HIVCareLink

Provider Referral Form

Participant Name: _____ DOB: _____

Participant Address: _____

Participant City/State/Zip: _____

Participant Phone(s): _____

Referring Agency: _____ Referral Date: _____

Agency Contact Name/Title: _____

Agency Phone: _____ Email: _____

Refer to Service.

☐ **Care Program:** Provides trained individual **Peer Allies/Support-Specialists** for people living with HIV—offering practical and emotional (and spiritual if requested) support that can help the participant feel less alone and more empowered.

☐ **Medical Procedure Transportation:** Provides transportation, by a trusted peer, for people living with HIV who are undergoing a procedure with anesthesia that requires a responsible person to sign the patient out and bring them home safely. We require at least 2 weeks' notice and do our best to accommodate requests.

Please provide the following documentation with this referral.

- Release of information
- Proof of current ADAP/SDAP/Ramsel Card
    - If no ADAP/SDAP/Ramsel card, we need the following:
        - HIV status
        - Proof of Income
        - Proof of Health Insurance
        - Proof of Residence

Please note relevant dates/times and participant concerns/information: _____

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Please make referrals to Mike Tucker at 303-382-1344 and securely email qualifying documentation to Mike@hivcarelink.org.