Index – Case Management Comprehensive Assessment – F-01708

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-01708 (03/2016)

STATE OF WISCONSIN
AIDS/HIV Program
608-267-5287

CASE MANAGEMENT COMPREHENSIVE ASSESSMENT

This form is issued under Wis. Stats. 252.12 (2) 8, personally, identifiable information is collected to assist case managers in planning and coordinating services for persons with HIV infection and is used for only that purpose. Disclosure of social security number is voluntary and will used to assist the client in obtaining various federal, state, and local entitlements.

Name of Assigned Case Manager	**File No.**

Intake Date _____	Assessment Date _____	Assign Date _____

CLIENT CONTACT INFORMATION

Name of Client	Date of initial contact

Preferred Name/Nickname/Alias

Address	County	City/Township	State	Zip Code

Home Telephone Number (include area code)	Preferred Contact Method: ☐ Phone call ☐ Text message Should we: ☐ Leave a message: ☐ Yes, detailed ☐ Yes, discreet ☐ No
Cellphone Number (include area code)	Preferred Contact Method: ☐ Phone call ☐ Text message Should we: ☐ Leave a message: ☐ Yes, detailed ☐ Yes, discreet ☐ No
Work Telephone Number (include area code)	Preferred Contact Method: ☐ Phone call ☐ Text message Should we: ☐ Leave a message: ☐ Yes, detailed ☐ Yes, discreet ☐ No

Email Address

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact	Relationship

Address	City	State	Zip Code

Home Telephone Number (include area code)	Cellphone Number (include area code)
Work Telephone Number (include area code)	Email Address
Is your Emergency Contact aware of your status? ☐ Yes ☐ No	Is the Release of Information (ROI) signed? ☐ Yes ☐ No

If you are not actively engaged in medical care and the case manager is unable to reach you which of the following can the case manager contact?

Name of Contact	**Relationship**	**Telephone number (include area code)**	**Can we leave a message?**	**Is this contact aware of your status?**	**Is the ROI Signed?**
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Name of Assigned Case Manager	**File No.**

CLIENT DEMOGRAPHICS

Date of Birth	Assigned Sex at Birth ☐ Male ☐ Female	Gender ☐ Male ☐ Female ☐ Transgender MTF ☐ Transgender FTM ☐ Unknown	Preferred Pronoun ☐ He/Him ☐ She/Her ☐ They/Them ☐ Zie/Zir ☐ Other

Race

☐ American Indian or Alaska Native ☐ Black or African American ☐ White

☐ Asian

☐ Asian Indian ☐ Chinese ☐ Filipino
☐ Japanese ☐ Korean ☐ Vietnamese
☐ Other Asian

☐ Native Hawaiian or Other Pacific Islander

☐ Native Hawaiian ☐ Guamanian or Chamorro
☐ Samoan ☐ Other Pacific Islander

Ethnicity

☐ Hispanic/Latino/a or Spanish Origin ☐ Non-Hispanic/Latino/a or Spanish Origin

☐ Mexican/Mexican American/Chicano/a ☐ Puerto Rican
☐ Cuban ☐ Another Hispanic/Latino/a or Spanish Origin

Primary spoken language	Primary written language

HIV STATUS AND RISK INFORMATION

HIV Diagnosis Year	HIV/AIDS Status ☐ HIV+, not AIDS ☐ HIV+, AIDS status unknown ☐ CDC-defined AIDS ☐ HIV-indeterminate (<2 years old)

Proof of Status Received* ☐ Yes ☐ No
*Proof of status must be received within 30 days of intake to continue receiving services

HIV Risk Factor (check all that apply)	☐ Men who have sex with men (MSM) (includes men who report sexual contact with other men and men who report sexual contact with both men and women)	☐ Injection drug user (IDU) (includes client who report use of drugs intravenously or through skin-popping)	☐ Hemophilia/coagulation disorder (includes clients with delayed clotting of the blood)
☐ Heterosexual contact (includes clients who report specific heterosexual contact with an individual with, or increased risk for, HIV (e.g. sexual contact with and IDU and/or MSM)	☐ Receipt of transfusions of blood, blood components or tissues given for medical care	☐ Perinatal transmission (cases include transmission from mother to child during pregnancy)	☐ Risk factor not reported or not identified

