New York State Department of Health AIDS Institute

HIV Counseling and Testing Resource Directory

Correction Form

Name: _____ Title: _____

Organization: _____

Address: _____
Street

_____ ____ _____ _____
City *State* *ZIP code* *County*

Telephone: _____ _____ URL: _____
Area Code *Phone Number* *Web Site Address*

Testing Type: ☐Anonymous ☐Confidential

Testing Method: ☐Standard Blood Test ☐Standard Oral Fluid
(Check all that apply) ☐Rapid Blood Test ☐Rapid Oral Fluid

Type of Visit: ☐Walk-in ☐By Appointment ☐Evening Hours ☐Weekend Hours
(Check all that apply)

Language: ☐English ☐French ☐Spanish ☐Creole ☐Chinese
(Check all that apply) ☐Russian ☐Sign Language ☐Others. Specify_____

Fee Information: ☐HIV C&T services provided free of charge to all clients regardless of their ability to pay.
(Check all that apply) ☐HIV C&T services provided free of charge or reduced fee based on client income.
☐Accept government programs, including Medicaid, Medicare, and ADAP+.
☐Accept 3rd-party private insurance.
☐Accept out-of-pocket payment.
☐Other payment methods. Please specify _____

Service Features/Limitations:

1._____
2 _____
3 _____

Please send this form to : or By Fax to:

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