Health First: Community Health Center (*Adult Intake Form*) E

In order to help the check in process, please fill in ALL information.

PART A

I. Patient Information

_____, _____, _____

Last Name *First Name* *Middle Name*

What name would you like to go by? _____**Preferred Pharmacy:**_____**Phone:**_____

Circle Gender at Birth: M / F **SSN:** _____ - _____ -_____ **Date of Birth:** _____

Gender Identification (please choose one): ☐Male ☐ Female ☐Transgender- male-to-female ☐Transgender female-to-male ☐Other ☐Choose Not To Disclose

Sexual Orientation (please choose one): ☐Lesbian or Gay ☐ Straight (not Lesbian or Gay) ☐ Bisexual ☐ Something Else ☐ Don't Know ☐ Choose Not To Disclose

Marital Status: ☐ Married ☐Divorced ☐ Separated ☐ Single ☐Widow / Widowed ☐ Unknown

Education: (choose the highest education level completed) ☐none ☐1-6 grade ☐7-8 grades ☐some high school ☐ GED high school diploma ☐some college ☐ Bachelors' degree ☐Masters' degree or higher

Race:

☐Native American/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ White ☐ Other

Ethnicity: ☐Hispanic / Latino ☐ Non-Hispanic / Non-Latino ☐ Other:_____

Address:_____ **Zip Code**: _____

Home Phone: (___)_____ **Cellular:** (___)_____**Work**: (____)_____

Email Address:_____ **Preferred Communication:** ☐Phone ☐Text ☐Email

Preferred Phone Contact: ☐ Home ☐ Cell ☐ Work

Preferred Language: ☐ English ☐ Spanish ☐ Other_____ ☐ Interpreter Needed

Living Situation: ☐Homeless ☐Not Homeless ☐Transitional ☐ Doubling Up ☐ Street ☐Other ☐Unknown

Agricultural Worker: ☐ Migrant ☐Seasonal ☐ Not an Agricultural Worker

Are you a U.S. Veteran? ☐ **Yes** ☐ **No**

Who is / was your last Primary Care Provider? _____

Reason for Transfer of Care (if transferring):_____

How were you referred to Health First? _____

Please complete the back of this page.

II. IN CASE OF EMERGENCY

Please contact (name):_____Phone(s):_____

Address:_____Relation:_____

III. INSURANCE INFORMATION

Primary Insurance: _____ ID#_____ Group#_____

Subscriber's Name:_____ DOB:_____ Phone#_____

Secondary Insurance:_____ ID#_____ Group#_____

Subscriber's Name:_____ DOB:_____ Phone#_____

Subscriber Address (if different than the patient): _____

_____

IV. RESPONSIBLE PARTY INFORMATION

Employment: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Full-Time Student ☐ Retired

☐ Active Military ☐ Unknown

Responsible Party Name: _____Employer Name:_____

Employer Address: _____Employer Phone:_____

Are you seeking treatment that is related to a Workers Compensation or Auto Accident injury? ☐ yes ☐ no

_____

V. HOUSEHOLD INCOME INFORMATION

***Note:** As a Federally Qualified Health Center (FQHC), we provide Sliding Fee Scales which may help you with your health care expenses. To help us determine if you may qualify, please answer below.* **IF YOU ARE NOT INTERESTED, PLEASE PROCEED to SECTION VI.**

What is your annual household income? How many people are in your household?_____

☐ No Income ☐ Less than 24,999 ☐ 25, 000 to 39,999 ☐ 40,000 to 59,999 ☐ 60,000 to 99,999 ☐ 100,000 or more

If you are interested to know more about our Sliding Fee Scale Program, please fill out the enclosed Sliding Fee Scale discount program document that appears on the next page.

HealthFirst
Community Health Center

Sliding Scale Program

A **sliding scale** discount program is available for our uninsured and under-insured patients who may have difficulty paying.

□ Yes, I am interested in information regarding the sliding scale program.

□ No, I am not interested at this time in the sliding scale program.