Do you receive MCM services from another HIV case manager? ☐ Yes ☐ No	**If Yes, please provide:** Name of Case Manager	
	Telephone number (include area code)	Agency

EDUCATION

Highest level of education completed ☐ Some High School ☐ High School ☐ 2 Year College/Technical Training ☐ 4 Year College ☐ Graduate	If applicable, Type of degree/training received	Are you currently in school ☐ No ☐ Yes If Yes, Specify:

Describe your reading ability	Describe your writing ability

Describe any future educational goals you may have

Name of Assigned Case Manager	**File No.**

EMPLOYMENT

Are you currently employed? ☐ Yes ☐ No **If Yes**, complete **Section 1 - If NO**, complete **Section 2**.

SECTION 1 EMPLOYER INFORMATION (Only complete If client is currently employed)

Name of Employer / Company

Type of employment	Length of time at employment	Hours worked per week

Describe any future employment goals you may have

SECTION 2 EMPLOYMENT STATUS (Only complete If client is currently unemployed)

Reason(s) for unemployment

☐ Determined disabled by Social Security Administration (SSA)
☐ Medically unable to work, but not determined disabled by SSA
☐ Laid off
☐ Unable to find work
☐ Not currently seeking work
☐ Other, Specify

Describe any future employment goals you may have	Referral to job training/placement program provided ☐ Yes ☐ No ☐ N/A

FINANCIAL INFORMATION

INCOME SOURCE	Amount per month	Notes
Employment	$	
Unemployment	$	
SSDI	$	
SSI	$	
SSI-E	$	
W-2	$	
FoodShare	$	
VA	$	
Pension	$	
Workman's Comp	$	
Other (Specify)	$	
Other (Specify)	$	
Total Monthly Income	$ 0.00	

Proof of Income Received* ☐ **Yes** ☐ **No** ***Proof of income must be received within 30 days to continue receiving services**

Name of Assigned Case Manager	**File No.**

ASSETS		**EXPENSES**	
Type	**Amount**	**Type**	**Amount per Month**
Cash	$	Mortgage/Rent	$
Checking Account	$	Food	$
Savings Account	$	Health Insurance	$
Stocks/Bonds	$	Other Insurance (life, rental, auto, etc.)	$
Certificates	$	Utilities	$
Cash Value of Life Insurance	$	Phone/Internet	$
Other	$	Alimony/Child Support	$
Other	$	Loans	$
Other	$	Credit Cards	$
Other	$	Medical Expenses (co-pay, medical bills, etc.)	$
Other	$	Other	$
TOTAL	**$** 0.00	**TOTAL**	**$** 0.00

HOUSEHOLD MEMBERS (Includes legal spouse and any tax dependents)

Name	**Relationship**	**Age**	**Income**
			$
			$
			$
			$
			$

Total Household Income	Total Household Size
$ 0.00	

Federal Poverty Level ☐ ≤100% ☐ 101-199% ☐ 200-300% ☐ >300%

Name of Assigned Case Manager	**File No.**

HEALTH INSURANCE

Do you have health insurance? ☐ Yes ☐ No **If Yes**, Complete **Section 1**. **If NO**, Complete **Section 2**.

SECTION 1 INSURANCE POLICY INFORMATION (Only complete if client currently has health insurance)

Carrier	Policy/ID Number	Effective Dates	Contact Information
BadgerCare			
Elderly, Blind, Disabled (EBD) Medicaid			
Medicare ☐ Part A ☐ Part B ☐ Part C ☐ Part D			
Medicare Supplement Plan Riders			
Employer-Sponsored			
COBRA			
Marketplace Plan Insurance Company ☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Catastrophic			
Dental			
Vision			
Other			

Are you enrolled in ADAP? ☐ Yes ☐ No

Are you enrolled in the Health Insurance Assistance Program? ☐ Yes ☐ No

SECTION 2 INSURANCE ENROLLMENT STATUS (Only complete if client is currently uninsured)

Client's household income is

☐ Under 100%FPL

☐ Over 100% FPL

If UNDER, have you applied for BadgerCare?

