CLEAR FORM

LifeLong Medical Care
Health Services For All Ages
a californiahealth+center

Lifelong EBCRP Ryan White Referral Form
Substance Abuse or Mental Health Counseling

FAX form to: Leora Myers at 510-446-7108

Name of Referring Party: _____ Date of Referral: _____

Name of Medical Provider: _____ Contact #: _____

Social Worker: _____ Contact #: _____

CLIENT INFORMATION

Client Name: _____

Sexual Orientation: _____ Gender Identity: _____ Preferred Pronouns: _____

Contact: (H) _____ (C) _____ Email: _____

OK to say Lifelong-EBCRP when calling? ☐ Yes ☐ No

Address: _____

DOB: _____ Health Insurance: _____

REASON FOR REFERRAL: *(Client's reported symptoms and/or stated primary concern for therapy)*

Need mental health support? ☐ Yes ☐ No

Need substance use support? ☐ Yes ☐ No

REVIEW BY LIFELONG EBCRP PROGRAM MANAGER

Reviewed by : _____ Date: _____

Assigned Therapist: _____ Date: _____

Refer-Out – Suggestions: _____

Referral Outcome? _____

Referring party/Manager notified?

Whom: _____ Date:_____

Office of HIV Care

ALAMEDA COUNTY PUBLIC HEALTH DEPARTMENT

RYAN WHITE PROGRAM ELIGIBILITY VERIFICATION FORM

Client (Print): _____ **DOB:** _____

ARIES ID #: _____ **Phone:** _____

Form Generated by: _____ **ARIES consent to share on file:** yes ☐ no ☐

Criteria	*Description*	*Verified by*	*Date(s) Verified*
HIV Status	*Documented with copy of one of the below:* _____ Letter of diagnosis on provider letterhead _____ Confirmed HIV test with client's name _____ Viral Load (detectable) with client's name	_____ Contact with Case Manager _____ In-House documentation	_____ Only needed once
Income	*Documented with copy of one of the below:* _____ Pay-check stub _____ Benefit award letter _____ Dated and signed letter from the client stating they have no form of income IN ADDITION a signed letter from a guardian/care taker/ partner that they are covering the living costs of the client _____ No Change	_____ Contact with Case Manager _____ In-House documentation	_____ Annual Certification _____ Update
Residency (Not Immigration Status)	*Documented with copy of one of the following:* _____ Lease/mortgage – with client's name & address _____ Utility bill – with client's name & address _____ Dated and signed affidavit stating client is homeless _____ No Change AND the following _____ Clients' CA Driver's License, State issued ID or other Government issued ID card with current address	_____ Contact with Case Manager _____ In-House documentation	_____ Annual Certification _____ Update
Health Insurance Status	*Documented with copy of one of the below:* Medical Health Plan: _____ _____ Insurance card _____ Benefit letter or denial letter _____ Dated and signed letter from the client stating he/she has no form of insurance coverage _____ No Change	_____ Contact with Case Manager _____ In-House documentation	_____ Annual Certification _____ Update
***Viral Load**	*Documented with a copy of one of the following* _____ Most Recent Viral Load Lab Result with client's name and date _____ Dated and signed letter from HIV medical provider with viral load value and date	_____ Contact with Case Manager _____ In-House documentation	_____ Initial _____ 6 month
Case Manager / Social Worker Information	*I am the Case Manager of Record for this client and have the documentation listed above on file for chart audit verification.* ****Required*** _____ _____ ***Print- Case Manager / Social Worker on record*** ***Agency*** _____ _____ _____ ***Phone*** ***Fax*** ***Email*** _____ _____ ****Case Manager or Social Worker's Signature*** ***Date***		

* Viral Load is not required for eligibility. Viral Load value and date are required for Quality Improvement and will be collected for Medical Case Management and Outpatient Ambulatory Health Services.