Division of Disease Prevention Resource and Referral Guide Update Form

Organization name:

Address:

City: State: Zip Code:

Phone number:

Fax number:

Website:

Email address:

Please indicate if your organization offers any of the following medical services:

	YES, for general population	**YES, for HIV positives**	**NO**
Outpatient/Ambulatory Health Services	☐	☐	☐
AIDS Drug Assistance Program (ADAP) treatments	☐	☐	☐
AIDS Pharmaceutical Assistance (local)	☐	☐	☐
Oral Health Care (Dental)	☐	☐	☐
Early Intervention Services (EIS)	☐	☐	☐
HIV Prevention Services	☐	☐	☐
HIV Rapid Testing	☐	☐	☐
HIV Conventional Testing	☐	☐	☐
Home Health Care	☐	☐	☐
Home and Community-based Health Services	☐	☐	☐
Hospice Services	☐	☐	☐
Health Insurance Premium and Cost Sharing Assistance	☐	☐	☐
Mental Health Services	☐	☐	☐
Medical Nutrition Therapy	☐	☐	☐
Medical Case Management (including Treatment Adherence)	☐	☐	☐
Reproductive Health	☐	☐	☐
Substance Abuse Services- outpatient	☐	☐	☐
STD Testing	☐	☐	☐
STD Treatment	☐	☐	☐

Organization name:

Please indicate if your organization offers any of the following support services:

	YES, for general population	**YES, for HIV positives**	**NO**
Case Management (non-Medical)	☐	☐	☐
Child Care Services	☐	☐	☐
Emergency Financial Assistance	☐	☐	☐
Food Bank/ Home Delivered Meals	☐	☐	☐
Health Education/ Risk Reduction (HIV Prevention)	☐	☐	☐
Housing Services	☐	☐	☐
Legal Services	☐	☐	☐
Linguistics Services	☐	☐	☐
Medical Transportation Services	☐	☐	☐
Outreach Services	☐	☐	☐
Psychosocial Support Services	☐	☐	☐
Referral for Health Care/Supportive Services	☐	☐	☐
Rehabilitation Services	☐	☐	☐
Respite Care	☐	☐	☐
Substance Abuse Residential	☐	☐	☐
Treatment Adherence Counseling	☐	☐	☐

Please indicate all age groups your organization services:

☐ Children
☐ Youth/Adolescents
☐ Adults
☐ Seniors

Please indicate any specific populations that your organization services:

☐ Transgender men
☐ Transgender women
☐ Chronic hepatitis B patients
☐ Chronic hepatitis C patients
☐ Refugees
☐ Other: _____

Please indicate how your organization charges for services:

☐ All services free of charge
☐ Reduced fee based on ability to pay
☐ Ryan White funded services utilize eligibility criteria
☐ Medicare
☐ Medicaid
☐ Other public insurance
☐ Private insurance

Please use the space below to add any additional information you would like included in the guide. You may attach more pages to this form as needed. Please fax or mail this form to:

Schilqua Thompson
P.O. Box 2448, Rm 326
Richmond, VA 23218-2448
Fax: 804-864-8053

Questions can be directed to Schilqua Thompson at Schliqua.Thompson@vdh.virginia.gov or 804-864-8009.

www.vdh.virginia.gov