☐ Yes ☐ No ☐ Not Eligible- Reason

☐ Declines-Reason

If OVER, have you applied for Marketplace coverage?

☐ Yes ☐ No ☐ Not Eligible- Reason

☐ Declines-Reason

If client declined enrollment in BadgerCare or Marketplace are they aware of consequences of not having health insurance, including possible IRS fine and increase in likelihood of losing ADAP coverage in the future? ☐ Yes ☐ No

Are you enrolled in ADAP? ☐ Yes ☐ No

Are you enrolled in the Health Insurance Assistance Program? ☐ Yes ☐ No

PHYSICAL HEALTH AND MEDICAL CARE

How would you describe your overall health

How has your health changed in the past year (improved, declined, stayed the same)

If your health has remained stable or improved, what steps have you taken to stay healthy?	If your health has declined, what things got in the way of being able to stay healthy?

Name of Assigned Case Manager	**File No.**

HIV CARE	
HIV Medical Provider	Hospital/Clinic Affiliation
Address	
Phone	Fax
Date of last medical appointment	Date of next medical appointment
Current CD4 Count Date	Current Viral Load Date

PRIMARY CARE	
Primary Care Provider ☐ Same as Above	Hospital/Clinic Affiliation
Address	
Phone	Fax
Date of last medical appointment	Date of next medical appointment

OTHER MEDICAL PROVIDERS

Name of Provider	Diagnosis	Specialty of Provider	Address/Phone

Name of Assigned Case Manager	**File No.**

MEDICATIONS

Name of Medication	Diagnosis	Name of Prescriber	Dosage	Name of Pharmacy

Medication Allergies

SCREENING TESTS

Test	Recommendation	Most Recent Date	Most Recent Result
TB Screening	At least once since diagnosis		
Fasting Lipid Screen	Annually for clients on ART		
Hepatitis B Screen	At least once since diagnosis, or annually for non-immune clients with high risk		
Hepatitis C Screen	At least once since diagnosis, or annually for HCV negative clients actively injecting drugs		
Chlamydia Screen	At least annually for sexually active clients, or more frequently as indicated by risk		
Gonorrhea Screen	At least annually for sexually active clients, or more frequently as indicated by risk		
Syphilis Screen	At least annually for sexually active clients, or more frequently as indicated by risk		
Anal Cancer Screen (Anal Pap Smear)			
Cervical Cancer Screen (Vaginal Pap Smear)	Annually for women		
Testicular Exam	Annually for men		
Mammogram			
Colonoscopy	Adults over 50 every 10 years, or more frequently as indicated by risk		

Name of Assigned Case Manager	File No.

VACCINATIONS

Vaccine	Recommendation	Date
Influenza	Annually	
Hepatitis A Series		
Hepatitis B Series	Once for clients without chronic HBV or immunity to HBV	
Pneumococcal	Once	

ACTIVITIES OF DAILY LIVING

Do you require assistance with any of the following activities (check all that apply)

☐ Bathing	☐ Using the bathroom	☐ Grooming	☐ Getting dressed
☐ Walking	☐ Eating	☐ Preparing meals	☐ Grocery shopping
☐ House work	☐ Managing money	☐ Using the telephone	☐ Taking medications as prescribed

Do you use any assistive devices? ☐ No
☐ Yes- Specify

Do you receive home health services or help with personal care? ☐ No
☐ Yes- Specify

Client provided referral to home health services and/or personal care assistance ☐ N/A ☐ Yes ☐ No

NUTRITION

Describe the meals you eat in a typical day

Do you have access to nutritional food? ☐ Yes
☐ **If No,** was referral made to FoodShare and/or food pantries
☐ Yes ☐ No

Have you been prescribed a specific diet by your medical provider?
☐ No
☐ If, Yes- Specify

Are you currently taking supplements (Ensure, vitamins)?
☐ No
☐ If, Yes- Specify

Have you recently experienced significant unexpected weight gain or loss?

