Appendix C

Action Point Information and Consent Forms
CONSENT FOR ACTION POINT SERVICES

HOW CARE PLANS WORK

CARE PLANS

• Upon intake, a client will meet with a nurse and case manager to create an individualized adherence care plan that lays out how the client will work with Action Point staff toward the goal of taking medications independently.

• Clients are expected to meet regularly with nurse and case manager to evaluate how the care plan is working and whether it needs to be changed.

• There are some standard expectations which are part of everyone’s care plan. These will be reviewed in detail when you meet to develop your care plan. They include:
  
  - Providing proof of TB clearance every 6 months
  - Visiting your primary care provider on a regular basis as determined by you and your provider
  - Getting labs drawn regularly per your provider
  - Meeting with an Action Point nurse and Case Manager on a regular basis

Client Signature ___________________________ Date __________

Print Name _______________________________
CLIENT NAME ________________________________________ DOB ______________ MR#_________

PRIMARY DIAGNOSES ____________________________________________ Allergies ______________________________

OTHER DIAGNOSES ______________________________________________

OPPORTUNISTIC INFECTION HX ______________________________________

TB CLEARANCE Action Point requires a negative PPD within the past 30 days and/or a neg. CXR (PA + LAT) within
the past 90 days. We send new clients to TOPS for clearance as needed. Please note TB
clearance/prevention/treatment history below:

LABS: Recent CD4______ Date ______ Recent VL _______ Date_______

Nadir CD4 ______Date_______ Highest VL _______ Date ______

MEDS CLIENT HAS TAKEN IN THE PAST (and reasons for stopping, if known):

HIV DRUG RESISTANCE (IF KNOWN):

CURRENT MEDICATIONS

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<tr>
<th>DATE STARTED</th>
<th>A. MEDICATION/STRENGTH</th>
<th>B. Dosage</th>
<th>Rt.</th>
<th>Frequency</th>
<th>Quantity</th>
<th># RF's</th>
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MAY OUR NURSING STAFF CALL THESE MEDS INTO RITE AID PHARMACY (VAN NESS & MARKET) FOR
DELIVERY TO ACTION POINT? YES_____ (INITIAL) NO______ (INIT.)

SIGNATURE __________________________________ DATE __________

PRINT NAME_________________________________ Lic. #____________ DEA#____________

Best person to contact at your facility regarding this client: ______________________________

Contact information for this person: __________________________________________

COMMENTS: ____________________________________________________________
CONSENT FOR ACTION POINT CENTER SERVICES

HOW MONEY AND PAGERS WORK

MONEY

- $130 will be placed on account for active clients.
- $10 may be withdrawn from your account every Monday.
- Clients must pick up money themselves.
- Withdrawals can be made until the balance is $0 or until you stop being an active client.
- If you end service with Action Point before your balance is $0, the remaining money in your account will be held for you, should you re-enroll. After re-enrolling, $10 per week may be withdrawn from the remaining money in the account.
- No client will receive more than $130 from Action Point no matter how many times they re-enroll.

PAGERS

- A client may receive a pager if it is part of the care plan.
- There is no charge for pager rental.
- If a client loses a pager he or she may receive another one after a month waiting period.
- If a client loses a second pager, he or she will re-evaluate with a nurse and case manager whether or not a pager should be included as part of the care plan.
- Action Point Center will program pagers to remind clients of medication times and to remind clients of various appointments.

Client Signature ____________________                                       Date _______
Printed Name  ________________________
DISCLOSURE OF SHARED INFORMATION

This information is in addition to any Release of Information a client signs between Action Point and the client’s providers.

- Action Point Center is a collaborative effort between the San Francisco Department of Public Health (DPH) and the San Francisco AIDS Foundation (SFAF). Therefore, Action Point staff has access to both DPH and SFAF documentation, including information available from San Francisco General Hospital, TB control, AIDS Health Project and Shanti.

- Action Point South of Market and Action Point Bayview/Hunters Point may share client information in order to avoid duplication of services.

Client Signature ___________________________ Date __________

Print Name ________________________________
RELEASE OF INFORMATION

I, _________________________________________________(AKA)____________________

Authorize_______________________________________________________________

To disclose records obtained in the course of my diagnosis and treatment for:

INITIAL MEDICAL
   Any such disclosure shall be limited to the following specific types of information or dates of treatment: ______________________________

INITIAL PSYCHIATRIC
   Any such disclosure shall be limited to the following specific types of information or dates of treatment: ______________________________
   (I understand that psychiatric records are protected by the California Welfare and Institutions Code Section 5000 et. seq. and are not subject to re-disclosure.)

INITIAL AIDS/HIV
   Any such disclosure shall be limited to the following specific types of information or dates of treatment: ______________________________

INITIAL SUBSTANCE USE
   Any such disclosure shall be limited to the following specific types of information or dates of treatment: ______________________________

INITIAL OTHER
   Any such disclosure shall be limited to the following specific types of information or dates of treatment: ______________________________

   to: ________________________________

This authorization shall become effective immediately and shall remain in effect for this one request only unless otherwise specified. This authorization will terminate on ____________. I understand that I have a right to a copy of this authorization upon my request.

DATE ___________________________ SIGNATURE OF CLIENT ___________________________

WITNESS ___________________________ PRINT CLIENT NAME ___________________________

Client Date of Birth: / / no day year
RULES, REGULATIONS, AND EXPECTATIONS

1. Clients must maintain the confidentiality of other clients. Names and identities of other clients and any personal or medical information are strictly confidential.

2. Action Point Center is not responsible for loss or damage to personal property. Items lost or missing should be immediately reported to the front desk.

3. The following behaviors are considered to be destructive and/or disruptive to Action Point Center and may result immediate suspension from the program:

   - Use or possession of illicit drugs on Action Point Center premises.
   - Threats or acts of physical violence toward other clients or staff.
   - Possession of weapons on the premises.
   - Falsification of any required documentation.
   - Stealing.
   - Willful destruction of property on the premises.
   - Verbal abuse towards staff or other clients.
   - Repeated or serious violation of confidentiality.
   - Sexually inappropriate behavior toward others.
   - Willful breach of confidentiality.

   Clients of Action Point Center OR Urban Health Study are expected to respect the above. 
   CLIENTS WILL BE HELD RESPONSIBLE FOR THE BEHAVIOR OF THEIR GUESTS.

4. A client who does not show up to Action Point Center may be dis-enrolled if 6 weeks has passed since the day the client was expected for services. During that 6 weeks a case manager and/or nurse will make at least 3 documented efforts to contact the client. A missing client will not be dis-enrolled if the reason for the absence is hospitalization, incarceration, or participation in an in-patient treatment program. However, we ask that a client contact Action Point Center staff if they are interested in returning to Action Point Center upon their release.

If you wish to appeal actions or decisions rendered by staff, you may use attached Grievance Procedure.

Client Signature ___________________________________   Date ____________
Print Name  __________________________________________