AIDS Services Foundation Orange County

Referral for ASF Nutrition and Transportation Services

Must be updated every 6 months **Fax to (949) 809-5779**

(Revised 3/6/15)

Date: _____

Client Name: _____ First ____ MI or ☐ None _____ Last MMN: _____

Residence: _____ Street Address _____ City _____ Zip Code

Phone #: _____ OK to call? ☐ Yes ☐ No Message OK? ☐ Yes ☐ No

Date of Birth: _____ Hispanic: ☐ Yes ☐ No ☐ Unknown

Gender:
☐ Male ☐ Transgender M2F
☐ Female ☐ Transgender F2M
☐ Other ☐ Refused to report

Race:
☐ White ☐ Pacific Islander ☐ Unreported/Unknown
☐ Black ☐ Asian ☐ Other: _____
☐ American Indian or Native Alaskan

Emergency Contact: _____ First _____ Last _____ Phone #

OK to call? ☐ Yes ☐ No Aware of HIV? ☐ Yes ☐ No Message OK? ☐ Yes ☐ No

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Referring Agency: _____ Staff Member: _____ Staff Phone: _____

Signature of Referring Staff Member: _____

☐ Ryan White eligibility screening has been completed.

☐ Date of completed eligibility screening: _____ Expiration date: _____

or ☐ Eligibility screening has not been completed yet.

☐ Client been informed of the Client Rights and Responsibilities and the Client Grievance Process.

☐ Client has signed a current ARIES Consent Form.

☐ ARIES Form is Shared and is valid from _____ to _____

or ☐ ARIES Form is Non-Shared and is valid from _____ to _____

☞ Fax ARIES Form with bottom section filled out giving ASF permission to share client's info with ARIES

☞ Fax signed ASF Notice of Privacy Practices (HIPAA). - With initial referral only

☞ Fax Release of Information indicating PHI can be shared between referring agency and ASF.

Monthly Household Income: _____ # in Household: _____ ☐ Head of Household

☐ Nutrition Services

☐ Client is permanently disabled. Date of permanent disability: _____

or ☐ Client is temporarily disabled.

Date of disability: _____ Date of reevaluation: _____

☐ Food Pantry - Client does not have sufficient food resources (i.e. Food Stamps, WIC, board and care).

or ☐ Mini Pantry is requested. *Client receives home-delivered meals but needs additional food.*

☐ Nutritional Supplements - Clients cannot receive supplements through medical insurance.

☞ Fax Physician's Recommendation for Nutritional Supplements or nutritional assessment by RD or Nurse CM.

☐ Medical Transportation

☐ Client does not have other means of transportation (i.e. car, friends, family, caregiver).

☐ Client has been assessed in the past 6 months for appropriateness of transportation requested.

☐ Bus passes are requested. *or* ☐ ACCESS fare coupons are requested.

☞ Fax copy of proper ID for reduced fare bus pass or ACCESS approval letter

Fax or email Bus Pass/ACCESS Fare Coupon Request Form at least 1 week prior to first appointment.

☐ Van rides requested for medical, dental or mental health appointment.

Contact ASF's Transportation Supervisor for arrangements at least 2 business days prior to appointment.