Current Weight

Client provided referral to nutritionist ☐ Yes ☐ No ☐ N/A

PREGNANCY ☐ N/A

Pre-Natal Care Provider	Hospital/Clinic Affiliation
Address	Phone

If client is not currently enrolled in pre-natal medical care has referral been made? ☐Yes ☐ No

Primary Care Support Network (PCSN) Case Manager	Phone

If client is not currently enrolled in PCSN has referral been made? ☐ Yes ☐ No-Reason

TRANSGENDER HEALTH ☐ N/A

For clients in transition; What questions or needs do you have related to transition

Are you currently on hormone replacement therapy (HRT)? ☐ Yes ☐ No

If YES, How do you access HRT?

Do you have access to clean needles? ☐ Yes ☐ No

If NO, referral to syringe exchange made? ☐ Yes ☐ No

Name of Assigned Case Manager	**File No.**

ORAL HEALTH

Date of last dental visit

Oral Health Provider	Hospital/Clinic Affiliation
Address	Phone

If client does not have an oral health provider, has referral been made? ☐ Yes ☐ No

Describe your current dental needs	Are you prescribed dentures? ☐ Yes ☐ No **If YES**, date of last fitting

VISION CARE

Date of last optical visit

Vision Provider	Hospital/Clinic Affiliation
Address	Phone

If client does not have a provider, has referral been made? ☐ Yes ☐ No ☐ N/A

Describe your current vision needs	Were you prescribed glasses/contacts? ☐ Yes ☐ No **If YES**, date of last prescription check

ALTERNATIVE THERAPIES

Are you accessing alternative therapies (acupuncture, herbal remedies, etc.) ☐ No ☐ Yes- Specify	**If YES**, are medical providers and pharmacists aware of alternative therapies. ☐ Yes ☐ No

RETENTION AND ADHERENCE

HIV MEDICAL APPOINTMENTS

How often are you *supposed* to attend scheduled HIV medical appointments ☐ Monthly ☐ Quarterly ☐ Twice a year ☐ Annually ☐ Other	How often are you *able* to attend scheduled HIV medical appointments ☐ Never ☐ Sometimes ☐ Most of the time ☐ All of the time

What helps you remember to attend your HIV medical appointments?

What gets in the way of attending HIV medical appointments?

How have you overcome these barriers in the past, or what would need to change for you to be able to attend your HIV medical appointments?

Name of Assigned Case Manager	**File No.**

HIV MEDICATIONS

Are you currently taking antiretroviral therapy (ART) ☐ Yes ☐ No **If YES**, complete Section 1 - **If NO**, complete Section 2.

SECTION 1 ADHERENCE TO ART (Only complete If client is currently taking ART)

How often are you *supposed* take your HIV medications	How often are you *able* to take your HIV medications
☐ Once a day ☐ Twice a day ☐ Three times a day ☐ Other	☐ Never ☐ Sometimes ☐ Most of the time ☐ All of the time

What helps you remember to take your HIV medications?

What kind of things get in the way of taking your HIV medications as prescribed?

How have you overcome these barriers in the past, and what would need to change for you to be able to take your medications as prescribed?

SECTION 2 READINESS FOR ART (Only complete If client is not currently prescribed ART)

Have you taken HIV medications in the past ☐ Yes ☐ No

What do you already know about HIV medications

On a scale of 0-10 (0 being "not important" and 10 being "very important") how *important* is it to you to start HIV medications

0	1	2	3	4	5	6	7	8	9	10

If 5 or below, why are you at a (current number) and not a "0"	**If 6 through 9**, what would it take to go from a (current number) to a (slightly higher number) **If 10**, tell me about why you're at a 10?

On a scale of 0-10 (0 being "not confident" and 10 being "very confident") how *confident* are you in your ability to take HIV medications every day

0	1	2	3	4	5	6	7	8	9	10

If 5 or below, why are you at (current number) and not a "0"	**If 6 through 9**, what would it take to go from a (current number) to a (slightly higher number) **If 10**, tell me around you're at a 10?

BEHAVIORAL HEALTH HISTORY

How would you describe your overall mental and emotional health?

