Brief Intake/Enrollment
Screening

Enrollment Date	Social Security Number	Date of Birth	Unique Client ID
01/01/2000	000-00-0000	01/01/2000	

Legal Last Name	Legal First Name	Middle Initial and/or Maiden Name

Preferred Pronoun	Preferred Name	OK to receive mail?
		Yes ☐ No ☐

Street Address	City/State	ZIP	County

Homeless? ☐

Mailing Address (if different than above)	City/State	ZIP	County

Phone Number	Type	Text OK?	VM Message OK?
	Home ☐ Work ☐ Cell ☐	Yes ☐ No ☐	Yes ☐ No ☐

Emergency Contact: Name/Address	Relationship	Phone Number	Aware of Status?
			Yes ☐ No ☐
			Yes ☐ No ☐

Household Members: Name/Address	Relationship	Phone Number	Aware of Status?
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐

Employer Name	Phone Number	OK to Contact at Work?
N/A ☐		Yes ☐ No ☐ N/A ☐

Gender

Male ☐	Female ☐ If female, pregnant? ☐	Transgender M to F ☐	Transgender F to M ☐	Transgender Other ☐
Sex at Birth	Male ☐	Female ☐		

Ethnicity

Non-Hispanic ☐				
Hispanic ☐	If Hispanic, subgroup: Mexican, Mexican American, Chicano/a ☐	Puerto Rican ☐	Cuban ☐	Other ☐

Race

American Indian or Alaska Native					
Asian ☐	If Asian, subgroup:	Asian Indian ☐	Chinese ☐	Filipino ☐	Korean ☐
Black ☐		Japanese ☐	Korean ☐	Vietnamese ☐	Other ☐
Native Hawaiian or Pacific Islander ☐	If NH or PI, subgroup:	Native Hawaiian ☐	Guamanian or Chamorro ☐	Samoan ☐	Other ☐
White ☐					

Literacy			
Primary Language: English ☐ Spanish ☐ Other ☐	Need an interpreter? ☐	Difficulty speaking primary language? ☐	Difficulty writing primary language? ☐
Have you been told you have a Developmental/Disability/ Cognitive Impairment? ☐	If yes, specify:		
	If Services are in place, specify:		

HIV Status		**HIV Risk Factors**			
HIV Positive (not AIDS) ☐	Dx date:	MSM ☐	Heterosexual ☐	IDU ☐	Perinatal ☐
HIV Positive (AIDS unknown) ☐	Dx date:	Receipt of blood or tissue ☐			
CDC-defined AIDS ☐	Dx date:	Hemophilic coagulation disorder ☐			
Unknown or not reported/identified ☐		Other (specify:)			

Eligibility Status	
Notice of Eligibility: Yes ☐	**Expiration Date:**
Referred to Eligibility, if yes what agency:	

Medical History		
Primary Physician:	Address	Phone
Primary Physician:	Address	Phone

Current Medications including Over-the-Counter (OTC)			
Viral Load Count	Viral Load Date	CD4 Count	CD4 Date

Insurance and Other Coverage				
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. ☐
Other coverage:				
Issues with understanding, navigating and using insurance benefits				
Needs help with health insurance enrollment				

Presenting Problem/Immediate Case Management Needs