CLIENT INTAKE

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

Date: Social Security #: Client #:

PERSONAL INFORMATION

PRIMARY LANGUAGE ___________________________ NEED INTERPRETER ☐ YES ☐ NO

STREET ADDRESS ________________ CITY/STATE ________________ ZIP ________

ALTERNATE ADDRESS ________________ CITY/STATE ________________ ZIP ________

___________________________COUNTY Preferred Method of Contact ☐PHONE ☐ MAIL ☐EMAIL

Consent to Send Mail ☐ YES ☐ NO Consent to Send Email ☐ YES ☐ NO Email ___________________________

Anonymous return address requested ☐ YES ☐ NO

(_____)__________ 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 ☐ NATIVE HAWAIIAN /PACIFIC ISLANDER

☐ AMERICAN INDIAN OR ALASKAN NATIVE ☐ OTHER

KEY CONTACTS

EMERGENCY CONTACT ________________ RELATIONSHIP ________________ PHONE NUMBER (___)__________

AWARE OF STATUS? ☐ YES ☐ NO

HIV /AIDS PROVIDER____ (_____)______________

PRIMARY CARE PROVIDER _____________________________________ (_____)______________

DENTAL PROVIDER_ ____ ( )

BEHAVIORAL HEALTH PROVIDER____________________________ (____)______________

REFERRAL AGENCIES ________________________________ (____)______________

EDUCATION

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

Highest level of education completed? ____________________

Place Client Label Here

Case Managers Initials:_______________

Date:______________________________

HIV STATUS

☐ HIV positive not AIDS ☐ HIV positive, AIDS status unknown ☐ CDC-defined AIDS

Date tested positive____________ Date of AIDS Dx: ____________

Risk 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

____

HOUSING SITUATION

☐ Permanently Housed (Stable) ☐ Temporary Housing (hotel, family, friend, college dorm, etc.)

☐ Transitional Housing (Substance Abuse Treatment Program, Transitional Housing Program) ☐ HUD/Section 8

☐ Emergency Housing (Shelter, Salvation Army, Etc.) ☐ Medical Facility (Adult Foster Care, Personal Care Home, Skilled Nursing Facility, Hospice, Etc.) ☐ Homeless ☐ 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

Place Client Label Here

Case Managers Initials:_______

Date:____________________________

Do you have any issues related to child custody? ☐ YES ☐ NO
If yes please explain: ____

____

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?

______________________________________ (_____)________________
Name Phone Number

______________________________________ _________________________________
Address City/State/Zip

Do they know your HIV status? ☐ YES ☐ NO
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: ____

____

____

____

____

____

Place Client Label Here

Case Managers Initials:________

Date:__________________________

PREVENTION SCREENING TOOL

1) Are you in a relationship now? ☐ YES ☐ NO
Are you sexually active currently? ☐ 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? ____

8) Have you ever had or are you currently having thoughts of hurting yourself or someone else within the past 12 mths ?
☐ 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? ____

CM Signature: ____________________

Place Client Label Here

Case Managers Initials:____________________

Date:____________________

Acuity Level: ____________________

INTAKE CHECK LIST

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

DOCUMENTATION PROVIDED FOR:

- ☐ Proof of residence
- ☐ HIV Status
- ☐ Primary Care Provider
- ☐ Insurance
- ☐ Photo ID

DOCUMENTATION ATTACHED: (Checklist) **Federal** Poverty Level: _____% of poverty

- ☐ Bank statements showing deposits
- ☐ Copy of Social Security Check
- ☐ Year end 1099 form
- ☐ W-2 tax form from employer
- ☐ Income/Expense form
- ☐ Social Security award letter
- ☐ Pay Stubs
- ☐ Accounting Paperwork
- ☐ Federal income tax return

Place Client Label Here

CM Signature: ______________________________

Case Managers Initials:___________________

Date:______________________________________

Acuity Level: ____________________