Signature: _____

Date:_____

Once the paper is signed, please return it to the receptionist.

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VI. Required Information and Acknowledgements

Release of Medical Records

In the event that my physician / provider recommends (and I agree to) referral to a specialist, an outside Health Care Center, or other outside medical provider, I hereby authorize Health First to release my medical records as required to the indicated specialty physician, provider and/or the referral health center for the purpose of continuity of care.

I understand that this release does not apply to my behavioral health records, HIV/AIDS status, nor substance (drug, alcohol, etc.) abuse information, if it exists. If there is need for the release of behavioral health records, substance abuse history, or HIV/AIDS status, I will be notified. I will need to complete another Release of Information form specifically granting my consent for such release, if I agree to the records transfer.

I also understand that if I am being referred to a specialist physician or provider, or to a specialty health center, Health First will make the referral to the qualified entity of the patient's choice. If the patient's preferred entity refuses the referral, can't see the patient in a timely manner, or is unavailable, the Health First referral team will seek 'like-specialists' (i.e. physicians, providers, or specialty health centers) to provide care for the patient.

I understand that this release of my medical information is required to facilitate a referral (which is made by my Health First provider and accepted by me) stays in force unless I revoke it in writing to Health First.

Patient Signature:_____ **Date**:_____

Patient's Legal Representative's Signature (if needed) _____ **Date:**_____

CONSENT for TREATMENT

In seeking medical care from Health First, CHC, I do hereby voluntarily consent to such examination and treatment as is deemed necessary by Health First, CHC. I understand the practice of medicine is not an exact science, and that diagnosis and treatment involve risks of injury or even death. I acknowledge that Health First providers have made no guarantees to me as a result of examination or treatment.

Patient / Representative Signature:_____ **Date:**_____

Do you have an Advance Directive? ☐ **yes** ☐ **no**

If no, would you like some information about Advance Directives? ☐ **yes** ☐ **no**

Please complete the back of this page.

Acknowledgements (please read, check the boxes, and sign/date below)

- ☐ **1. Cancellation of Appointments.** I agree to schedule appointments for my treatment. I agree that I will call and cancel my appointment at least 24 hours prior to the appointment time, if cancellation is necessary. I understand that if I have three missed or cancelled appointments, I may be discharged from the Health Center practice.
- ☐ **2. No Call / No Show.** I understand that missing 3 appointments within 12 months as a no call/no show **may** cause me to be discharged from the practice.
- ☐ **3.** I understand that if I have any problems getting to my appointment, I can let Health First know in advance and they may be able to **help me with transportation**.
- ☐ **4. Notice of Privacy Practices.** I have received a copy of the Notice of Privacy Practices.
- ☐ **5. Responsibility for Payment.** For and in consideration of services rendered, or to be rendered, to the named patient, I or we, or either of us do hereby promise to pay Health First CHC the full amount of all charges incurred. I/we understand that Health First CHC will file commercial insurance as a courtesy. Health First will allow 30 days for the insurance to resolve the outstanding charges. After the 30 days, any remaining charges will become due and payable by the financially responsible person(s).
- ☐ **6. Co-pays, co-insurance and sliding scale fees** are due at the time of service.

Patient / Representative Signature:_____ Date:_____

Co-Signature (if needed)_____ Date:_____

END PART A

Please continue to the next section, PART B.

PART B

VII. Your Health History

Do you have vision impairment? ☐ yes ☐ no
Do you have hearing impairment? ☐ yes ☐ no
Do you have trouble reading? ☐ yes ☐ no
Do you require treatment/medication for chronic pain? ☐ yes ☐ no
Have you ever had a heart catheterization? ☐ yes ☐ no **If yes, when? _____**
Have you ever had any arterial stents placed? ☐ yes ☐ no **If yes, when? _____**
Have you ever had a colonoscopy? ☐ yes ☐ no **If yes, when? _____**

Please List other physicians or health care providers that you currently see and why you see them.

