social services or law enforcement. Other than these circumstances and as outlined above, Rainbow Health cannot use or release information without your express written or verbal permission.

My signature below means that I have read this document and have also been offered a copy of this information.

_____ _____

Client Signature Date

_____ (Staff initial and date if no client signature)

This document is available in alternate formats upon request.

Rainbow Health Client Bill of Rights

As a client of Rainbow Health, you have the right to:

1. Be treated with consideration and respect by staff, volunteers and interns of Rainbow Health. You have the responsibility to treat Rainbow Health staff, volunteers and interns in a similar manner.

2. Quality services without discrimination regardless of race, ethnicity, national origin, religion, age, sexual orientation, gender or disability.

3. Confidentiality of information we collect about you. No identifying information about you will be shared outside of Rainbow Health without a release of information dated and signed by you listing individuals and agencies with whom you have agreed to have us share information by fax, phone, email or meeting and that all releases will be renewed if needed, on an annual basis. **Any exceptions are outlined in the data practices guidelines.** All records and files pertaining to the services you receive at Rainbow Health will be kept in locked filing cabinets and/or secure computer files when not in use.

4. Review all private information in your file and obtain a copy of this information. If you request a copy, the request must be in writing and signed by you. We will not give or send a copy of your file to any other person without a signed release from you except if we receive a valid court order.

5. Expect reasonable assistance to overcome language, cultural, physical or communication barriers. This means for example, that upon request Rainbow Health will provide interpreters for the deaf and for those who do not speak English.

6. Prompt and reasonable response to your questions and requests.

7. Participate in developing your service plan including developing service goals that meet your needs.

8. Prompt information on how to make complaints and pursue a grievance if you are having difficulties or are dissatisfied with the services you are receiving.

9. Refuse services or recommended services and to discontinue services at Rainbow Health.

10. Receive timely notice and explanation of changes in program guidelines including changes in eligibility criteria and funding availability.

If you have questions about Rainbow Health services, or would like to make a suggestion, you may do so with your service provider, the program manager, or the director of programs.

Specific Rainbow Health programs or services may have additional rights and responsibilities that will be made available to you upon entry into the program.

As a provider of services, Rainbow Health will:

- Determine your eligibility to receive and to continue services.
- Assign the staff, volunteers or interns who will work with you.

This document is available in **alternate formats** upon request.

Rainbow Health
GRIEVANCE PROCEDURE

1. Any person receiving services from Rainbow Health may voice comments, concerns, or grievances directly to the staff person they are working with or to that staff person's supervisor.

2. If your comment, concern or grievance was not addressed to your satisfaction, you may arrange a meeting with or submit a written statement to the Program Director of the service your grievance is connected to. The Rainbow Health staff person you talked with will provide the contact information including the name, address and phone number of this Director. Your written statement or request for a meeting must be received within two weeks of the date you last addressed this issue or concern with the staff person or their supervisor.

3. You will receive a written response within 30 days after we receive your written statement. This written decision is the final decision of Rainbow Health.

4. Some programs offered by Rainbow Health are funded through contracts with various government agencies that will also accept your grievance if your concern or grievance has not been settled to your satisfaction. Information with the appropriate name and contact information at each agency is available upon request or will be mailed to you within one working day of your written or verbal request for it.

This document is available in **alternate formats** upon request.

LEGAL SERVICES CONSENT FORM

I, _____, understand that the Rainbow Health provides legal services. These services consist of advice and representation to eligible persons to help them understand or resolve legal issues. Also, when needed I understand that Legal Services would connect me with resources that can be beneficial.

I have requested Legal Services assistance with my _____ issue and agree to cooperate with legal program staff in advising and representing me. I understand that the legal services provided will stop with the conclusion of this matter and that I can contact the program at anytime in the future if I need assistance with a new legal issue.

The legal program has offered me the following documents:

- Grievance Procedure
- Data Practices Notice
- Patient Bill of Rights

The State of Minnesota funds this program and requires some personal information be collected and reported periodically for the following purposes:

1. To identify the services persons with HIV disease, need and use.
2. To identify barriers to those services.
3. To evaluate future funding needs.

The Minnesota Department of Human Services and Hennepin County Ryan White Program will have access to information sufficient to carry out payment, treatment and operations as specified by the HIV/AIDS Bureau of the U.S. Department of Health and Human Services Health Resource and Service Administration (HRSA).

