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| **Client:** | | **Last Name** | | | | | | | | **First Name** | | | | | | | | | | | | **MI** | | | | **Client ID** | | | | | | | | | | |
|  | |  | | | | | | | |  | | | | | | | | | | | |  | | | |  | | | | | | | | | | |
| Assessment Date | |  | | | | | | | | MCM Name | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| **Medical Care** | | | | | | | | | | | | | | | | | | | | | | | | | | **No Change?** | | | | | | | |  | | |
| New to Care | | |  | | Returning to Care | | | | |  | | | Established in Care | | | | | | | | | | |  | |  | | | | | | | | | | |
| None | | |  | | Publicly funded clinic | | | | |  | | | Private Practice | | | | | | | | | | |  | | Veterans Affairs | | | | | | | | |  | |
|  | | | | | Hospital Outpatient | | | | |  | | | ER | | | | | | | | | | |  | | Other | | | | | | | | |  | |
| **Medical Care Providers** | | | | | | | | | | | | | | | | | | | | | | | | | | **No Change?** | | | | | | | |  | | |
| Primary Physician | | | | | Address | | | | | Phone | | | | | | | | | | | | Specialty | | | | Last Seen | | | | | | | | Next Appt. | | |
|  | | | | |  | | | | |  | | | | | | | | | | | |  | | | |  | | | | | | | |  | | |
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| **History of Hospitalizations (Include Psychiatric and Substance Abuse)** | | | | | | | | | | | | | | | | | | | | | | | | | | **No Change?** | | | | | | | |  | | |
| Illness | | | | | | | | | | Date | | | | | | | Where | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | | | | | | | | |
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| **Other Illnesses and Opportunistic Infections** | | | | | | | | | | | | | | | | | | | | | | | | | | **No Change?** | | | | | | | |  | | |
| Have you been diagnosed with an Opportunistic Infection? | | | | | | | | | Yes | | |  | | | | No |  | | | | | Describe | | | |  | | | | | | | | | | |
| Have you been diagnosed with an STD? | | | | | | | | | Yes | | |  | | | | No |  | | | | | Describe | | | |  | | | | | | | | | | |
| Have you been tested for TB? Please provide date/results. | | | | | | | | | Yes | | |  | | | | No |  | | | | | Describe | | | |  | | | | | | | | | | |
| Have you been tested for Hepatitis A, B, C, and if yes, when? | | | | | | | | | Yes | | |  | | | | No |  | | | | | Describe | | | |  | | | | | | | | | | |
| If female, are you pregnant? If yes, when is your due date? | | | | | | | | | Yes | | |  | | | | No |  | | | | | Describe | | | |  | | | | | | | | | | |
| If female, when was your last pap smear (gynecological exam)? | | | | | | | | | Yes | | |  | | | | No |  | | | | | Describe | | | |  | | | | | | | | | | |
| Other medical issues, such as high blood pressure, diabetes, etc. | | | | | | | | | Yes | | |  | | | | No |  | | | | | Unknown | | | |  | | | |  | | | | | | |
| If so, describe | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Current Health Status** | | | | | | | | | | | | | | | | | | | | | | | | | | **No Change?** | | | | | | | |  | | |
| What is your latest Viral Load? | | | | | | | | |  | | | | | | | | Date | | | | | |  | | | | | | | | | | | | | |
| What is your latest CD4 count? | | | | | | | | |  | | | | | | | | Date | | | | | |  | | | | | | | | | | | | | |
| **Current Medications including over the counter (OTC)** | | | | | | | | | | | | | | | | | | | | | | | | | | **No Change?** | | | | | | | |  | | |
| Medication | | | | | | | | | | Dosage | | | | | | | Frequency | | | | | | | | | Prescribed for | | | | | | | | | | |
|  | | | | | | | | | |  | | | | | | |  | | | | | | | | |  | | | | | | | | | | |
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| Any known drug allergies? | | | | | | Yes | | |  | No | | | | | |  | Describe | | | | | | | | |  | | | | | | | | | | |
| **Pharmaceutical Providers** | | | | | | | | | | | | | | | | | | | | | | | | | | **No Change?** | | | | | | | |  | | |
| Name/Address | | | | | | | | | | | | | | | | | | | | | | | | | | Phone | | | | | | | | Fax | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | |
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| **Medication Adherence** | | | | | | | | | | | | | | | | | | | | | | | | | | **No Change?** | | | | | | | |  | | |
| Do you take medications (including antiretroviral) as directed? | | | | | | | | | Yes | | |  | | | | No | | | | | |  | | Describe | | | | | |  | | | | | | |
| Do you require assistance taking your medications? | | | | | | | | | Yes | | |  | | | | No | | | | | |  | | Describe | | | | | |  | | | | | | |
| Do you have any problems with provider appointments? | | | | | | | | | Yes | | |  | | | | No | | | | | |  | | Describe | | | | | |  | | | | | | |
| Describe any problems or assistance you need with medications | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| **Oral Health** | | | | | | | | | | | | | | | | | | | | | | | | | | **No Change?** | | | | | | | |  | | |