Doctor / Provider	Condition / Reason you see them

VIII. Personal Habits / Social History:

Do you now or have you ever used tobacco? ☐ yes ☐ no
If yes, do /did you - ☐ **smoke** ☐ **chew** ☐ **use both ?**
If you smoke or have smoked, how many packs per day? _____
Are you currently using tobacco? ☐ **yes** ☐ **no**
If no, when did you quit tobacco use? _____
How long did you smoke? _____months or years(circle one)?
How long did you dip/chew? _____ months or years (circle one?
Do you use or have you used E-cigs or Vaping? ☐ **yes** ☐ **no**
Have you ever used recreational / street drugs? ☐ **yes** ☐ **no**
If yes, What? _____When?_____

Do you regularly drink alcohol? ☐ **yes** ☐ **no**

If yes, what and how much on average? ☐ **Beer - Number of bottles or cans per day _____**
☐ **Wine - Number of glasses per day _____** ☐ **Liquor – Number of ounces per day_____**
If yes, have you had 6 or more drinks during a drinking session in the past year? ☐ **yes** ☐ **no**

Has a person that you live with hit you or hurt you physically in the past? ☐ **yes** ☐ **no**
Has any person verbally abused you? ☐ **yes** ☐ **no**
Do you feel safe? ☐ **yes** ☐ **no**

IX. Immunization History:

Vaccination	Date of Immunization
Influenza	
Pneumonia	
Tetanus / Tdap	
Hepatitis B	
Shingles	

X. SELF and FAMILY HISTORY: **Do <u>you</u> or <u>any family members</u>** have, or have had, any of the following conditions? *(grandparents, parents, aunt, uncle, brother, sister or you) Check the appropriate answers, Y/N.*

Condition	Y	N	ME (if yes applies)	Family Mbr if yes applies	Condition	Y	N	ME (if yes applies)	Family Mbr if yes applies
Heart Attack					Migraines				
High Blood Pressure					Seizures				
Congestive Heart Failure					Melanoma (skin cancer)				
Rheumatic Heart Disease					Ovarian Cancer				
Congenital Heart Disease					Pancreatic Cancer				
Breast Cancer					Any other Cancer				
Colon Cancer					Tuberculosis				
Colitis					Diabetes				
Crohn's Disease					Goiter/ Thyroid Disorder				
Colon Polyps					Blood Clotting Disorders				
Hepatitis					Bleeding Tendency				
Stomach Ulcer					Anxiety and/or Depression				
Kidney Disease					Suicide				
Stroke					Mental Illness				
Leukemia					Drug or Alcohol Abuse				

XI. THE FOLLOWING SECTION IS FOR FEMALES ONLY :

Are you pregnant or could you be? ☐ yes ☐ no
Have you had a hysterectomy? ☐ yes ☐ no
Do you regularly have a PAP smear? ☐ yes ☐ no
Have you had a mammogram? ☐ yes ☐ no
How many pregnancies have you had? _____
How many vaginal births have you had?_____
How many premature births?_____

Date of last menstrual period:_____
If yes, when? _____
Date of last test_____

Have you had a miscarriage? ☐ yes ☐ no
How many C-sections have you had? _____
Any complications of pregnancy? ☐ yes ☐ no
If yes, explain. _____
_____

XII. What We Should Know.

THE FOLLOWING QUESTION IS FOR EVERYONE:

Is there anything that you think we need to know about you? If so, please tell us in the space below.

_____
_____
_____
_____
_____
_____
_____

Thank you for Choosing Health First!

Your Health is our First concern and

we are very glad that you are here.

Health First
Community Health Center

Please proceed to PART C.

