Thursday's Child of Long Island: General Intake

All information will be kept strictly confidential

* This intake has 2 pages *

Office: 631-447-5044 Fax: 631-447-2494

Support, Prevention, Care For All
Free & Confidential HIV Services On Long Island

Name: _____

Desired Name: _____
How would you like us to call you?

Address: _____

Town: _____, NY _____
Zip Code

County: □ Nassau □ Suffolk

Home Phone: _____

Cell Phone: _____

Date of Application: _____
mm/dd/yyyy

Date of Birth: _____
mm/dd/yyyy

Age: _____

Sex: □ Male □ Female □ Intersex □ AFAB □ AMAB

Gender: □ Man □ Woman □ Trans □ Non-Binary □ GNC

How may we contact you? (check all that apply):

□ Phone □ Mail □ In Person

□ Email: _____

Referred from (Organization, Staff Member and Phone Number with Extension):

_____

_____

Where do you go for your HIV care? (Medical Center and Address):

_____

_____

Pharmacy (Name and Address):

_____

_____

Do you have a Case Manager?: □ Yes □ No

If yes, please fill (Organization, Name of Case Manager and Phone Number with Extension):

_____

_____

What language(s) do you speak?: _____

Race (check all that apply):

□ White □ Black/African American □ American Indian or Alaska Native

□ Asian □ MTOR □ Native Hawaiian or Pacific Islander
More Than One Race

Ethnicity: Are you Hispanic? □ Yes □ No

if yes, are you?:

□ Mexican □ Puerto Rican □ Cuban

□ Another Hispanic or Latin country: _____
Name of Country

Are you a Veteran?: □ Yes □ No

What is you sexual orientation?: □ Heterosexual □ Homosexual □ Bisexual □ Other: _____

Risk Factor (How did you contract HIV?):

□ MSM □ Heterosexual □ Injection Drug Use □ MSM and Injection Drug Use

□ Blood Transfusion □ Transmission from Mother □ Hemophilia/Coagulation Disorder

HIV Diagnosis Date: _____
required mm/dd/yyyy

AIDS Diagnosis Date: _____
if applicable mm/dd/yyyy

Health Insurance (check all that apply):

□ ADAP/APIC □ Medicare □ Medicaid □ No Insurance □ Private/Employer □ Private/NYS Health Market Place Plan □ Other:_____

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Are you currently employed?: □ Yes □ No If yes, what's your **monthly** employment income?: _____

Do you receive Benefits?: □ Yes □ No

If yes, which one(s)? and fill the amount:

□ SSD _____ □ SSI _____ □ Retirement _____ □ Section 8 _____

□ Unemployment _____ □ Worker's Comp _____ □ Other _____

Do you have a case/benefits with the Department of Social Services (DSS)?: □ Yes □ No

If yes, what type(s)? and fill the amount:

□ SNAP/food stamps _____ □ Public Assistance _____ □ Cash Assistance _____

□ Temporary/Emergency_____ □ Rental Assistance _____ □ HEAP _____

Housing arrangement : □ Single person □ Single person, with children □ Two adults □ Two adults, with children

If you have children, is there **at least one child under the age of 18** ?: □ Yes □ No

Housing Type: □ Rental □ Shared □ Own (Mortgage) □ Homeless □ Other: _____

Household Size: _____ (Including yourself)			**Monthly** Total Household Income $_____	
Name and Last Name	*Date of Birth*	*Relationship*	*Income Source*	*Monthly Income*
		self	as shown above	$
				$
				$
				$
				$
				$
				$

Yearly Total Household Income: $

FPL %: □ <100% □ 101% - 133% □ 134% - 138% □ 139% - 150% □ 151% - 200% □ 201% - 300%
□ 301% - 400% □ 401% - 500% □ >500%

* For the FPL, use the yearly total household income

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