Virginia Mason Franciscan Health
Bailey-Boushay House

OUTPATIENT PROGRAM REFERRAL FORM

Client Name _____

SSN _____ DOB _____

Phone/Text _____ Email _____ [circle preferred]

Address _____

Preferred Language _____ Preferred Pronouns _____

Primary Medical/HIV Provider _____

HIV Case Manager _____ **HMIS** Unique Identifier _____

Other Providers [ADS, Mental Health, CD, Payee, Housing etc.] _____

_____

General Eligibility:

- **HIV+**
- **Meets Ryan White financial eligibility or pays according to sliding scale**
- **Needs assistance to maintain or achieve independence, that includes one of the following:**
  - Assistance managing or organizing medications
  - Homelessness or at risk for losing housing
  - Assistance in optimizing health due to drug/alcohol use or mental health issues

Required Documentation for ALL programs:

- **Proof of Insurance:** *If not in Provider One*, provide proof of all current insurances
- **Proof of Residency:** *If not homeless*, provide proof showing current address
- **Proof of Income:** *If not zero income*, provide proof of current income
- **Proof of HIV:** Provider to complete Standing Orders which include certification of HIV
- **Clinical:** Comprehensive H&P including recent clinic note, allergies and HIV labs

Choose the program(s) you are referring to:

☐ **Day Program: 8 am – 3:30 pm for those with housing; 8 am – 7 pm for those without housing**
  - **Medication Management**

☐ **Emergency Homeless Shelter: Operates 24 hours/day, 7 days/week**
  - **Eligibility criteria:** HIV+ *and* Homeless

☐ **Rental Assistance Program: Requires pre-approval to refer**
  - **Eligibility criteria:**
    - Referred from a partner agency: POCAAN, BABES, Department of Corrections, Chief Seattle Club, Center for Multicultural Health, Entre Hermanos
    - HIV+ *and* Homeless