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PART C

Patient Rights & Responsibilities

Our Patients / Clients Have a Right to:

- **SERVICE:** Service regardless of your race, sex, religion, age, ethnic background, linguistic preference, education, social class, economic status, or disability.
- **RESPECT AND FREEDOM FROM ABUSE:** Expect that our staff will be sensitive to your needs and feelings, and to be treated with respect and dignity.
- **PRIVACY:** Consideration for your privacy. Treatment is confidential and should in all cases be conducted discreetly.
- **INFORMATION:** Know your diagnosis, treatment plan, prognosis, and probable consequences of treatment, as well as possible consequences if treatment is not given. To know any other significant information that would enable you to give informed consent.
- **CHOICE:** Be involved in the planning the medical services that you are to receive, and to consent to or refuse treatment.
- **CONFIDENTIALITY:** Confidentiality in personal matters, interpersonal relations, and written healthcare records, along with access to those written records.
- **CONTINUITY OF CARE:** Referral to other services, specialties, and agencies that are necessary for your health and continuity of care.
- **REVIEW THEIR MEDICAL RECORDS** and,
- **BILLING:** Obtain, question, review, and discuss a full accounting of charges for your medical or behavioral care regardless of the source of payment.
- **RECOMMENDATIONS:** Make constructive recommendations for improvement of policy, communications, or service changes that will affect you as a healthcare consumer.
- **KNOWLEDGE OF EXPECTATIONS:** Know the rules and standards that apply to your conduct as a patient/client.
- **COMMUNICATION:** Have all communication in a language that you clearly understand. If needed, you may have interpretive services.
- **GRIEVANCES:** File a complaint about service-related issues or the treatment being provided, and to request assistance in the filing of a complaint.
- **SUGGESTIONS AND COMPLIMENTS:** Participate in the patient satisfaction survey each time you visit us. You may call (270-667-7017) if you would like to discuss an issue or complaint you may have regarding your experience with Health First. As well, you can use this same line to give a compliment regarding any excellence of service you experienced at Health First. If you prefer, a staff member will help you reach a manager.

Our Patients / Clients Have the Responsibility To:

- Arrive on time for appointments.
- Provide at least twenty-four (24) hours' notice of appointment cancellation.
- Participate in the development of mutually agreed upon treatment plans and follow such plans.
- Ask questions about specific problems or request information when they do not understand their illness, diagnosis, medications, or treatment.
- Provide accurate and complete medical information to healthcare providers / physicians.
- Show respect and consideration of other patients, staff, Health First CHC property, and property of other patients or visitors.
- Tell us if one of our team members gave you excellent service.
- Let us know if you are dissatisfied with our service.
- Comply with signed patient contracts.
- Follow all insurance company guidelines about how to access services.
- Take financial responsibility for payment of all charges including:
    - To bring your insurance card, if you are insured, each time you come to Health First for services.
    - To pay all co-payments and deductibles at the time of your visit, if you are insured.
    - To pay at the time of your visit for services rendered if you are uninsured.
    - To bring in documentation of eligibility for discount in a timely manner, if you are uninsured.
    - To bring in documentation of eligibility for Medicaid in a timely manner, if requested by Health First.
    - To contact the billing department immediately to make payment arrangements if you can not pay.

Notice of Privacy Practices

Health First CHC values the privacy of your health information. This Notice of Privacy Practices describes examples of how we may use and give out ("disclose") your personal health information. This is not a complete list.

Our duties. We are required by law to protect the privacy of your health information. We are also required to give you this notice to tell you how we may disclose your personal health information. We are required to abide by the terms of this Notice. We may change the terms of our notice at any time. Any new notice will be effective for all personal health information that we maintain at that time.

What type of personal health information may we collect? The personal health information that we collect may include your name, address, birth date, social security number, medical and mental health history, payment sources, the names of your care givers (doctors, etc.) and how to contact your family and others involved in your care.

When we may use or give out your personal health information without your authorization? The following categories describe such Health Information disclosures.