Do you have any diagnosed mental health conditions ☐ No ☐ Yes- Specify	Are you currently engaged in mental health services ☐ Yes ☐ No **IF YES**, complete the provider information below.
Mental Health Provider	Hospital/Clinic Affiliation
Address	Telephone
Date of last appointment	Date of next appointment

Have you ever been hospitalized due to a mental health condition ☐ No
☐Yes- Specify

Name of Assigned Case Manager	**File No.**

BEHAVIORAL HEALTH SCREENS

Complete all of the following screens with all clients regardless of information provided above. These screens are not meant to diagnosis clients with depression, anxiety, PTSD or any other mental health condition, but rather to identify individuals who require referral to a mental health provider for professional assessment.

DEPRESSION

Over the **past 2 weeks**, how often have you been bothered by any of the following problems?

	Not At All	**Several Days**	**More Than Half the Days**	**Nearly Every Day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
			TOTAL SCORE Offer referral for professional assessment If total score is ≥ 3	

ANXIETY

	Yes (1)	**No (0)**
1. Do you often worry or feel nervous?		
2. Are you fearful of interacting with other people?		
3. Do you ever feel jittery, short of breath, or like your heart is racing?		
4. Do you even feel as If you might lose control or fear that you may be “losing it”?		
TOTAL SCORE Offer referral for professional assessment If total score is ≥ 2		

POST-TRAUMATIC STRESS DISORDER (PTSD)

Have you ever had any experience that was so upsetting, frightening, or horrible that in the **past month** you

	Yes (1)	**No (0)**
1. Have nightmares about it or think about it when you do not want to?		
2. Try hard not to think about it or go out of you way to avoid situations that remind you of it?		
3. Are you constantly on guard, watchful, or easily startled?		
4. Feel numb or detached from other, activities and your surroundings?		
TOTAL SCORE Offer referral for professional assessment If total score is ≥ 3		

Referral offered to mental health provider based on score of above screen(s)

☐ Yes- Client accepted referral	☐ Yes- Client declined referral. Reason
☐ No- Client already engaged in MH care	☐ No- Not indicated by screens

SUICIDE RISK ASSESSMENT

Complete this section with all clients.

Have you ever attempted suicide in the past? ☐ No

☐ **If Yes** - Specify (date of last attempt, method)

For each question, If the client answers “Yes,” continue to the next question.	**YES**	**NO**
1. In the past month have you had thoughts of killing yourself?		
2. Have you been thinking about *how* you might kill yourself? **IF YES**, relevant information regarding plan		
3. Do you intend to carry out this plan?		
4. Do you have access to items needed to carry out your plan (guns, pills, etc.)?		

Name of Assigned Case Manager	**File No.**

If client answers "Yes" to all questions or questions 1-3, immediate intervention (as detailed in your agency's Crisis Intervention Policy) is required.

Resulting Action (check all that apply)

- ☐ Action not indicated by assessment
- ☐ Immediate Intervention- Specify
- ☐ 24 Hour Crisis and Emergency Assistance Information provided
- ☐ Referral offered to mental health provider- Client accepted referral
- ☐ Referral offered to mental health provider- Client declined referral Client already engaged in mental health care- MH provider notified of assessment results

SUBSTANCE USE

SUBSTANCE USE HISTORY

Are you currently or have you ever used illegal drugs ☐ Yes ☐ No	**If YES,** what types of drugs have you used
Have you ever injected drugs ☐ Yes ☐ No	
Are you currently or have you ever used prescription drugs for non-medical reasons ☐ Yes ☐No	**If YES,** what types of prescription drugs have you used
Are you currently engaged in drug and/or alcohol treatment ☐ Yes ☐ No	**If YES,** describe type and frequency of treatment

For clients in recovery, How long have you been in recovery?	How can I support your recovery efforts?	What has helped you be able to stay clean?

SUBSTANCE USE SCREENS

Complete the **AUDIT** [Babor et al. (2001). World Health Organization] and **DAST** [Skinner (1982). Centre for Addiction and Mental Health with all clients.] If client answers "Never" to the first question on the AUDIT, the rest of the screen does not need to be completed. If client answers "No" to the first question on the DAST, the rest of the screen does not need to be completed.

