ARIES Client Intake Form

Intake Date: _____ / _____ / _____

General Information:

*Last Name:________________ *First Name:________________ *Middle Initial: ___ *Mother's Maiden Name: ______________

*Date of Birth: ____/____/____ Age: _____ *Gender: ☐ M ☐ F ☐ TMF ☐ TFM ☐ Other ☐ Unknown
MM DD YYYY

Residence Verification:

Current Residence Since: ____/____/____
MM DD YYYY

Street:_______________________________ City:______________ State:____ Zip: _______ County:_____________
Geographic Area HSDA: ☐ 4807 – Abilene ☐ 4826 - Fort Worth ☐ 4803-Wichita Falls

Mailing Address:

Same as residence? ☐ Yes ☐ No (If No, complete the following)

Street:_______________________________ City:______________ State:____ Zip: _______ County:_____________
Geographic Area HSDA: ☐ 4807 – Abilene ☐ 4826 - Fort Worth ☐ 4803-Wichita Falls
May we contact you by mail? ☐ Yes ☐ No Should mail to you be confidential? ☐ Yes ☐ No

Phone & Email:

	Phone Type (Work/Home/Mobile/Fax/Messages/TTY)	Allow Calls	Confidential	Messages OK
Phone 1: (_____) _____-______	☐ Wk ☐ Hm ☐ Mb ☐ Fx ☐ Ms ☐ TTY	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Phone 2: (_____) _____-______	☐ Wk ☐ Hm ☐ Mb ☐ Fx ☐ Ms ☐ TTY	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

Emergency Contact Info:

Name:_____________________________

Street 1:___________________________ Street 2:________ City:___________ State:___ Zip: ___________ County:________________

	Phone Type (Work/Home/Mobile/Fax/Messages/TTY)	Allow Calls	Confidential	Messages OK
Contact Phone 1: (_____) _____-______	☐ Wk ☐ Hm ☐ Mb ☐ Fx ☐ Ms ☐ TTY	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Contact Phone 2: (_____) _____-______	☐ Wk ☐ Hm ☐ Mb ☐ Fx ☐ Ms ☐ TTY	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Demographics:

By what names are you also known **(AKA)**_________________________________

Hispanic: *☐ Yes ☐ No ☐ Unknown

* Race: ☐ White ☐ Black / African-American ☐ Asian
☐ American Indian / Native Alaskan ☐ Unknown
☐ Other________________________

National Origin/Ethnicity:

☐ Mexican/Mexican-American ☐ Cuban ☐ Puerto Rican ☐ Central American ☐ South American ☐ Unknown / Unreported
☐ Spanish / Portuguese/Cape Verdean ☐ Other Carribean ☐ Other Hispanic ☐ Spanish, Hispanic, or Latino/a ☐ Chicano/a
☐ Jamaican, Haitian, Dominican Republic

SSN: _____-_____-______

Education Level ☐ No School ☐ Some high school ☐ High School/Diploma/GED ☐ Some College
☐ College Degree ☐ Some Graduate ☐ Graduate Degree ☐ Unknown

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed

Veteran: ☐ Yes ☐ No

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Lesbian ☐ Bisexual ☐ Declines to state ☐ Unsure ☐ Pediatric N/A ☐ Unknown

Special Needs: ☐ Hearing ☐ Vision ☐ Wheelchair ☐ Mobility ☐ More than once ☐ Unknown ☐ Other:_______________

Primary Language: ☐ English ☐ Spanish ☐ Other **Secondary Language:** ☐ English ☐ Spanish ☐ Other

Current Living Situation: ____/____/____
MM DD YYYY

☐ Homeless from the streets ☐ Homeless from Emergency Shelter ☐ Transitional Housing ☐ Psychiatric Facility ☐ Substance Abuse Treatment Facility ☐ Hospital or other Medical Facility ☐ Jail/Prison ☐ Domestic Violence Situation ☐ Living with Relatives/Friends ☐ Rental Housing ☐ Participant-owned Housing ☐ Board Care or Assisted Living ☐ Rental Room ☐ Refused to Answer ☐ Unknown ☐ Other: _______________

Housing Assistance: ☐ HOPWA ☐ HUD Shelter & Care ☐ Section 8/Housing Choice Vouchers ☐ HUD ☐ Tenant-based project ☐ Short Term Emergency ☐ Other