| When was your last dental exam? | | | | | | | | |  | | | Your Provider? | | | | | | | | | |  | | | | | | | | | | | | | | |
| Dental concerns or issues? | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Mental Health Screening** | | | | | | | | | | | | | | | | | | | | | | | | | | **No Change?** | | | | | | | |  | | |
| Do you have a history of mental health diagnosis? | | | | | | | | | | | | If yes, describe | | | | | | | | | |  | | | | | | | | | | | | | | |
| Have you ever been prescribed medication for a mental health condition? | | | | | | | | | | | | If so, what condition | | | | | | | | | | | |  | | | | | | | | | | | | |
| Diagnosis | | | | | | | Treatment | | | | | | | | | | | Date | | | | | | Provider | | | | | | | | | | Phone | | |
|  | | | | | | |  | | | | | | | | | | |  | | | | | |  | | | | | | | | | |  | | |
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| Are you taking medication for a mental health condition now? | | | | | | | | | | | | If so, what medication(s) | | | | | | | | | |  | | | | | | | | | | | | | | |
| Have you ever been hospitalized for a mental health condition? | | | | | | | | | | | | If so, explain | | | | | | | | | |  | | | | | | | | | | | | | | |
| Have you had any of the following in the past year? | | | | | | | | | | | | Depression | | | | | | | | | |  | | Anxiety | | | | | |  | | Insomnia | | | |  |
| Forgetfulness | | | | | | | | | |  | | Delusions | | | | | |  | | Dementia | | | |  |
| Withdrawal/ isolation | | | | | | | | | |  | | Suicidal thoughts | | | | | |  | | Other | | | |  |
| Who is your current mental health provider, if you have one? | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| Would you like to be connected with a counsellor? | | | | | | | | | | | | | | Yes | | | | |  | | | No | | |  | | | | | | | | | | | |
| *Suicide Assessment* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Have you ever attempted to hurt yourself or others? | | | | | | | | | | | | | Yes | | | | |  | | | | No | | |  | | | | | | | | | | | |
| Do you currently have thoughts of hurting yourself or others? | | | | | | | | | | | | | Yes | | | | |  | | | | No | | |  | | | | | | | | | | | |
| If yes, do you have a specific plan? | | | | | | | | | | | | | Yes | | | | |  | | | | No | | |  | | | | | | | | | | | |
| Do you have the means to carry out the plan? | | | | | | | | | | | | | Yes | | | | |  | | | | No | | |  | | | | | | | | | | | |
| ***If there is a “yes” answer to any of last 3 questions, case manager must follow the agency emergency crisis protocol for appropriate response.*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Substance Abuse/Addiction History and Screening** | | | | | | | | | | | | | | | | | | | | | | | | | | **No Change?** | | | | | | | |  | | |
| Are you currently using any substances? | | | | | | | | | | | | Yes | | | | |  | | | | | No | | | |  | | | | | | | | | | |
| If you have used substances within the past 6 months, please explain. | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you need assistance with any substance abuse issues now? | | | | | | | | | | | | Yes | | | | |  | | | | | No | | | |  | | | | | | | | | | |
| **Nutrition** | | | | | | | | | | | | | | | | | | | | | | | | | | **No Change?** | | | | | | | |  | | |
| Do you have a good appetite? | | | | | | | | | | | | Yes | | | | |  | | | | | No | | | |  | | | |  | | | | | | |
| Have you lost or gained weight in the last 6 months? (>/<10lbs) | | | | | | | | | | | | Yes | | | | |  | | | | | No | | | |  | | | |  | | | | | | |
| Are you currently seeing or do you need to see a nutritionist? | | | | | | | | | | | | Yes | | | | |  | | | | | No | | | |  | | | | | | | | | | |
| **Housing** | | | | | | | | | | | | | | | | | | | | | | | | | | **No Change?** | | | | | | | |  | | |
| What are your current living arrangements? | | | | |  | Rent home/apartment | | | | | |  | | | | Transitional living facility/half-way house | | | | | | | | | |  | | | | Homeless, on street/in car | | | | | | |
|  | Living with family | | | | | |  | | | | Nursing Home/medical facility, etc. | | | | | | | | | |  | | | | Homeless, in shelter | | | | | | |
|  | Own home | | | | | |  | | | | Other | | | | | | | | | |  | | | | Homeless, living with others | | | | | | |
| Are you receiving housing assistance (HOPWA, public housing, Section 8)? | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | |  | | No | |  |
| Do you need help finding affordable housing or shelter? | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | |  | | No | |  |
| Do you have any concerns about current housing? If so, explain. | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| **Household** | | | | | | | | | | | | | | | | | | | | | | | | | | **No Change?** | | | | | | | |  | | |