	AUDIT - In the past 12 months	**0**	**1**	**2**	**3**	**4**
1.	How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2.	How many drinks containing alcohol do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10 or more
3.	How often do you have four or more drinks on one occasion? ***Skip to Questions 9 and 10 If Total Score for Questions 2 and 3 = 0***	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4.	How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5.	How often during the last year have you failed to do what was normally expected of you?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6.	How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7.	How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8.	How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9.	Have you or someone else been injured because of your drinking?	No		Yes, not in the last year		Yes, during the last year
10.	Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down.	No		Yes, not in the last year		Yes, during the last year

Each of the above items is scored 0-4 based on the client's response **Total score =**

Name of Assigned Case Manager	**File No.**

DAST-10; In the past 12 months	**Yes (1)**	**No(0)**
1. Have you used drugs other than those required for medical reasons?		
2. Do you use more than one drug at a time?		
3. Are you always able to stop using drugs when you want to?		
4. Have you ever had blackouts or flashbacks as a result from drug use?		
5. Do you ever feel bad or guilty about your drug use?		
6. Do people in your life ever complain about your involvement with drugs?		
7. Have you neglected your family because of your use of drugs?		
8. Have you engaged in illegal activities in order to obtain drugs?		
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?		
10. Have you had medical problems as a result of your drug use for example, memory loss, hepatitis, convulsions, bleeding?		
Each of the above items is scored 1 for "Yes" or 0 for "No" **Item 3 is reversed scored 0 for "Yes" and 1 for "No"** **Total score =**		

AUDIT and DAST SCREEN RESULTS (Share results with client based on scores listed above)

AUDIT Score	**DAST Score**	**Description**
Male 0-8 Female 0-7	0	***Doing Ok -*** People who score in this range are unlikely to be experiencing current problems from substance use. To keep risk low, recommendation is that **men** drink no more than 4 standard drinks per occasion and up to 14 drinks per week, and **women** to drink no more than 3 standard drinks per occasion and up to 7 drinks per week. For illicit drug use, recommendation is abstinence because there is no known safe level of use.
M 9-15 F 8-15	1-2	***Red Alert -*** People who score in this range **have experienced**, or may be at risk for experiencing a consequence from substance use. A pattern of regular use may be developing, as well as tolerance to the substance effects. Tolerance tricks a person into believing they are less impaired than they actually are, thus increasing the risk for a consequence.
16-19	3-5	***Problems Ahead -*** People who score in this range may be **currently experiencing** consequences and problems from the substance use. Tolerance to the substance effects is usually established. The person is likely on a road to experiencing more problems. There is a strong risk for developing an addiction to the substance, especially If there is a family history. (Offer referral to AODA treatment)
20 or above	6 or above	***Very Concerning -*** People who score in this range may be **currently experiencing significant** consequences and problems from the substance use. Tolerance to the substance effects is usually high. The person may be having difficulty controlling their substance use and, for some, If they stop they may experience withdrawal symptoms. This is addiction, treatment needed. (Offer referral to AODA treatment)

Name of Assigned Case Manager	**File No.**

Referral offered to AODA treatment based on score of above screen(s)

☐ Yes- Client accepted referral	☐ Yes- Client declined referral. Reason
☐ No- Client already engaged in AODA treatment	☐ No- Not indicated by screens

RISK REDUCTION (RR)

RR 1 What do you already know about how HIV is transmitted?
☐ Client description accurate ☐ Client description incomplete or inaccurate

Keeping your viral load low is very important, both for your own health and to reduce the chance that you might pass HIV to a partner. (Case Manager may want to review most recent viral load test results with the patient at this time.)

SEXUAL RISK (SR)

SR 1 PARTNERS

Many people living with HIV have healthy and rewarding sexual relationships. Have you been in a sexual relationship during the last 2 years?
☐ Yes ☐ No – **If No**, skip to **SR 5**

If YES, Thinking about your sexual relationships over the past 2 years, how you would you describe your partner(s)?