Clients will have demographic data about them including their names, sent to the Minnesota Department of Health (MDH). MDH maintains this information in a confidential manner and does not share names with any other outside entity.

Many of Rainbow Health's services are dependent upon various funding sources, for this or for other reasons, Rainbow Health may at times decline to provide or need to discontinue a service.

I agree with the Rainbow Health that legal services require my active participation and may require cooperation between my coordination between my case manager and my medical provider. I understand that if I do not actively participate and cooperate, legal services will be discontinued.

I have reviewed and understand this consent with Legal Services Staff. I hereby authorize the Rainbow Health to provide Legal Services to me. I understand that I can discontinue Legal Services, in writing, at any time. The discontinuance will be effective the day my request is received by Legal Services Staff.

_____ _____

Print Name - (Client) Signature - (Client)

_____ _____

Date (Staff initial and date if no client signature)

This document is available in **alternate formats** upon request.

AUTHORIZATION TO EXCHANGE INFORMATION

I hereby authorize _____ at Rainbow Health to exchange information regarding:
(Name)

_____ _____ with
(Name) (Date of Birth)

_____ _____
(Organization /Individual) (Phone Number)

_____
(Address)

NOTE: CLIENT TO INITIAL EACH ITEM INDICATING AUTHORIZATION OR WRITE "N/A" IF NOT APPLICABLE

Purpose: To provide and coordinate services including:

- ☐ Verification of diagnosis
- ☐ Medical information related to date of diagnosis/information regarding ongoing medical care
- ☐ Services provided by Rainbow Health
- ☐ Psycho-social factors including, but not limited to, housing, financial status, hospitalizations, home care needs, and alcohol and drug use
- ☐ Medical history
- ☐ Chemical health assessment, diagnosis and recommendations
- ☐ Mental health/psychological history
- ☐ Program eligibility verification
- ☐ Coordination of care

Other information to include:

I understand that this information will be kept in a confidential manner by Rainbow Health staff and trained volunteers.
I have been informed of my right to refuse to allow Rainbow Health to exchange this information.
I understand that I may revoke this consent upon written notice. The revocation will be effective the day it is received by the staff named on this release or his/her successor. I understand that information shared prior to revocation can't be retracted.
I understand that when health information is released the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.
I understand a photocopy or fax of this form is the same as the original.
I understand I may have a copy of this form after I have signed it.
I understand that information may be exchanged via phone, fax, email or a meeting with provider.
I understand that the consent will automatically expire within one year after the date of my signature below, if an earlier date is not specified.

_____
Name (please print)

_____ _____
Signature Date

This document is available in **alternate formats** upon request.

No Income Statement

If you have no income ($0), please complete.

I**, _____** am receiving services from

_Rainbow Health_____
(agency name)
that are funded by the Ryan White Program. Federal regulations require income verification for all program recipients.

Income includes but is not limited to:

- Gross wages, salaries, overtime pay, commissions.
- Fees, tips and bonuses
- Net income from operation of a business or from rental or real personal property
- Interest, dividends and other net income of any kind for real personal property
- Periodic payments received from Social Security, annuities, insurance policies, retirement funds, pensions, disability or death benefits and other similar types of period receipts
- Payments in lieu of earnings, such as unemployment and disability compensation, worker's compensation, and severance pay
- Public assistance
- Alimony and child support payments (whether through the court system or not)
- Regular pay, special pay and allowances of a head of household or spouse who is a member of the Armed Forces (whether or not living in the dwelling)

I receive support through: *(please check all that apply)*

☐ One or more of my family members are working
☐ One or more of my family members own their own business
☐ One or more of my family members receive support other than work (Social Security, child support, Supplemental Security Income (SSI), Social Security Disability (SSDI/RSDI), spousal support, or retirement/pension income
☐ One or more of my family members gets money from a friend, relative or organization
☐ A relative, friend or organization pays all my bills and expenses
☐ I pay bills from the sale of personal items, money in a savings, checking or trust fund account
☐ I receive support from another source. Please list or provide an explanation of how you are meeting your basic needs:

I understand that any misrepresentation of information or failure to disclose information requested on this form may disqualify me from participation in this program, and may be grounds for termination of services.

I certify that the above information is true and correct. I also understand that it is my responsibility to report all changes to my household composition or income in writing within ten (10) business days of such change.

Signature:_____ Date: _____

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