| How long have you been living at your current residence? | | | | | | | | |  | | | | | | | | | | | | | | | Comment | | | | | |  | | | | | | |
| How many adults live with you? | | | | | | | | |  | | | | | | | | | | | | | | | Comment | | | | | |  | | | | | | |
| How many children live with you? | | | | | | | | |  | | | | | | | | | | | | | | | Comment | | | | | |  | | | | | | |
| Is your name on the lease/mortgage? | | | | | | | | | Yes | | |  | | | | No | | | | | |  | | Comment | | | | | |  | | | | | | |
| Are there any household pets? Describe. | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are all other household members aware of your status? | | | | | | | | | Yes | | |  | | | | No | | | | | |  | | Comment | | | | | |  | | | | | | |
| Do you have a living will and/or other advanced directives? | | | | | | | | | Yes | | |  | | | | No | | | | | |  | | Comment | | | | | |  | | | | | | |
| If you become unable to care for yourself, is there someone to help you? | | | | | | | | | Yes | | |  | | | | No | | | | | |  | | Comment | | | | | |  | | | | | | |
| **Literacy** | | | | | | | | | | | | | | | | | | | | | | | | | | **No Change?** | | | | | | | |  | | |
| Primary Language: | | English | | | |  | | Need an interpreter? | | | |  | | | | Difficulty speaking primary language? | | | | | | | | | |  | | | | Difficulty writing primary language? | | | | | |  |
| Spanish | | | |  | |  | | | |
| Other | | | |  | |  | | | |
| Have you been told you have a Developmental/Disability/ Cognitive Impairment? | | | | | |  | | If yes, specify: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| If Services are in place, specify: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| **Education** | | | | | | | | | | | | | | | | | | | | | | | | | | **No Change?** | | | | | | | |  | | |
| Your highest level of education achieved | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you have other training? Describe. | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Insurance and Other Coverage** | | | | | | | | | | | | | | | | | | | | | | | | | | **No Change?** | | | | | | | |  | | |
| Have any type of insurance: | | | | | | | | | No | |  | | | | | Yes | | | | | |  | | Don’t Know | | | | | | | | |  | | | |
| If yes, check all types that you currently have | | | | | | | | | | Medicaid | | | | | | |  | | | | | Medicare A/B | | | | | | | |  | | Medicare D | | | |  |
| Private Ins | | | | | | |  | | | | | Veterans Affairs/TriCare, Champa | | | | | | | | | | | | | |  |
| Other coverage | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Issues with understanding, navigating and using insurance benefits | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Needs help with health insurance enrollment | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Eligibility Period (See NOE for details)** | | | | | | | | | | | | | | | | | | | | | | | | | | **No Change?** | | | | | | | |  | | |
| From |  | | | to | |  | | | Redetermination due by | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| Client is eligible and enrolled in | | | | | | | | Ryan White | | | |  | | | | ADAP | | | | | |  | | HOPWA | | | | | | | |  | |  | | |
| **Daily Living Activities** | | | | | | | | | | | | | | | | | | | | | | | | | | **No Change?** | | | | | | | |  | | |
| Do you need help with: | | | | | | | | | Yes | | | No | | | | | Comments (How much, how often, who helps) | | | | | | | | | | | | | Referral Needed | | | | | | |
| Yes | | | | No | |  |
| Personal care: Dressing | | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | |  | | | |  | |  |
| Personal care: Bathing | | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | |  | | | |  | |  |
| Personal care: Eating | | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | |  | | | |  | |  |
| Personal care: Toileting | | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | |  | | | |  | |  |
| Mobility | | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | |  | | | |  | |  |
| Transportation | | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | |  | | | |  | |  |
| Using the telephone | | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | |  | | | |  | |  |
| Shopping | | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | |  | | | |  | |  |
| Preparing Meals | | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | |  | | | |  | |  |
| Laundry | | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | |  | | | |  | |  |
| Light housekeeping | | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | |  | | | |  | |  |
| Heavy chores | | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | |  | | | |  | |  |
| Managing personal finances | | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | |  | | | |  | |  |
