



Member Information Form

Shepherd Wellness Community
4800 Sciota Street
Pittsburgh, Pennsylvania 15224

You can help Shepherd Wellness Community to receive funding for our programs and services by filling out this form. The following information is required by our funding sources. This information is confidential and will only be seen by a limited number of SWC staff. Your information is protected to the full extent of the HIV Confidentiality Law of the State of Pennsylvania, commonly known as "Act 148".

Date: _____ **Date of Birth:** _____
Last Name: _____ **First Name:** _____ **Middle Initial:** _____
Street Address: _____ **City:** _____
County: _____ **State:** _____ **Zip Code:** _____
Contact Telephone: _____ **May we call or leave a message at this number?** Yes No
Gender: Male Female Transgender

Race (if you are of mixed race or unsure, choose the group that you identify with most closely):
 white African American Asian Hawaiian Native/Pacific Islander American Indian/Alaska Native Other
Are you of Hispanic origin? Yes No

What is your HIV status?
 HIV positive (Non-AIDS) HIV positive (AIDS status unknown) CDC-defined AIDS
Source of HIV infection: Male who had sex with Male(s) Injecting drug use Heterosexual contact
 hemophilia/coagulation disorder Receipt of Blood Transfusion Perinatal Transmission Other
Primary Insurance:
 Private Medicare Medicaid Other Public (CHAMPUS, etc.) Other No Insurance
Who is your primary health care provider or doctor? PACT Positive Health Clinic County Health Dept. None
 Emergency room Private practice _____ Other _____

Your living arrangement: permanently housed homeless institution other

Number living in Household: _____

Do you have biological or legally adopted children living with you? Yes No

If "Yes", list their names and birthdates: _____

Monthly Income: \$0-\$200 \$201-\$400 \$401-\$600 \$601-\$800 \$800 - \$1000 over \$1000



4800 Sciota Street
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Office Phone: 412-683-4477
FAX: 412-683-5755

Dear Shepherd Wellness Community Member:

It's almost summer and that means SWC/PATF Kennywood Day is just around the corner!

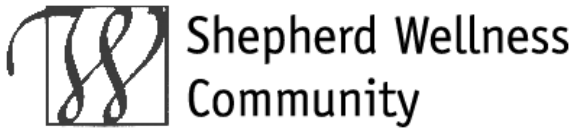
Some of the benefits that Shepherd Wellness Community offers our members are free or low cost outings and activities like Kennywood, Movie Night Out, Just Ducky tours, and trips to the zoo and museums.

To keep your SWC membership active we need to have your "Verification of Medical Care Form" on file at Shepherd Wellness Community showing a **date of medical testing in the past 12 months**. The form collects **only the date** of your most recent CD4 or Viral Load test, no test results or other medical information are requested.

Please return the enclosed form, signed by your medical provider OR case manager, so you qualify for the free or low cost tickets and admission to our outings. If we don't receive your "Verification of Care" form, then we cannot provide free or low cost tickets to our outings and the other activities we sponsor.

Federal Ryan White funding requires each SWC member to have a form on file at SWC verifying medical care in the past 12 months. Returning your form keeps your SWC membership active and enables SWC to qualify for Ryan White funding. It's an important win-win for all of us.

Sincerely,
Your Friends at Shepherd Wellness Community



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VERIFICATION OF MEDICAL CARE

Name: _____

I, hereby authorize _____

PHYSICIAN, MEDICAL PROVIDER, OR CASEWORKER

to provide information in my records to the **Shepherd Wellness Community**, for the purpose of verifying my medical care.

_____/_____/_____
Patient's Signature Date

CHOOSE THE ONE WITH THE MOST RECENT DATE:

Date of Last CD4 test: _____ **do not provide test results - not needed**
or
Date of Last Viral Load test: _____ **do not provide test results - not needed**

_____/_____/_____
CASE WORKER / MEDICAL STAFF SIGNATURE DATE

TO THOSE WHO RECEIVE INFORMATION UNDER THIS RELEASE: This information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.

This form must be completed each year.
Have your medical provider or case worker sign this form and
mail or fax (412-683-5755) the form to Shepherd Wellness Community.