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 ☐ Rainbow 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:** ☐ Yes ☐ No **Relationship & source:**
		☐ SSDI ☐ SSI ☐ Govt. Assistance ☐ Food stamps/WIC ☐ Private employer ☐ Self/other	

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_____

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.

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.

HERR and PSYCHOSCIAL SUPPORT SERVICES CONSENT FORM

I understand that the Rainbow Health provides Health Education/Risk Reduction (HERR) and Psychosocial Support Services. HERR Services seek to educate participants on HIV care management and transmission issues through the provision of information and support, primarily in group level events. Psychosocial Support Services seek to support participants in their management of their HIV and general health through the provision of information, mental health assessments and referral support to mental health services, primarily in one-on-one interactions.

The State of Minnesota and Hennepin County who fund this program and require some personal information be collected and reported periodically for the following purposes:

1. To verify eligibility of individual to receive services.
2. To identify the services persons with HIV disease, need and use.
3. To identify barriers to those services.
4. 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.

I hereby authorize Rainbow Health to provide HERR and PSS services to me.

In addition to this consent form, I have been offered the following: Client Bill of Rights, Data Practices Notice and Grievance Procedure.

_____ _____

Client Signature Date

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