| Keeping track of appointments | | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | |  | | | |  | |  |
| **Social Support** | | | | | | | | | | | | | | | | | | | | | | | | | | **No Change?** | | | | | | | |  | | |
| Relationship (Spouse, partner, parent, child, sibling, friend, relative, pet, other) | | | | | | | | | Aware of HIV Status | | | | | | | | Type of Support (ex. emotional/moral, financial, transportation, shelter, medical/adherence) | | | | | | | | | | | | | Signed release? | | | | | | |
| Yes | | | No | | | | | Yes | | | | No | |  |
|  | | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | |  | | | |  | |  |
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| Are you getting services from any other agencies? | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| **Legal Issues** | | | | | | | | | | | | | | | | | | | | | | | | | | **No Change?** | | | | | | | |  | | |
| Do you have | | | | | Trust | | |  | Will | | |  | | | | Physicians Directive | | | | | | | | | |  | | | | Durable Power of Attorney | | | | | |  |
|  | | | | | Health Care Power of Attorney | | | | |  | | Living Will | | | | | | | | |  | | | Guardian/Conservator for self/dependents | | | | | | | | | | | |  |
| Power of Attorney | | | | | Name | | | |  | | | | | | | | | | | | | | | Phone | | | |  | | | | | | | | |
| Legal Status | | | | | Arrest | | | |  | Conviction(s) | | | | | | | | | | | |  | | Restraining Order | | | | | | | | | | | |  |
| Name Change | | | |  | Immigration | | | | | | | | | | | |  | |  | | | | | | | | | | | | |
| Change in legal status of relationship like marriage, separation or divorce | | | | | | | | | | | | | | | | |  | | Describe | | | | |  | | | | | | | |
| **Sexual History/Risk Assessment** | | | | | | | | | | | | | | | | | | | | | | | | | | **No Change?** | | | | | | | |  | | |
| Are you sexually active? | | | | | | | | | | | | Yes | | | | | | | |  | | No | | | | |  | | | |  | | | | | |
| Is/are your partner(s) aware of your status? | | | | | | | | | | | | Yes | | | | | | | |  | | No | | | | |  | | | |  | | | | | |
| Is/are any of your sex partner(s) HIV positive? (Discuss test/treatment PrEP as needed) | | | | | | | | | | | | Yes | | | | | | | |  | | No | | | | |  | | | |  | | | | | |
| Are you using safe sex practices? Explain | | | | | | | | | | | | Yes | | | | | | | |  | | No | | | | |  | | | |  | | | | | |
| Are you having sex under the influence of drugs? | | | | | | | | | | | | Yes | | | | | | | |  | | No | | | | |  | | | |  | | | | | |
| Do you disclose HIV status to sexual partners? | | | | | | | | | | | | Yes | | | | | | | |  | | No | | | | |  | | | |  | | | | | |
| Do you have past or current experiences with sexually transmitted infections in addition to HIV? | | | | | | | | | | | | Yes | | | | | | | |  | | No | | | | |  | | | |  | | | | | |
| If so, have you been treated? | | | | | | | | | | | | Yes | | | | | | | |  | | No | | | | |  | | | |  | | | | | |
| If no, date of your last test | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you use needles for drugs, tattoos, piercings? | | | | | | | | | | | | Yes | | | | | | | |  | | No | | | | |  | | | |  | | | | | |
| Do you share needles? | | | | | | | | | | | | Yes | | | | | | | |  | | No | | | | |  | | | |  | | | | | |
| Have all your needle sharing partners been informed about your HIV status? | | | | | | | | | | | | Yes | | | | | | | |  | | No | | | | |  | | | |  | | | | | |
| How do you protect yourself and drug using partners? | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| **Information Services** | | | | | | | | | | | | | | | | | | | | | | | | | | **No Change?** | | | | | | | |  | | |
| Service Need | | | | | | | | Date Identified | | | | Referral Needed | | | | | | | | | | Referral Details | | | | | | | | | | | | | | |
| Yes | | | | | No | | | | |
| General HIV/AIDS Education Materials | | | | | | | |  | | | |  | | | | |  | | | | |  | | | | | | | | | | | | | | |
| Specific OI/Treatment Modalities Information | | | | | | | |  | | | |  | | | | |  | | | | |  | | | | | | | | | | | | | | |
| Safer Sex Practices | | | | | | | |  | | | |  | | | | |  | | | | |  | | | | | | | | | | | | | | |
| Living with HIV/AIDS Education Materials | | | | | | | |  | | | |  | | | | |  | | | | |  | | | | | | | | | | | | | | |
| Social Security and other Public Assistance | | | | | | | |  | | | |  | | | | |  | | | | |  | | | | | | | | | | | | | | |
| Family Planning/Women’s Health | | | | | | | |  | | | |  | | | | |  | | | | |  | | | | | | | | | | | | | | |
| Other | | | | | | | |  | | | |  | | | | |  | | | | |  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Assessment | | | | |  | Case Manager Signature | | | |  | | | | | | | | | | | | | | | | | | | | Date | | | |  | | |
| Reassessment | | | | |  |