HUD Application Date:____/____/____
MM DD YYYY

If rent or own, do you have a signed lease, title or tax receipt? ☐ Yes ☐ No ☐ Unknown

Living Situation in Past 12 Months: (check all that apply)

☐ Homeless from the streets ☐ Homeless from Emergency Shelter ☐ Transitional Housing ☐ Psychiatric Facility ☐ Substance Abuse Treatment Facility ☐ Hospital or other Medical Facility ☐ Jail/Prison ☐ Domestic Violence Situation ☐ Living with Relatives/Friends ☐ Rental Housing ☐ Participant-owned Housing ☐ Board Care or Assisted Living ☐ Rental Room ☐ Refused to Answer ☐ Unknown ☐ Other: _______________

Agency Specifics: (FOR OFFICE USE ONLY)

Client Agrees to Share Data: ☐ Yes ☐ No ☐ Did Not Ask

Release Faxed to Admin Agency: ☐ Yes ☐ No

(In agreement to sharing client-level data, proves indication to sharing all ARIES Client-Level data among HSDA agencies ONLY providing services to the client. All HSDA agencies providing services to the client are bounded by the same terms under the same conditions. An indication of agreement must be present with all service providing agencies for sharing of ARIES client-level data. The following client-level data WILL NOT be shared among HSDA providers under any circumstances: Legal, Substance, and Mental Status. Optional sharing of client-level case notes may be determined between a client and his/her case manager and indicated accordingly.)

*Agency Status: ☐ Active ☐ Inactive ☐ Disenrolled ☐ Lost to Follow up ☐ Discharged ☐ Reported Deceased ☐ Confirmed Deceased ☐ Unknown/Unreported Reason for Status Change______________________

*Status as of Date: ____/____/____ (MM DD YYYY) **Agency Enrollment Date:** ____/____/____ (MM DD YYYY) **Referral Date:** ____/____/____ (MM DD YYYY)

Agency Client ID1:__________ Agency Client ID2:__________ Referral Source: ☐ MD ☐ CM ☐ RN ☐ Self ☐ Other

Referral Source If Other:_________________________

Eligibility Documents:

Doc Type	Pending	Doc Date	Obtained	Expires	Location
Proof of Residency	☐ Y ☐ N	____/____/____	____/____/____	____/____/____	________________
HIV Letter of Diagnosis	☐ Y ☐ N	____/____/____	____/____/____	____/____/____	________________
Proof of Income	☐ Y ☐ N	____/____/____	____/____/____	____/____/____	________________
Picture ID	☐ Y ☐ N	____/____/____	____/____/____	____/____/____	________________
ARIES Consent Form	☐ Y ☐ N	____/____/____	____/____/____	____/____/____	________________
Agency Consent Form	☐ Y ☐ N	____/____/____	____/____/____	____/____/____	________________
Release of Information	☐ Y ☐ N	____/____/____	____/____/____	____/____/____	________________
HOPWA	☐ Y ☐ N	____/____/____	____/____/____	____/____/____	________________
________________	☐ Y ☐ N	____/____/____	____/____/____	____/____/____	________________
________________	☐ Y ☐ N	____/____/____	____/____/____	____/____/____	________________
________________	☐ Y ☐ N	____/____/____	____/____/____	____/____/____	________________

Financial Screening: Client Income: ☐ Monthly ☐ Annual Public Assistance: ☐ Yes ☐ No ☐ Unknown

Employed: ☐ F/T ☐ P/T ☐ Not employed ☐ Other (Student, Volunteer, etc.) ☐ Unknown

________	Employment/Wages	________	State Disability Ins/SDI	________	Retirement
________	Supp Security Income/SSI	________	Long Term Disability/LTD	________	Investment
________	Soc Sec Disability Ins/SSDI	________	Worker's Compensation	________	Gift
________	Social Security Retirement	________	TANF	________	Other 1 ________
________	General Assist/Relief	________	Veteran's Benefits/VA	________	Other 2 ________
________	Unemployment/UI	________	Alimony/Child Support	________	Other 3 ________
________	**Total**	________	☐ No Source of Income	________	Food Stamps

