CLIENT INTAKE

☐ **New Client** ☐ **Updated** ☐ **Reactivated Client**

Date: SOC. SEC. #: Client #:

PERSONAL INFORMATION

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL/ MAIDEN NAME _____

STREET ADDRESS _____ CITY/STATE _____ ZIP _____

ALTERNATE ADDRESS _____ CITY/STATE _____ ZIP _____

O.K. to Mail to Mailing address ☐ YES ☐ NO Anonymous return address requested ☐ YES ☐ NO

COUNTY _____ AGE/DOB _____/_____ GENDER _____

(_____)_____ May we leave message? ☐ YES ☐ NO Message/Day Phone (_____)_____

HOME PHONE

Discreet message only: ☐ YES ☐ NO May we contact you at work? ☐ YES ☐ NO

PHONE (_____)_____

ETHNICITY: ☐ HISPANIC/LATINO ☐ NON HISPANIC/NON LATINO

RACE: ☐ WHITE ☐ BLACK OR AFRICAN-AMERICAN ☐ ASIAN ☐ OTHER
☐ NATIVE HAWAIIAN/PACIFIC ISLANDER ☐ AMERICAN INDIAN OR ALASKAN NATIVE

PRIMARY LANGUAGE _____ NEED INTERPRETER ☐ YES ☐ NO

KEY CONTACTS

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE NUMBER (___)_____

AWARE OF STATUS? ☐ YES ☐ NO

HIV/AIDS PROVIDER _____ (___) _____

PRIMARY CARE PROVIDER _____ (___) _____

DENTAL _____ (___) _____

MENTAL HEALTH _____ (___) _____

OTHER AGENCIES WORKING WITH CLIENT _____ (___) _____

Place Client Label Here

Case Managers Initials: _____

Date: _____

HEALTH INSURANCE (Check all that apply)

☐ Medicaid/OHP # _____ ☐ Private Ins. _____
☐ Date of Medicaid Eligibility _____ ☐ ID # _____
☐ Medicare A & B #_____ ☐ Medicare D Provider _____
☐ Veterans Benefits#_____ ☐ Dental Insurance _____
☐ ADAP_____ ☐ Not Insured _____

ARE YOU EMPLOYED: ☐ YES ☐ NO AWARE OF HIV/AIDS STATUS? ☐ YES ☐ NO

_____
EMPLOYER

_____ _____
ADDRESS CITY/STATE/ZIP CODE

EDUCATION

Highest grade you completed in school? _____

Do you have difficulty reading? ☐ YES ☐ NO
Do you have difficulty writing? ☐ YES ☐ NO

HIV STATUS

☐ HIV positive not AIDS ☐ HIV positive, AIDS status unknown ☐ CDC-defined AIDS
Date tested positive _____ Date of AIDS Dx: _____

Transmission Category (Check One)

☐ MSM ☐ MSM/IDU ☐ Heterosexual ☐ Unknown ☐ Occupational Exposure
☐ IDU ☐ Maternal/Child ☐ Undisclosed ☐ Blood Products ☐ Other

NON-HIV RELATED CONDITIONS

_____
_____
_____
_____

MEDICATIONS - Including all current medication, prescriptions, over-the-counter & experimental

MEDICATION	PURPOSE	DOSE	FREQUENCY	BEGAN/REFILLED

Do you need help obtaining medications? ☐ YES ☐ NO

_____
_____

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Date:_____

ADHERENCE **NEW TO CARE** ☐ YES ☐ NO **PREVIOUSLY IN CARE** ☐ YES ☐ NO

On the average, how many appointments have you missed within the past 6 months?

☐ None ☐ 1-3 ☐ 3-5 ☐ 5-7 ☐ 7 or more

What keeps you from attending your appointments and how can we help you to keep your appointments? _____

Are you presently taking or have you ever taken medications for HIV (antiretrovirals)? ☐ YES ☐ NO

What do you do when you have side effects?

_____

On average how many days per week would you say that you missed at least one dose of your HIV medications? ☐ Every day ☐ 4-6 days/week ☐ 2-3 days/week ☐ Once a week ☐ Less than once a week ☐ Never

What keeps you from taking your medications? _____

What is the hardest thing about taking your medications? _____

Would you like more information about medications for HIV? ☐ YES ☐ NO _____

LIVING SITUATION

☐ Apartment ☐ Own House ☐ Rental House ☐ HUD/Section 8 ☐ Adult Foster Care
☐ With Friends ☐ With Family ☐ Transitional Housing ☐ Hospice
☐ Emergency/Shelter ☐ Homeless ☐ Skilled Nursing Facility
☐ Personal Care Home ☐ Other

