POSITIVELY NUTRITIOUS Application

Please provide as much information as you can and print clearly.

Name (Last, First):_____ **Date of Birth:**_____
Address: _____ **Apartment:** _____
City: _____ **State:**_____ **Zip:**_____
Primary Phone #: (_____)-_____-_____ **Other #:**(_____)_____-_____
Ethnic Group: ❒ Black/African American ❒ White/Caucasian ❒ Latino
❒ Asian ❒ Other: _____

Doctor's Name: _____ **Location:**_____
Phone #: (_____)_____-_____ **Fax #:** (_____)_____-_____

Month and year of your Diagnosis as HIV positive: ____-_____

CoexistingConditions:_____

_____

Current Medications or Supplements: _____

_____

Hospitalizations in past year (provide dates and reasons for each):

_____

_____

Height:_____ **Current Weight:** _____ **Usual Body Weight:** _____

Significant Lab Values:
(You may also attach a copy of your most recent labs from your Dr.)
CD4: _____ **Viral Load:** _____ **Albumin:** _____
Cholesterol: _____ **Triglycerides:** _____ **Glucose:** _____

Are you experiencing frequent (please circle all that apply):
Diarrhea Constipation Nausea Vomiting

Ambulation or living environment concerns that affect nourishment:

_____

Medical Care Provider:
Please review the information provided by your patient and make any corrections or additions that may be needed. Once the application is complete, please sign below and fax back to 215-496-9102. Thank you.

Signature:_____ **Date:**_____

The signature on page 1 will be the proof of HIV/AIDS status. In addition, all applicants must have the following to participate:

- Picture identification
- Proof of address
- Proof of income
- Proof of medical insurance

Notice of Information Practices and Privacy Statement

How We Do Use Your Information: Information is only used as is reasonably necessary to process your application or to provide you with services which may require communication between MANNA and health care providers to verify your medical information is accurate.

What We Do Not Do With Your Information: Information about your financial situation or medical conditions provided to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence. We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

Limited Right to Use Non-Identifying Personal Information from Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of MANNA. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission. Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission. You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos sent to us will ever be publicly used without your direct or indirect consent.

Revision Date: 10/31/2011

Privacy Notice:

I, Mr./Ms.*_____ authorize MANNA to release any relevant information to my care providers. This release is reciprocal, i.e., I am giving my permission for all parties identified above to communicate back and forth with one another. I understand that all information obtained by MANNA will remain confidential and will only be available to MANNA staff and volunteers as necessary for me to receive services. I am aware that I may rescind this authorization any time by notifying MANNA in writing.

Client Signature: _____ Date: _____