Shepherd Wellness Community

Helping people living with HIV/AIDS improve their wellness

Member Application Form

Shepherd Wellness Community
4800 Sciota Street
Pittsburgh, Pennsylvania 15224

To become a member of the Shepherd Wellness Community, please complete this form.
The following information is required by our funding sources. This information is confidential and will only be seen by a limited number of SWC staff. Your information is protected to the full extent of the HIV Confidentiality Law of the State of Pennsylvania, commonly known as "Act 148". Este formulario de solicitud de miembro tambien esta disponible en espanol.

Today's Date: _____ **Date of Birth:** _____/_____/_____

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Street Address: _____**City**:_____

County: _____ **State:** _____ **Zip Code:** _____

Contact Telephone: _____-_____-_____ **Is this a** ❒ Mobile (cell) or ❒ Land line?
May we call or leave a message at this number? ❒ Yes ❒ No

Email Address: _____**May we add you to the SWC Mailing List? ❒ Yes ❒ No**

Gender: ❒ Male ❒ Female ❒ Transgender M to F ❒ Transgender F to M ❒Nonbinary
Preferred Pronoun(s): _____
Emergency Contact
Name: _____ **Phone:** _____-_____-_____ **Relationship:** _____
Is this person aware of your HIV Status? ❒ Yes ❒ No

Race *(choose the group or groups that you identify with most closely):*
❒ African American ❒ American Indian/Alaska Native ❒Hawaiian Native/Pacific Islander ❒ White

Are you of Asian Origin? *Please indicate:* ❍ Indian ❍ Chinese ❍ Filipino ❍ Japanese ❍ Vietnamese ❍ Korean ❍ Other

Are you of Hispanic origin? *Please indicate:* ❍ Mexican, Mexican/American, Chicano/a ❍ Puerto Rican ❍ Cuban ❍ Other

What is your HIV status? ❒ HIV positive (Non-AIDS) ❒ HIV positive (AIDS status unknown)
Diagnosis date (mm/yy): _____
❒ CDC-defined AIDS **Diagnosis date (mm/yy): _____**

Source of HIV infection: ❒ Male who had sex with Male(s) ❒ Injecting drug use ❒ Heterosexual contact
❒ Hemophilia/coagulation disorder ❒ Receipt of Blood Transfusion ❒ Perinatal Transmission ❒ Not reported

Primary Insurance: ❒ Private–Individual ❒ Private–Employer ❒ Medicare Part A/B ❒ Medicare Part C ❒ Medicare Part D
❒ IHS ❒ Medicaid ❒ VA or Other Military Insurance ❒ Other ❒ No Insurance

Was your health insurance purchased through the Affordable Care Act (ACA) marketplace? ❒ Yes ❒ No

Who is your primary health care provider or doctor?
❒ PACT ❒ Positive Health Clinic ❒ Allies ❒ Central Outreach ❒ None ❒ Emergency room
❒ Private practice _____ ❒ Other _____

Your living arrangement: ❒ Stable/Permanent ❒ Unstable ❒ Temporary ❒ Homeless ❒ Unknown

Number of people living in your household: _____
Do you have biological or legally adopted children living with you? ❒Yes ❒No

If "Yes", list their names and birthdates: _____

Yearly Income: ❒ $0-15,060 ❒ $15,060-30,120 ❒ $30,120-45,180 ❒ $45,180-60,240 ❒ $60,240-75,300 ❒ over $75,300

Are you certified to receive Ryan White funded services? ❒Yes Where? _____ Date Certified: _____
❒No. Please talk to an SWC staff member about the question of certification.

I CONSENT TO RECEIVE RYAN WHITE FUNDED SERVICES FROM SWC

Signature _____ Date _____/_____/_____ *Updated 2/1/2024*