1. **Treatment, payment, and health care operations.** The following are examples of how we may disclose your personal health information to deliver treatment, obtain payment, and operate our programs and business:
   a. We may share information with other health care providers who are involved in your care such as physicians, outside consultants and other facilities to which you may be transferred.
   b. We may share information with our business associates who perform services for us (e.g. billing, audit services). If we do share information with them, we will have a written contract that will obligate the business associate to protect the privacy of your personal health information.
   c. We may disclose your information to obtain payment. This may include sharing information with your health insurance as it makes payment decisions. They may verify your coverage and review services for medical necessity. We may also disclose your information to another health care provider to help them obtain payment.
   d. We may disclose your information to operate our programs and business. For example, we may use your information for our quality and safety programs. We may also use it to train medical students.
   e. We may contact you about your appointment.
   f. We may call you by name in the waiting room.
   g. We may contact you for a donation.
   h. We may contact you about treatment options, other health-related benefits, and other products and services that we offer.
   i. We may share your information with manufacturer representatives. For example, a technical advisor on new devices may be present during surgery to answer questions from the operating team.
   j. We may collect data for analysis. In many cases, we will take out information that might identify you personally. In other cases, we will use only limited information as permitted by the privacy laws for research, public health purposes, or health care operations.
2. **Required By Law**. We may use or disclose your personal health information as required by law. The use or disclosure will be made in strict compliance with the law.
3. **Public Health.** We may give out your personal health information for public health purposes. For example: We report limited information to a public health authority in order to prevent or control disease, injury, or disability.

For example, we contact the Health Department when we identify certain diseases, such as tuberculosis. We may give your personal information to the Food and Drug Administration (FDA) about a product or activity that relates to your health.

4. **Contagious Diseases.** When permitted by law, we may disclose your information to a person who may have been exposed to a communicable disease.
5. **Health Oversight.** We may disclose your information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the healthcare system, government benefit programs, or other government regulatory programs. For example, we may disclose information to the state agency that issues our practice license.
6. **Abuse or Neglect.** We may disclose your personal health information to a governmental agency authorized to receive such information if we believe that you have been a victim of abuse, neglect, or domestic violence. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
7. **Legal Proceedings.** We may disclose your personal health information for judicial and administrative proceedings, such as responding to a subpoena or court order.
8. **Law Enforcement.** We may disclose your personal health information for law enforcement purposes, such as providing limited information to locate a missing person, reporting certain types of wounds, and reporting crimes that occur on our property.
9. **Coroners, Funeral Directors, and Organ Donation.** We disclose your information to a coroner or medical examiner in order for them to perform their legal duties such as making identification and determining cause of death. We disclose your information to funeral directors to permit them to carry out their duties. We also are required to disclose your information for organ donation. You or your family must approve organ donations.
10. **Research.** We may disclose your personal health information for research studies that meet all privacy law requirements such as research related to the prevention of disease or disability.
11. **Criminal Activity.** We may disclose your information if we believe it is necessary to prevent or lessen a serious threat to health or safety. We may also disclose personal health information if it is necessary for law enforcement authorities to identify or apprehend an individual.
12. **Military Activity and National Security.** If you are a member of the United States Military, we may disclose your information as required by military command authorities. We may disclose your personal health information for federal officials to conduct national security and intelligence activities, to protect the President or other specified people, or to conduct special investigations. We disclose information for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits.
13. **Workers' Compensation.** We may disclose your personal health information under workers' compensation laws and other similar programs.
14. **Inmates.** If you are in custody, we may disclose your personal health information to the correctional facility or the law enforcement official that maintains your custody.
15. **Your authorization is required for other uses and disclosures.** You must give us your written authorization before we disclose your personal health information for other uses. You may revoke an authorization at any time by contacting Health First. A revocation will not apply to any action we have taken in reliance on the authorization.

You have the opportunity to agree or object. You have the opportunity to agree or object to the use or disclosure of all or part of your personal health information as described below.

1. **Others Involved in Your Healthcare.** Unless you object, we may disclose your information to a relative, a close friend, or any other person you identify. We may also give out your information when it appears, under the circumstances, to be in your best interest to do so.

2. **Disaster Relief.** We may disclose limited information to an authorized entity to assist in disaster relief efforts if we cannot contact you.
3. **You have the right to access your information.** You may see and receive a copy of your personal health information. In some cases, we may deny your request. When required by law, we will give you an opportunity to have our denial reviewed.

   Under federal law, you may not inspect or copy certain records such as psychotherapy notes. Please contact our Compliance Officer if you have questions about access to your medical record.