Household Income: *$__________ ☐ Monthly ☐ Annually Percent of Federal Poverty Level:_____ %
People in Household*:____ # Children in Household: ____ #HIV + Persons in Household: ____

Family Income: $_________ ☐ Monthly ☐ Annually Percent of Federal Poverty Level: _______ %
Family Members in Household: ________

Assets: Do you own a house: ☐ Yes ☐ No **A Car?** ☐ Yes ☐ No
Do You Have Other Assets? ☐ Yes ☐ No **Approx Value: $__________**

Client Insurance:
(Please enter your Insurance Source, Type, and Carrier using the selections below)
Source: ADAP; Public 1; Public 2; Private 1,2,3; Vision; Dental; Medicaid; Veteran; Medicare; Other Public; Other; Unknown; No Insurance
Type: Full Scope; Shared Costs; Managed; Restricted; Baby'; Medicare A; Medicare A & B; Veterans; County Sponsored; CMSP; Champus; COBRA; OBRA; HIPIC; Conversion (Rx); Private Self Pay; Other; Unknown; No Insurance
Carrier: Blue Cross; Kaiser; Aetna; Other

Source	Type	Pending	Carrier	Policy #	Start Date	End Date	Monthly Premium
________	________	☐ Y ☐ N	________	________	____/____/____	____/____/____	$ ________
________	________	☐ Y ☐ N	________	________	____/____/____	____/____/____	$ ________
________	________	☐ Y ☐ N	________	________	____/____/____	____/____/____	$ ________
________	________	☐ Y ☐ N	________	________	____/____/____	____/____/____	$ ________

Basic Medical History:

Primary Medical Care: ☐ Alternative/Complimentary ☐ County Hospital or DPH Clinic ☐ Community Based Clinic-Public ☐ Community Based Clinic-Private ☐ HMO Hospital/Clinics (e.g. Kaiser) ☐ VA Hospital/CHAMPUS ☐ Other ☐ Private MD ☐ Emergency Room ☐ No Primary Care ☐ Unknown

Name:____________________________ Phone: (____) ____-_____ Last Visit: ____/____/____

Primary HIV Care: ☐ Alternative/Complimentary ☐ County Hospital or DPH Clinic ☐ Community Based Clinic-Public ☐ Community Based Clinic-Private ☐ HMO Hospital/Clinics (e.g. Kaiser) ☐ VA Hospital/CHAMPUS ☐ Other ☐ Private MD ☐ Emergency Room ☐ No Primary Care ☐ Unknown

Name:____________________________ Phone: (____) ____-_____ Last Visit: ____/____/____

*HIV/AIDS Status:
☐ HIV Negative
☐ HIV A symptomatic
☐ HIV Positive-Disabling
☐ Disabling AIDS
☐ Unreported
☐ HIV Positive-Disease Stage Unknown
☐ HIV Symptomatic-Not AIDS
☐ CDC Defined AIDS
☐ Pediatric Indeterminate
☐ Unknown

Source: ☐ Letter of Diagnosis ☐ Medical Record ☐ Awaiting Letter of Diagnosis

First HIV+ Diagnosis Year:___________ AIDS Diagnosis Date: ____/____/____ **County of Diagnosis**_____________
State of Diagnosis:______________________ Source:________________________

ART Medications:

	Name	Phone	Allergies
Pharmacy 1	______________________	(____) ______-______	____________________________________
Pharmacy 2	______________________	(____) ______-______	____________________________________
Pharmacy 3	______________________	(____) ______-______	____________________________________

ART Type:

	Start Date	End Date
Highly Active Anti-Retroviral Therapy (HAART)(Triple Therapy)	____ /____ /____	____ /____ /____
Combination Anti-Retroviral but not HAART (Dual Therapy)	____ /____ /____	____ /____ /____
Mono Therapy	____ /____ /____	____ /____ /____
Salvage Therapy	____ /____ /____	____ /____ /____
None / Not applicable	____ /____ /____	____ /____ /____
Unknown / Unreported	____ /____ /____	____ /____ /____

Anti-Retroviral Drugs:

	Drug	Prescribed By	Side Effects	Start Date	End Date	Dosage
1.	______________	________________	__________________	___/___/___	___/___/___	____________
2.	______________	________________	__________________	___/___/___	___/___/___	____________
3.	______________	________________	__________________	___/___/___	___/___/___	____________
4.	______________	________________	__________________	___/___/___	___/___/___	____________
5.	______________	________________	__________________	___/___/___	___/___/___	____________
6.	______________	________________	__________________	___/___/___	___/___/___	____________

Adherence: In the last three days, not including today, how many days did you take your ART medications at the times and in the amounts prescribed by your doctor? ☐ 0 ☐ 1 ☐ 2 ☐ 3 as of ____ / ____ / ____

Adherence to HIV treatment for the past four weeks: (select one)
☐ Never missed a pill (100% of doses taken) ☐ Almost all the time (>95%,>19-20 doses taken) ☐ Most of the time (80-95%)
☐ Usually (60-80%) ☐ Half (40-60%, half of doses taken) ☐ Some (20-40%) ☐ Very little (<20%, <1-5 doses taken) ☐ Unknown

Genotype / Phenotype testing performed to determine resistance to HIV medication ☐ Yes ☐ No ☐ Unknown

Date of Test: ____ / ____ / ____ DAM Custom: ____

Other Medications:

	Drug	Prescribed By	Side Effects	Start Date	End Date	Dosage
1.	________________	___________________	_____________________	___/___/___	___/___/___	______________
2.	________________	___________________	_____________________	___/___/___	___/___/___	______________
3.	________________	___________________	_____________________	___/___/___	___/___/___	______________
4.	________________	___________________	_____________________	___/___/___	___/___/___	______________
5.	________________	___________________	_____________________	___/___/___	___/___/___	______________
6.	________________	___________________	_____________________	___/___/___	___/___/___	______________

Adherence: In the last three days, not including today, how many days did you take your ART medications at the times and in the amounts prescribed by your doctor? ☐ 0 ☐ 1 ☐ 2 ☐ 3 as of ____ / ____ / ____

Client Risk Factors: (Check all behaviors engaged in prior to first HIV+ test results) ☐ **Pediatric**

☐ Sex with a male ☐ Sex with a female ☐ Injected nonprescription drugs ☐ Received clotting factor for hemophilia or coagulation disorder
☐ Received transfusion of blood / blood components (other than clotting factor), (transplant of tissue / organs or artificial insemination)
☐ Worked in healthcare or clinical lab setting ☐ Mother HIV infected / perinatal transmission ☐ Sexual Abuse (pediatric only) ☐ Unknown
☐ Other

Sex Partner Risk Factors:

☐ Intravenous / Injection Drug User ☐ Bisexual Male ☐ Person with AIDS or documented HIV
☐ Other (person with hemophilia or coagulation disorder, transfusion recipient with documented HIV infection or transplant recipient with Documented HIV infection ☐ Unknown

Substance Abuse: (select one) ☐ No ☐ Yes, active within last 3 months ☐ Yes, not active within past 3 months ☐ Unknown

Date last used ____ / ____ / ____ Age First Used: _______ Frequency: ☐ Daily ☐ Weekly ☐ Monthly

Treatment Status: ☐ In Treatment ☐ Waiting list for treatment ☐ Refused Treatment ☐ Completed Treatment ☐ Pre-Treatment Process
☐ Dropped out of Treatment ☐ No Active Treatment or Counseling ☐ Other ☐ Unknown ☐ N / A

Mental Health : (select one) ☐ No ☐ Yes, active within last 3 months ☐ Yes, not active within past 3 months ☐ Unknown
Date: ____ / ____ / ____

Treatment Status: ☐ In Treatment ☐ Waiting list for treatment ☐ Refused Treatment ☐ Completed Treatment ☐ Pre-Treatment Process
☐ Dropped out of Treatment ☐ No Active Treatment or Counseling ☐ Other ☐ Unknown ☐ N / A

ARIES Application for Services

In applying for services at **AIDS Outreach Center** I attest that I meet the following criteria:

- I am HIV positive, as shown by a HIV antibody test or proof of diagnosis from my physician.
- I am a resident of Texas.
- I reside within one of the following Texas counties: Archer, Baylor, Brown, Callahan, Clay, Coleman, Comanche, Cottle, Eastland, Erath, Fisher, Foard, Hardeman, Haskell, Hood, Jack, Johnson, Jones, Kent, Knox, Mitchell, Montague, Nolan, Palo Pinto, Parker, Runnels, Scurry, Shackelford, Somervill, Stephens, Stonewall, Tarrant, Taylor, Throckmorton, Wichita, Wilbarger, Wise, or Young.
- I do not claim residency in any other state.
- I maintain a residence within the county indicated and not merely a post office box.

