CASE MANAGEMENT POLICY
Case Management Process

Subject: SOP 3 – Assessments: Intakes
Date: March 21, 1996 (Previously SOP 2)/ Revised/Reviewed: August 21, 2008  Revised 6/23/2009
Revised 01/29/2010

PURPOSE:
To set a minimum standard across Cooperative subcontractors regarding the process for gathering required intake information and assessing client’s current needs.

POLICY:
Client intakes will be completed by the assigned case manager on a timely basis (based on Response Expectation identified during the AIDS Foundation of Chicago (AFC) screening, see SOP 1) and will include documentation of eligibility, demographic information, and an assessment of client needs.

PROCEDURE:
Intake is the process by which a case manager forms a relationship with the client, documents eligibility, and gathers information necessary to determine the initial assessment of need and preliminary service plan.

Intake is conducted by a case manager of a Cooperative agency in a face-to-face interview with a client eligible for services. Intakes may be conducted in an agency office, a client's home, or at a health or social service institution. In any case, the intake must be conducted in a confidential setting.

During intake the case manager will verify screening information and the need for case management services, explain the case management system and services provided, collect client data, and prioritize areas of need. Case managers will maintain client confidentiality regarding the information shared and describe the policy on confidentiality to the client.

With this information, the case manager will formulate and share with the client an assessment of service needs and suggest areas of focus for the service plan. Either in the initial intake session or in a next meeting with the client, the case manager and client will develop a formal service plan to guide the case management relationship. (See SOP 6 for details on Service Planning.)

Below is a list of all documentation that must be obtained to complete an initial intake assessment:

- Client Screening Feedback Form (received from AFC) (SOP 1)*
- Consent to Enroll in the Central Database (SOP 4)*
- Consent to Participate in Case Management (SOP 4)
- AFC Release of Information (SOP 4)
- Case Intake Form*
- Medical Assessment Form (completed by physician) (SOP 5B)*
- Photo ID
- Proof of Residency
- Proof of Income
- Proof of HIV Status
- Client Rights and Responsibilities (agency-specific form)
• Grievance Policy (agency-specific form)
• HIPAA Policy (when applicable)
• Updated Service Plan (SOP 6)
  * Must be entered into AFC’s client-level data system

This list is also available in the Ryan White Initial Assessment Checklist, which includes specific information on each required item. In cases where clients do not have income or health insurance, AFC will accept a letter signed by both the client and case manager affirming that the client has no source of income or insurance as adequate documentation. Case managers should use this tool when completing the intake.

FORMS:
Case Assessment (Intake) Form
Ryan White Initial Assessment Checklist
Case Intake Form Instructions
AIDS FOUNDATION OF CHICAGO
NORTHEASTERN ILLINOIS HIV/AIDS CASE MANAGEMENT COOPERATIVE

MASTER ASSESSMENT TYPE: ____ INTAKE _____ SIX MONTH REASSESSMENT

DATE: __ __ / __ __ / __ __

CLIENT ID #: ______________________

AGENCY: __________________________________

CASE MANAGER: __________________________________

Client Profile:

LAST NAME: ____________________________

FIRST NAME: ___________________________

MIDDLE INIT: ______

DOB: ___ / ___/ ____

SS#: ______ - ______ - _______ □ Don’t know/have SS# □ Refused SS#

CURRENT GENDER: □M □F □ Don’t know □Refused

GENDER AT BIRTH: □M □F □ Don’t know □Refused

RELATIONSHIP STATUS: □Single □ Divorced □ Widowed □ Married □ Engaged □ Partnered □ Separated □ Other

CONTACT INFORMATION

STREET ADDRESS: ______________________________

CITY: ____________ COUNTY: ___________ ZIP: ________

MAILING ADDRESS: _____________________________

CITY: ____________ COUNTY: ___________ ZIP: ________

OKAY TO SEND MAIL? □ Yes □ No

HOME PHONE: (___) ___-_____ □ Any □ Discreet □ None

MOBILE PHONE: (___) ___-_____ □ Any □ Discreet □ None

WORK PHONE: (___) ___-_____ □ Any □ Discreet □ None

E-MAIL ADDRESS: _____________________________

E-MAIL TYPE: □ Any □ Discreet □ None

ETHNICITY: □ Hispanic/Latino/a □ Non-Hispanic/Non-Latino/a

RACE: (check all that apply) □ American Indian/Alaska Native □ Asian □ Black/African-American