4. **You have the right to limit what we use and disclose.** You may ask us to limit how we use and disclose your health information to provide treatment, to obtain payment, to operate our programs and business, and to communicate with your family, friends and others you have identified. Your request must state the specific restriction requested and to whom you want the restriction to apply. ***We are not required to agree to that request***.

   If Health First CHC does agree to the requested restriction, we may not use or disclose your personal health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with Medical Records Department or the Compliance Officer.

5. **You have the right to confidential communications.** We will accommodate reasonable requests. However, we may require you to tell us how you will handle payment and give details about where and how to contact you. We will not ask you why you make this request. Please make this request in writing to our Compliance Officer or Clinic Manager.

6. **You have the right to amend your personal health information.** You may ask that we amend your personal health information. We may deny your request. If we deny your request, you can appeal the denial in writing. We will respond to your appeal in writing. Please contact the Medical Records Department or our Compliance Officer.
7. **You have the right to a list of disclosures.** You have the right to receive a list of those who received your personal health information from us during the six years before your request. We do not have to include what we disclosed:
   a. Before March 1, 2010
   b. To carry out treatment, payment, and health care operations
   c. To persons involved in your care
   d. For national security or intelligence purposes
   e. To prisons or jails, if you are an inmate
   f. To you or someone you have formally asked to speak for you, such as a documented medical power of attorney, or heath care surrogate
   g. To those who get this information with your approval

Reporting a problem

If you believe we violated your privacy rights, you may let us know by contacting:

- The Patient Representative of Health First CHC at **(270) 667-7017.**
- The Safety/Compliance Officer of Health First CHC at **(270) 667-7017**, or
- By email at **Healthfirstcares@hfchc.net**

Health First welcomes your feedback and concerns. We will not retaliate against anyone who makes a complaint.

Additional Information

We may collect information that is not described above. We may use and disclose your information in any manner that is consistent with the concepts described in this Notice or permitted by the privacy laws.

For additional information about our privacy policies, please contact our Safety/Compliance Officer,

John Hibbs toll free at **(877) 667-7017** or by email at **Healthfirstcares@hfchc.net.**

This notice was published and becomes effective on March 1, 2010. Last updated on June 23, 2017.

Patient Care and Safety Concerns

Individuals are encouraged to contact Health First CHC toll free at **(877) 667- 7017 or by email at Healthfirstcares@hfchc.net**, regarding patient care or safety concerns that appear to not have been addressed.

For Patient complaint and grievance reporting, please contact our Patient Representative toll free at **(877) 667-7017** to report complaints or grievances regarding your care or a loved one's care.

You may also report complaints or grievances to the Cabinet for Health Services Office of Inspector General at (270) 889-6052.

Thank you for Using Health First

HealthFirst
Community Health Center

WHAT YOU SHOULD KNOW ABOUT HIV AND AIDS

What is AIDS?

AIDS is the **A**cquired **I**mmune **D**eficiency **S**yndrome—a serious illness that makes the body unable to fight infection. A person with AIDS is susceptible to certain infections and cancers. When a person with AIDS cannot fight off infection, this person becomes ill. These infections can eventually kill a person with AIDS.

What causes AIDS?

The human immunodeficiency virus (HIV) causes AIDS. Early diagnosis of HIV infection is important. If you have been told that you have HIV, you should get prompt medical treatment. In many cases, early treatment can enhance a person's ability to remain healthy as long as possible. Free or reduced cost anonymous and confidential testing with counseling is available at every local health department in Kentucky. After being infected with HIV, it takes between 2 weeks and 6 months before the test can detect antibodies to the virus.

How is the virus spread?

Sexual contact (oral, anal, or vaginal intercourse) with an infected person when blood, pre-ejaculation fluid, semen, rectal fluids, or cervical/vaginal secretions are exchanged.

Sharing syringes, needles, cotton, cookers, and other drug injecting equipment with someone who is infected.

Receiving contaminated blood or blood products (very unlikely now because blood used in transfusions has been tested for HIV antibodies since March 1985).