By signing below I confirm that this form is complete, and to the best of my knowledge all information contained herein is accurate.

Client Name: ________________________________ Signature: ______________________________ Date: ____/____/____

(Please Print)

Case Manager/
Intake Coordinator: ________________________________ Signature: ______________________________ Date: ____/____/____

(Please Print)

ARIES Client URN and Consent Form

Client Name: ____
Last First Middle Initial

Client Mother's Maiden Name: ____

Client Date of Birth: ____

Client Gender: ________ Male ________ Female
________ M-F Transsexual ________ F-M Transsexual
________ Other ________ Unknown

I confirm that the above information is true.

I understand my rights and obligations and the rights and obligations of healthcare and social service professionals in regard to the gathering and sharing of my information.

I understand that by checking "YES" and signing below I am agreeing to share information contained within the AIDS Regional Information and Evaluation System (ARIES) with the agencies and/or personnel who provide services throughout the Fort Worth – Arlington Health Service Delivery Area (it is not possible to opt out of sharing your data with relevant health authorities, such as the local Health Department and the Department of State Health Services).

I understand that even though I consent to share information within the ARIES system, at no time will information about mental health or substance abuse counseling or legal counseling be shared with anyone but those personnel engaged in providing those services.

I understand that I may decide to stop sharing my data at any time by requesting and filling out a new ARIES Consent Form.

I understand that this consent form is solely for the purpose of consent to sharing data within the ARIES system, and this form does not replace any existing release of information documentation I may have on file with this or any other agency.

I understand that this form will need to be updated once per year.

☐ Yes, I wish to Share my Data in ARIES

☐ No, I do not wish to Share my Data in ARIES*

Signed: ______________________________ Date: ______________
Client Signature Today's Date

Signed: ______________________________ Date: ______________
Case Manager/Intake Coordinator Signature

* I understand that by checking "No", my data will still be shared with Tarrant County Public Health, the Texas Department of State Health Services, and other legally required entities for surveillance and reporting purposes, or as required by state and federal law. Checking "No" only excludes me from sharing my demographic and service data with other agencies from which I may or may not be receiving HIV/AIDS related services.

North Central Texas HIV/AIDS Service Organizations

Release of Information and Referral

I, ________________________, agree to let the following agencies' staff communicate with other agencies that help people with HIV and AIDS about my needs. I understand that these agencies work together to help people get the services they need. **If I do not want an agency to get my information, I will cross out that agency and put my initials there.**

HIV/AIDS Service Organizations	Client Initials
1. AIDS Outreach Center	________________
2. Cook Children's Medical	________________
3. Tarrant County Hospital District (JPS)	________________
4. Tarrant County MHMR	________________
5. Tarrant County Public Health (PMC)	________________
6. Tarrant County Samaritan Housing, Inc.	________________

I understand that I can stop these agencies from talking with any of these agencies at any time. I agree to contact this agency to tell them I want to change this form.

Others Who May Get My Information

Family and Friends that may get my information, including emergency contact.

________________________________ ________________________________
Name and Relationship Client Initials and Date

________________________________ ________________________________
Name and Relationship Client Initials and Date

Doctors/Nurses/Hospital/Clinics:

________________________________ ________________________________
Name and Relationship Client Initials and Date

________________________________ ________________________________
Name and Relationship Client Initials and Date

Client Signature: ________________________________
Date

Witness Signature: ________________________________
Date

*Note: This release form expires one year from the date of signing.

North Central Texas HIV/AIDS Service Organizations*

CLIENT POLICIES AND PROCEDURES

I. Statement of Confidentiality

1. All North Central Texas HIV/AIDS Service Organizations' staff and volunteers are required to undergo a background check and sign a statement of confidentiality. All of these agencies, listed below, agree to comply with all federal/ state laws and regulations regarding the confidentiality of information. Included in these laws are those referred to as HIPAA (please refer to attached HIPAA brochure).
2. As an agency client, I may be exposed to confidential information regarding HIV status of individuals receiving care and treatment or volunteering. I agree not to seek out, nor disclose confidential information and report any instance of inappropriate disclosure.
3. I understand that there are three situations where the right to confidentiality is limited: a) if a client reveals information about child abuse or neglect, it must be reported to the authorities; b) if a court orders the release of information, the court's order must be obeyed; and, c) if a client reveals that he or she has immediate plans to harm someone, we must call 911.

