

INDIANA ALL PARTS PROGRAM: HIV VERIFICATION FORM

HSP eligibility requirements: To be eligible for the Indiana HIV Services Program (HSP), applicants must be able to document diagnosis of HIV. HIV surveillance data will be used to verify HIV status for all applicants and no other documentation is required with the following exception:

If an application has moved to Indiana or been diagnosed in the last 60 days, the applicant must also provide proof of status as outlined below.

- Lab report that shows a detectable HIV viral load that documents client's full name and date of test;
- Lab report that shows positive confirmatory HIV testing that documents client's full name and date of test; and/or,
- Hospital Discharge Summary that documents a positive HIV diagnosis, client's full name, date of admission and discharge, medical provider name, and hospital/facility address.

Instructions: Please complete the front side of this form and submit it with a new client's application. The completed application should be uploaded to HIVE.

Date completed	
Care Site	
Non-medical Case Manager (NMCM)	

COMPLETED BY NMCM	Legal First Name	
	Legal Last Name	
	Alias/Other Name used by applicant	
	Date of birth	
	Social Security Number (SSN)	
	<input type="checkbox"/> Check here if client does not have a SSN	
	Current address (P.O. Box not permitted)	
	<input type="checkbox"/> Check here if homeless/unstably housed	
	Sex at birth	
	Did applicant move to Indiana or was diagnosed with HIV in last 60 days?	
City and state in which applicant was diagnosed (if known)		
City and state where applicant was living when diagnosed (if known)		

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COMPLETED BY ES	HIVe ID (if needed)	
	RWise ID	

COMPLETED BY HIV SURVEILLANCE	STATENO	
	HIV diagnosis date	
	AIDS diagnosis date (if applicable)	
	Risk factor(s)	Check all that apply: <input type="checkbox"/> Male to Male sexual contact <input type="checkbox"/> Injection drug use <input type="checkbox"/> Hemophilia/coagulation disorder <input type="checkbox"/> Heterosexual contact <input type="checkbox"/> Receipt of blood transfusion, blood components, or tissue <input type="checkbox"/> Perinatal transmission <input type="checkbox"/> Risk factor not reported or not identified
	Most recent CD4 count	
	Most recent CD4 date	
	<input type="checkbox"/> No CD4 count found	
	Most recent viral load count	
	Most recent viral load date	
	<input type="checkbox"/> No viral load found	
Date form completed		
<input type="checkbox"/> Check here if HIV diagnosis could not be confirmed		
Notes from surveillance		

COMPLETED BY ES ONCE FORM RECEIVED FROM SURVEILLANCE	
<input type="checkbox"/> Check when data have been entered into RWISE	Date entered