Relationship Structure
☐ One main partner only ☐ One main partner + others ☐ Multiple partners, no main partner

Gender of Partner(s)
☐ Male partners only ☐ Female partners only ☐ Male and female and/or TG partners

HIV Status of Partner(s)
☐ Partner(s) known to be HIV positive

If YES, ☐ Partner is in care ☐ Partner NOT in care ☐ Partner(s) HIV; mix of both positive and negative; or not sure

If you think any of your partner(s) might be interested, we have information about it.

SR 2 SEXUAL ACTIVITIES

There are many different activities people are talking about when they say "sex" – some are less likely than others to pass HIV to your partner are. What types of activities are parts of your sexual relationships?

Higher Risk
☐ Anal intercourse ☐ Vaginal intercourse ☐ Sexual play with risk of significant bleeding

SR 3 DISCLOSURE

Do you discuss your HIV status with your partners? ☐ Yes ☐ No ☐ Sometimes
Do you ever discuss HIV risk with partners without mentioning your status? ☐ Yes ☐ No

At what times are you most likely to discuss HIV w/ your partners?

At what times are you most likely to avoid discussing HIV w/ your partners?

If client has more than one partner, Are you more likely to talk about HIV risk or your HIV status with some partners than with others?

SR 4 SEXUALLY TRANSMITTED DISEASES

We know people with HIV can be at extra risk from other sexually transmitted diseases like syphilis and gonorrhea. What extra steps are you taking to protect yourself from STDs when you have sex?

Have you been diagnosed with a STD in the last year ☐ Yes ☐ No

SR 5 RISK REDUCTION

What is your best strategy for making sure you are not passing HIV to your partner(s)?

Name of Assigned Case Manager	**File No.**

High-risk practices indicating need for further discussion regarding behavior change and/or referral to other services. (For example - prevention, mental health, AODA, etc.)

☐ Client has been sexually active during last two years (**SR1)**, **AND** at least two of the following
- ☐ Client indicates multiple sexual partners (**SR1- Structure)**
- ☐ Client indicates partners of HIV-negative or HIV-unknown status (**SR1- HIV Status)**
- ☐ Client indicates one or more of the three *higher risk* practices **(SR 2)**
- ☐ Client describes difficulty discussing HIV with sexual partners (independent of serostatus disclosure) (**SR3)**
- ☐ Client strategy for HIV prevention **(SR5)** is misinformed or inadequate

Referral to Partner Services provided (in cases where client has partners in need of notification) ☐ N/A ☐ Yes- Client accepted referral ☐ Yes- Client declined referral. Reason	Referral to other service provide ☐ Yes- Client accepted referral ☐ Yes- Client declined referral. Reason

INJECTION RISK ☐ N/A

Do you have access to clean needles and equipment when you inject drugs/hormones? ☐ No ☐ Yes- Specify	**If NO**, referral to syringe exchange provided ☐ Yes- Client accepted referral ☐ Yes- Client declined referral. Reason

Referral to Partner Services provided (in cases where client has partners in need of notification)
☐ N/A
☐ Yes- Client accepted referral
☐ Yes- Client declined referral. Reason

HOUSING

Which of these best describes your current housing situation

☐ **Stable Permanent Housing**	☐ **Temporary Housing**	☐ **Unstable Housing Arrangements**
☐ Renting and living in an unsubsidized room, house or apt	☐ Transitional housing	☐ Emergency shelter
☐ Owning and living in an unsubsidized house or apt	☐ Temporary arrangement to stay with family/friends	☐ A public or private place not designated or, or normally used as a regular sleeping accommodation for human beings (vehicle, abandoned building, bus station, anywhere outside, etc.)
☐ Unsubsidized permanent placement with family/friends	☐ Temporary placement in an institution (psychiatric facility, detoxification center, etc.)	☐ Jail, prison or a juvenile detention center
☐ HOPWA-funded assistance including Tenant-Based Rental Assistance and Facility-Based Housing Assistance (excludes STRMU)	☐ Hotel or motel paid for without emergency shelter voucher	☐ Hotel or motel paid with emergency shelter voucher
☐ Subsidized, non-HOPWA (house or apt. Section 8, Public Housing, etc.)	☐ Other temporary arrangement	
☐ Permanent housing for formerly homeless persons (Shelter Plus Care, SHP)		
☐ Institutional setting with support and continued residence expected (nursing home, long-term care facility, etc.)		