Describe current situation (Stability, safety, affordability) _____

_____

HOUSEHOLD MEMBERS

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCE ☐ WIDOWER ☐ PARTNER

NAME	RELATIONSHIP TO CLIENT	PHONE #	AWARE OF HIV STATUS
			☐YES ☐NO
			☐YES ☐NO
			☐YES ☐NO

FAMILY MEMBER(S) WHO ASSIST WITH YOUR CARE

			☐YES ☐NO
			☐YES ☐NO

HOUSEHOLD MEMBERS LIVING WITH HIV ☐ YES ☐ NO WHO? _____

FAMILY DEPENDENT CHILDREN

Do you have dependent children? ☐ YES ☐ NO Names/Ages _____

If yes, do they live with you? ☐ YES ☐ NO

Do you have any issues related to child custody? ☐ YES ☐ NO

If yes please explain: _____

_____

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Date: _____

TRANSPORTATION

Is transportation available to you? ☐ YES ☐ NO

Own car? ☐ YES ☐ NO Public Transportation ☐ YES ☐ NO _____

What problems have you encountered with transportation? _____

Does the client need help obtaining any of the following? ☐ YES ☐ NO

☐ Clothing ☐ Food ☐ Food Stamps ☐ Housing ☐ Income

Access to Food Programs? ☐ YES ☐ NO

If yes, which ones? _____

Other Household/Personal Items (Toiletries, cleaning supplies, etc.)_____

_____

LEGAL ISSUES ☐ YES ☐ NO

Do you have the following (Check all that apply)

☐ Trust ☐ Will ☐ Advance Directives of Health Care

☐ Financial Power of Attorney

Guardian/Conservator for: ☐ Self and/or ☐ Dependents

If you have a Power of Attorney, who is Power of Attorney?

Do they know your HIV status? ☐ YES ☐ NO

_____ (_____)_____

Name Phone Number

_____ _____

Address City/State/Zip

Have you ever been arrested? ☐ YES ☐ NO _____

Have you ever been convicted of a felony? ☐ YES ☐ NO _____

_____

_____

Do you have/ever had any restraining orders against you? ☐ YES ☐ NO

Have you ever been incarcerated? ☐ YES ☐NO

Are you currently on probation/parole? ☐ YES ☐ NO

If yes, name of probation or parole officer/phone: _____

_____

_____

_____

_____

_____

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Case Managers Initials:_____

Date:_____

PREVENTION SCREENING TOOL

1) Are you in a relationship now? ☐ YES ☐ NO
Are you sexually active at this time? ☐ YES ☐ NO
If yes, tell me about the relationship?_____

2) What do you do/use to protect yourself from getting an STD, a resistant strain of HIV or infecting others?_____

3) Have you ever been infected with a STD or Hepatitis? ☐ YES ☐ NO
If yes, please explain (i.e. type of STD or Hepatitis, treatment date and/or date of completion)?

4) When was your last TB skin test (PPD), and what were the results? _____

5) Are you currently or have you ever used drugs or alcohol? ☐ YES ☐ NO
If, yes when did you last use and what was your drug of choice? _____

6) Have you ever attended a drug and/or alcohol treatment/recovery program? ☐ YES ☐ NO
If yes, tell me about the program? _____

7) Do you feel that there are other factors or issues in your life that put you at risk for transmitting HIV/AIDS? ☐ YES ☐ NO
If yes, what are they? _____

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Date:_____

8) Have you ever had or are you currently having thoughts of hurting yourself or someone else within the past 12 months? ☐ YES ☐ NO
If yes, please explain? _____

9) Have you ever been hurt physically by anyone within the past 12 months? ☐ YES ☐ NO
Have you ever been hurt by a partner, or been afraid you might be hurt within the past 12 months? ☐ YES ☐ NO
If yes, to either question tell me about incident? _____

INTAKE CHECK LIST
- ☐ Client Rights and Responsibilities
- ☐ Authorization to Release Information
- ☐ Grievance Policy
- ☐ HIPAA Form
- ☐ ISP Complete/Care Plan

DOCUMENTATION PROVIDED FOR:
- ☐ Proof of residence
- ☐ HIV Status
- ☐ Primary Care Provider
- ☐ Insurance
- ☐ Photo ID
- ☐ Income

DOCUMENTATION ATTACHED: (Check List)
- ☐ Bank statements showing deposits
- ☐ Copy of Social Security Check
- ☐ Year end 1099 form
- ☐ W-2 tax form from employer
- ☐ Income/Expense form

Federal Poverty Level: _____% of poverty
- ☐ Social Security award letter
- ☐ Pay Stubs
- ☐ Accounting Paperwork
- ☐ Federal income tax return

Place Client Label Here

CM Signature: _____

Case Managers Initials: _____

Date: _____

Acuity Level: _____