□ Hawaiian/Pacific Islander □ White □ Other □ Don’t Know □ Refused

COUNTRY OF BIRTH (ORIGIN): _________________

PRIMARY LANGUAGE: __________________________

LIMITED ENGLISH PROFICIENCY? □ Yes □ No

Household Members

□ Refused

NAME DOB/AGE GENDER RELATIONSHIP to CLT DEPENDENT? ETHNICITY RACE

Y / N

Y / N

Y / N

Y / N

Emergency Contacts

NAME RELATIONSHIP to CLT CONTACT AWARE CLIENT IS HIV+ PHONE: LEAVE MSG?

□ Any/Discreet/None

□ Any/Discreet/None

NOTE: at this point in the electronic form you will be asked to record information about the assessment

RW ASSESSMENT FORM FINAL 03.15.2010
Referral Information:

SOURCE OF REFERRAL (NON-AFC):
- Court System
- DCFS
- Family & Friends
- HIV Counseling & Testing Sites
- Hotline
- Other Agency
- Other Unit in Provider Agency
- Primary Care Provider
- Self Referral
- STD Clinics

REFERRAL DATE: ___/___/____  REFERRAL PERSON: ________________________

AFFILIATION: ________________________  PHONE #: (_____) ___-____

Additional Demographic Information:

CLIENTS’ HIGHEST EDUCATION LEVEL COMPLETED:
- Unreported/Refused
- No School Completed
- Nursery to 4th
- 5th - 6th
- 7th - 8th
- 9th
- 10th
- 11th
- 12th, No Diploma
- High School Diploma
- GED
POST SECONDARY:
- No Degree
- Associates
- Bachelors
- Masters
- Doctorate
- Vocational
- Certificate

VETERAN: □ Yes □ No  VETERAN DISABILITY STATUS: _____ % (FROM 1 – 100 PERCENT) □ Unknown/NA

LIVING ARRANGEMENT STATUS
DATE THE CLIENT BEGAN THE CURRENT LIVING TYPE: ___/___/____

INSTITUTION
- Hospital
- Institution
- Jail, Correctional Facility
- Psychiatric Hospital
- Substance Abuse Facility

TRANSITIONAL/TMPORARY
- Group or Foster Home
- Supportive Housing Unit
- Transitional Housing
- Hotel/Motel
- Temporarily with Friend
- Temporarily with Family

HOMELESS
- Shelter
- Street

PERMANENT
- Rental Unit
- SRO
- Homeownership
- Live with Friend
- Live with Family

Current Employment:

CURRENTLY EMPLOYED? □ Yes □ No

IF YES, Hours worked last week: ________________________

Tenure: □ Permanent □ Temporary □ Seasonal □ Don’t Know □ Refused

Looking for additional employment/increased hours? □ Yes □ No □ Don’t Know □ Refused

IF NO, Status: □ Unemployed □ Retired □ Permanent Medical Disability □ Temporary Medical Disability

Looking for work? □ Yes □ No □ Don’t Know □ Refused

Income Sources:

INCOME STABILITY: □ Has steady source of income □ Minimal unstable income □ No current income

How much money did you receive from the following sources in the past 30 days? (SKIP IF NO CURRENT INCOME)

CASH SOURCE
- Earned Income (Employment)
- Other household income
- Unemployment Insurance
- Supplemental Security Income
- Social Security Disability Income
- Veteran’s Disability Payment
- Private Disability Insurance
- Workers Compensation
- TANF
- General Assistance
- Retirement (Social Security)
- Veteran’s Pension
- Other Pension
- Child Support
- Alimony/spousal support

DESCRIPTION

AMOUNT $
Partner / Family Support: $ 
Other Income: $ 

**Non-Cash Benefits**
- Foodstamps / money for food on benefits card: $ 
- WIC: $ 
- TANF Child Care: $ 
- TANF Transportation: $ 
- Other TANF: $ 
- Other Source: $ 

**Insurance Sources:**

- [ ] DEFAULT TO LAST ASSESSMENT (NO CHANGE)
- No Insurance

If no insurance, how are you receiving your medications?

