|  |  |  |  |
| --- | --- | --- | --- |
| **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?** |
|   |   | Y 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?** |
|   |   | Yes |  | No |  | N/A |  |
| N/A  |  |
| **Gender** |
| Male |  | FemaleIf female, pregnant?  |  | TransgenderM to F |  | TransgenderF 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 |  | Need an interpreter? |  | Difficulty speaking primary language? |  | Difficulty writing primary language? |  |
| Spanish |  |
| Other |  |
| Have you been toldyou 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** |
|   |