An infected mother passing HIV to her unborn child before or during childbirth and through breastfeeding.

Receipt of transplant, tissue/organs, or artificial insemination from an infected donor.

Needle stick or other sharps injury in a health care setting involving an infected person. Infections can sometimes be prevented by taking post-exposure prophylaxis anti-retroviral drugs. Strict adherence to universal precautions is the best way to prevent exposures.

You cannot get HIV through casual contacts such as:

Sharing food, utensils, or plates

Touching someone who is infected with HIV

Hugging and shaking hands

Donating blood or plasma (this has **never** been a risk for contracting HIV)

Using public restrooms

Being bitten by mosquitos or other insects

Using tanning beds (always clean before and after use)

How can I prevent HIV/AIDS?

Do not share needles or other drug paraphernalia.

Do not have sexual intercourse except with a monogamous partner whom you know is not infected and who is not sharing needles. If you choose to have sex with anyone else, use latex condoms (rubbers), female condoms or dental dams, and water based lubricants every time you have sex.

Educate yourself and others about HIV infection and AIDS.

Pregnancy and HIV/AIDS

Mothers can pass HIV infection to their babies during pregnancy, labor and delivery, and by the child ingesting infected breast milk.

Without treatment, about 25%, (1 out of 4) of the babies born to HIV infected women will get HIV.

Medical treatment for the HIV infected women during pregnancy, labor and delivery, can reduce the chance of the baby getting HIV from its mother to less than 2% (less than 2 out of 100).

An HIV infected mother should not breast feed her newborn baby.

What is unsafe sex?

Vaginal, anal, or oral sex without using a condom or dental dam.

Sharing sex toys.

Contact with HIV infected, pre-ejaculation fluid, semen, rectal fluids, or cervical/vaginal secretions.

What is safer sex?

Abstinence (not having sex of any kind).

Sex only with a person who does not have HIV, does not practice unsafe sex, or inject drugs.

Using either a male or female condom or dental dam (for oral sex).

How to use a latex condom:

1. Use a new latex condom every time you have sex.
2. The condom should be rolled onto the erect (hard) penis, pinching ½ inch at the tip of the condom to hold the ejaculation(semen) fluid. Air bubbles should be smoothed out.
3. Use plenty of WATER-BASED lubricants such as K-Y Jelly, including a drop or 2 inside the condom, before and during intercourse. **DO NOT USE** oil-based lubricants such as petroleum jelly, mineral oil, vegetable oil, Crisco, or cold cream.
4. After ejaculating, withdraw the penis holding the condom at the base so it will not slip off.
5. Throw away the used the condom into a garbage can and wash hands.

Remember: You can't tell whether or not someone has HIV just by looking at them

Is treatment available if I already have HIV/AIDS?
After being infected with HIV, it takes between 2 weeks and 6 months before antibody tests can detect HIV. **Early diagnosis of HIV infection is important!** If you have HIV, you should get prompt medical treatment. In many cases, early treatment can enhance a person's ability to remain healthy as long as possible. Your doctor will help determine the best treatment.

Getting tested for HIV:
If you have never been tested for HIV, you should be tested at least once. Free anonymous and confidential rapid antibody testing and counseling are available at every health department in Kentucky. Centers for Disease Control and Prevention (CDC) recommends **being tested at least once a year if you do things that can transmit HIV.** These include:
Injecting drugs or steroids with used injection equipment
Having sex with someone who has HIV or any sexually transmitted disease (STD)
Having more than one sex partner who has had other sex partners since your last HIV test
Having sex for money or drugs (prostitution-male or female)
Having unprotected sex or sex with someone who has had unprotected sex
Having sex with injection drug user(s)
Having had a blood transfusion between 1978 and 1985
Pregnant women or women desiring to become pregnant
This agency provides quality services to all patients, regardless of HIV status.

If you need more information call:
Kentucky HIV/AIDS Program: 502-564-6539
The National AIDS Hotline: 1-800-342-AIDS
Your local health department's HIV/AIDS Coordinator