<table>
<thead>
<tr>
<th>INSURANCE SOURCE</th>
<th>STATUS</th>
<th>PRIMARY?</th>
<th>Medications Covered?</th>
<th>START DATE</th>
<th>END DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Insurance</td>
<td>Pending / Applied / Active</td>
<td>Y / N</td>
<td>Y / N</td>
<td><strong>/</strong>/____</td>
<td><strong>/</strong>/____</td>
</tr>
<tr>
<td>Medicaid</td>
<td>Pending / Applied / Active</td>
<td>Y / N</td>
<td>Y / N</td>
<td><strong>/</strong>/____</td>
<td><strong>/</strong>/____</td>
</tr>
<tr>
<td>Medicare</td>
<td>Pending / Applied / Active</td>
<td>Y / N</td>
<td>Y / N</td>
<td><strong>/</strong>/____</td>
<td><strong>/</strong>/____</td>
</tr>
<tr>
<td>ADAP</td>
<td>Pending / Applied / Active</td>
<td>Y / N</td>
<td>Y / N</td>
<td><strong>/</strong>/____</td>
<td><strong>/</strong>/____</td>
</tr>
<tr>
<td>IL All Kids</td>
<td>Pending / Applied / Active</td>
<td>Y / N</td>
<td>Y / N</td>
<td><strong>/</strong>/____</td>
<td><strong>/</strong>/____</td>
</tr>
<tr>
<td>Illinois Rx</td>
<td>Pending / Applied / Active</td>
<td>Y / N</td>
<td>Y / N</td>
<td><strong>/</strong>/____</td>
<td><strong>/</strong>/____</td>
</tr>
<tr>
<td>CHIC</td>
<td>Pending / Applied / Active</td>
<td>Y / N</td>
<td>Y / N</td>
<td><strong>/</strong>/____</td>
<td><strong>/</strong>/____</td>
</tr>
<tr>
<td>GA (General Assistance)</td>
<td>Pending / Applied / Active</td>
<td>Y / N</td>
<td>Y / N</td>
<td><strong>/</strong>/____</td>
<td><strong>/</strong>/____</td>
</tr>
<tr>
<td>Other Public Insurance</td>
<td>Pending / Applied / Active</td>
<td>Y / N</td>
<td>Y / N</td>
<td><strong>/</strong>/____</td>
<td><strong>/</strong>/____</td>
</tr>
<tr>
<td>VA Benefits</td>
<td>Pending / Applied / Active</td>
<td>Y / N</td>
<td>Y / N</td>
<td><strong>/</strong>/____</td>
<td><strong>/</strong>/____</td>
</tr>
<tr>
<td>Other</td>
<td>Pending / Applied / Active</td>
<td>Y / N</td>
<td>Y / N</td>
<td><strong>/</strong>/____</td>
<td><strong>/</strong>/____</td>
</tr>
</tbody>
</table>

**HIV Medical Care Assessment:**

- HIV/AIDS STATUS: HIV+? [ ] Yes [ ] No [ ] Do not know
- DATE OF HIV DIAGNOSIS: __/__/____

**Transmission Category**
- MSM/Bisexual
- MSM/IDU
- IDU
- Heterosexual
- Transfusion
- Hemophilia
- Perinatal+
- Undetermined / Unknown / Other

**CDC Defined-AIDS Diagnosis?**
- Yes [ ] No [ ] Do not know
- DATE OF AIDS DIAGNOSIS: __/__/____

- Fearful of sharing status [ ] No fear of harm by sharing status [ ] Fear of sharing due to past history of violence

**How Would You Assess Your Knowledge of How HIV Impacts Your Body?**
- No understanding of HIV disease [ ] Basic understanding of HIV disease [ ] Comprehensive understanding of HIV disease

- