LAS VEGAS TGA
PART A HIV/AIDS PROGRAM
CLARK | MOHAVE | NYE COUNTIES

Eligibility Application for Clark County Ending the HIV Epidemic (EHE) Programs

Application Date: _____ ☐ **Rapid stART** ☐ **Project Home**

CONTACT INFORMATION

Legal Last Name:	**Legal First Name:**	**Middle Name:**
Birth Date:	**Preferred Name or AKA:**	
Language Preference: ☐English ☐ Spanish ☐ Other: _____ In Need of a Translator: Yes ☐ No ☐	**SSN or TIN*:**	
Home Address:	**City:** / **State:** / **Zip:**	
Mailing Address *(if different than home):*	**City:** / **State:** / **Zip:**	
1. Phone – include area code: / **Type:**	**May we contact you by phone?** ☐ **Yes** ☐ **No**	
2. Phone – include area code: / **Type:**	**May we leave a message?** ☐ **Yes** ☐ **No**	
E-mail Address: / **May we E-Mail you?** ☐ Yes ☐ No	**May we contact you by mail?** ☐ **Yes** ☐ **No**	
	Should mail be confidential? ☐ **Yes** ☐ **No**	

**SSN/TIN information is not used for eligibility. It is used only to verify Medicaid or Health Insurance information.*

DEMOGRAPHICS

Gender Identity:
☐Male ☐ Transgender Male-to-Female (MTF)
☐Female ☐ Transgender Female-to-Male (FTM)
☐ Non-Binary ☐ Genderqueer/gender non-conforming
☐ Transgender Other: _____

Sex at Birth:
☐ Male
☐ Female
*As shown on Birth Certificate

Preferred Pronoun(s)

Ethnicity:
☐ Non-Hispanic/Latino
☐ Hispanic/Latino, *(if checked, choose an option below)*
☐ Mexican, Mexican American, Chicano/a
☐ Puerto Rican
☐ Cuban
☐ Other Hispanic/Latino: _____

Race:
☐ White
☐ Black
☐ American Indian/Alaskan Native
☐ Native Hawaiian/Pacific Islander *(if checked, choose an option below)*
☐ Native Hawaiian ☐ Guamanian/Chamorro
☐ Samoan ☐ Other Pacific Islander: _____
☐ Asian *(if checked, choose an option below)*
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese
☐ Korean ☐ Vietnamese ☐ Other Asian: _____

Relationship Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Unmarried Couple ☐ Divorced ☐ Separated ☐ Widowed

Are you a veteran? ☐ Yes ☐ No

HIV/AIDS STATUS/DIAGNOSIS INFORMATION/RISK FACTORS

HIV/AIDS Status: ☐ HIV Positive (not AIDS) ☐ HIV Positive (AIDS status unknown) ☐ CDC Defined AIDS
☐ HIV Negative (Affected) ☐ HIV Indeterminate (infants <2 years old)

Date of First HIV+ Diagnosis:	☐ **Estimated?**	**Date of First AIDS Diagnosis:**	☐ **Estimated?**

HIV Risk Factor

How do you believe you contracted HIV?

- ☐ Male to Male sexual contact
- ☐ Injection Drug Use
- ☐ Male to Female Sexual Contact
- ☐ Hemophilia/Coagulation Disorder
- ☐ Recipient of transfusion of blood, blood components, or tissue
- ☐ Perinatal Transmission
- ☐ Undetermined/Unknown, risk not reported or identified
- ☐ Other, please specify: _____

Proof of Diagnosis

Please select one option from the list below and attach a copy to this application. **Documentation must contain the client's full name**.

Proof of Diagnosis Documents
☐ Western Blot
☐ Letter on physician's/clinician's letterhead, with signature of physician/clinician, indicating that the applicant is HIV positive with diagnosis date.
☐ Electronic medical record from physician's office, with electronic signature of doctor, indicating that the applicant is HIV positive.
☐ Positive HIV test (immunoassay) and detectable viral load (HIV RNA)
☐ Two positive HIV tests (immunoassays- should be different assays based on different antigens or different principles)

Income

What is your estimated current annual gross income? $_____

Health Insurance

Do you currently have health insurance?

☐ No ☐ Yes

Select all of the health insurance types you have:

- ☐ Medicaid
- ☐ Medicare Parts A/B/C/D/Supplement
- ☐ Private- Individual (Direct Purchase/ Marketplace/ COBRA)
- ☐ Private- Employer
- ☐ Veterans' Health Administration (VA), TRICARE, CHAMPVA
- ☐ Indian Health Service (IHS)
- ☐ Other Health Insurance: _____

Release of Information

I fully understand that by applying for this program, my information will be kept confidential. I also understand that supplied information or records associated with my case will not be released to anyone outside of the agency gathering the information without my informed written consent, a subpoena, court order, or legal statute.

In addition, by signing this form, I understand that the information contained may be used by staff to review my eligibility for this program and to verify all application information provided. By applying for this program, I understand that this does not mean that my application will be accepted, as eligibility requirements must be met, and funds are limited.

I fully release and hold Clark County, Office of HIV employees and agents harmless from any and all damages, losses, liabilities (joint or several), payments, obligations, penalties, clients, litigation, demands, defenses, judgments, suites, proceedings, costs, disbursements or expenses (including without limitation, fees, disbursements, and expenses of attorneys, and other professional advisors and of expert witnesses and costs of investigation and preparation) of any kind or nature relating to or arising out of my receipt of services.

I certify that the information provided in this application is true and accurate as of the date below and acknowledge that any intentional or negligent misrepresentation of the information may result in nullification of this application and termination of benefits and services.

Printed Name	**Signature**	**Date**