|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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. |
|   |   |   |   |   |   |
|   |   |   |   |   |   |
|   |   |   |   |   |   |
| **History of Hospitalizations (Include Psychiatric and Substance Abuse)** | **No Change?** |  |
| Illness | Date | Where |
|   |   |   |
|   |   |   |
|   |   |   |
| **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 |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
| Any known drug allergies? | Yes |  | No |  | Describe |   |
| **Pharmaceutical Providers** | **No Change?** |  |
| Name/Address | Phone | Fax |
|   |   |   |
|   |   |   |
|   |   |   |
| **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 |
|   |   |   |   |   |
|   |   |  |   |   |
|   |   |  |   |   |
| 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 toldyou 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 |  |
|   |  |  |   |  |  |  |
|   |  |  |   |  |  |  |
|   |  |  |   |  |  |  |
| 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 |  |