Who else lives with you?	Do you feel safe in your home? ☐ Yes ☐ No- Specify **If NO**, is immediate intervention required ☐ Yes ☐ No

Describe any housing needs you have at this time.	Are you currently on a waiting list for housing program(s) and/or rental assistance? ☐ No ☐ Yes- Specify	Referral for rental/housing assistance (housing case management) provide ☐ Yes ☐ N/A

Name of Assigned Case Manager	**File No.**

TRANSPORTATION

What is your primary mode of transportation? ☐ Personal vehicle ☐ Friends/family/other support people ☐ Bus ☐ Taxi ☐ Other-Specify	Do you have a valid driver's license? ☐ Yes ☐ No
Describe any transportation needs you have at this time	Transportation assistance or referral for assistance provided ☐ Yes ☐ N/A

SUPPORT AND RELATIONSHIPS

Who are your biggest sources of social and emotional support? Are these people aware of your HIV status ☐ Yes ☐ No

How do you cope with stress or difficult situations?

Are you currently in a relationship or dating ☐ Yes ☐ No	Do you feel safe in your relationship or with the person you are dating (Do not ask with client's partner present) ☐ Yes ☐ No	**If NO**, Complete Intimate Partner Violence Screen.

Intimate Partner Violence Screen

Complete only If client states they do not feel safe with their partner. Do not administer this screen If client's partner is present during assessment. Administer the screen at a time when the client can respond privately	**Yes**	**No**
1. Has your partner ever hit you of physically hurt you?		
2. Has your partner ever threatened to hurt you or someone close to you?		
3. Do you feel controlled by your partner or feel you are in danger?		
4. Has your partner ever forced you to have sex when you didn't want to?		
5. Has your partner ever refused to practice safe sex?		
6. Has your partner ever threatened to out or disclose your HIV status, sexual orientation, or gender identity?		

If client has one or more affirmative responses, referral to domestic abuse or other support services offered

☐ N/A

☐ Yes- Client accepted referral ☐ Yes- Client declined referral. Reason

Name of Assigned Case Manager	**File No.**

DEPENDENTS

Do you have minor children whose care you are responsible for ☐ Yes ☐ No **If YES**, Complete table below.

Name	**Age**	**Gender**	**Child aware of your HIV status**		**Child's HIV status**			**If child is HIV+, are they aware of their status**	
			Yes	**No**	**POS**	**NEG**	**UKN**	**Yes**	**No**

If the child's HIV status is unknown, referral provided for testing ☐ Yes ☐ No, Reason	If the child is HIV+, referral provided for Primary Care Support Network ☐ Yes ☐ No, Reason
Describe any other needs you have related to childcare at this time.	Referral provided for childcare assistance? ☐ N/A ☐ Yes

LEGAL

PAST CONVICTIONS

Have you ever been incarcerated ☐ No ☐ If Yes- Specify	Are you aware of any outstanding warrants, summons and/or pending cases in your name ☐ No ☐ If Yes- Specify

Are you currently on extended supervision/probation ☐ Yes ☐ No **If YES,** Supervision End Date

Describe any restrictions related to the terms of your supervision/probation.

Name of Parole Office	Parole Office Telephone Number (include area code)

OTHER LEGAL NEEDS

Have you completed a Power of Attorney for HealthCare (POA-HC) ☐ Yes ☐ No	**If YES**, Have you provided a copy of your POA-HC to your medical provider(s) ☐ Yes ☐ No
Describe any other legal needs you have at this time (divorce, immigration, bankruptcy, permanency planning, living will, etc.)	Referral for legal assistance provided ☐ N/A ☐ Yes ☐ No

Name of Assigned Case Manager	**File No.**

Additional Notes:

Clear Entire Form