Client Initials:_______

II. Client Bill of Rights

Each person receiving care funded by the Department of State Health Services (DSHS) has a right to:

1. Not be physically or mentally abused or exploited.
2. Be treated with respect, consideration and recognition of his or her dignity and individuality. The client must also render the same to the provider to receive personal care and treatment in safe, clean surroundings.
3. Appropriate care regardless of his/her race, religious practice, color, national origin, sex, age, handicap, marital status, or sexual orientation.
4. Communication in a culturally sensitive manner to address the client's needs for the purpose of getting any type of treatment, care or services.
5. Receive service, care and treatment regardless of any disabilities.
6. Present grievances to the executive director, agencies, or other persons without denial of services. The grievance policy/procedure, as set by the administrative agency must be presented and explained to the client by any service provider. In the event that this procedure cannot be followed because of direct conflict with the administrative agency or subcontractor, the grievance will be submitted to the administrative agency.
7. Have local, confidential records, which cannot be released without his/her written permission. A client may inspect his/her personal records that are maintained by the agency providing services.
8. Have freedom of choice when choosing a provider of comprehensive outpatient health and psychosocial support services.
9. Be given the opportunity to actively participate in the planning of his/her service plan or medical treatment.
10. Refuse treatment.
11. Participate in an annual needs assessment survey.

Client Initials:_______

III. Grievance Policy

When a client or volunteer voices a complaint about a staff member's conduct or performance of duties, a formal grievance procedure is initiated. The procedure is as follows:

1. When a client or volunteer voices a complaint, s/he must first attempt to resolve the difference directly with the staff member in question.

2. If unresolved, the client or volunteer may then meet with the staff member's supervisor to review the complaint. At this meeting, the staff member, client or volunteer and the appropriate supervisor meet to attempt to resolve the situation.
3. If the issue remains unresolved, the client or volunteer may then request in writing a meeting with the agency's chief executive.

4. If unresolved, the client or volunteer may then request that the agency's chief executive forward a written complaint for review by the agency's governing body.
5. Should the grievance remain unresolved, the client or volunteer may contact the Planning Council and (or) Margie Drake at: Tarrant County Public Health, 1101 South Main Street, Suite 2500, Fort Worth, Texas 76104-4802. (817) 321-4740.

Client Initials:_______

IV. Right To Refuse Service

The North Central Texas HIV/AIDS Service Organizations* reserve the right to refuse services to anyone who is:

1. Being verbally abusive to anyone;
2. Threatening physical abuse to anyone;
3. In possession of illegal substances, drug paraphernalia, or weapons on agency property; and/or
4. Otherwise acting in an unacceptable manner

Until in the judgment of the agency, the individual ceases such behavior.

Client Initials:_______

V. Consent to Receive Services

By signing below, client hereby consents to receive services from The North Central Texas HIV/AIDS Service Organizations and to abide by the foregoing policies and procedures.

Client Initials:_______

______________________________	______________________________
Client's Printed Name	**Client's Signature**
______________________________	______________________________
Date	**Witness**

*North Central Texas HIV/AIDS Service Organizations includes:

1. AIDS Outreach Center 400 N. Beach Street , Fort Worth, TX 76111 /817-335-1994
2. Cook Children's Medical 800 Seventh Avenue, Fort Worth, TX 76104/682-885-1485
3. Tarrant County Hospital District (JPS) 1500 S. Main Street, Fort Worth, TX 76104/ 817-927-3701
4. Tarrant County MHMR 1527 Hemphill Street, Fort Worth, Texas 76104/817-569-4200
5. Tarrant County Public Health (PMC) 1101 S. Main Street, Fort Worth, TX 76104/ 817-321-4850
6. Tarrant County Samaritan Housing, Inc. 929 Hemphill, Fort Worth, TX 76104/ 817-332-6410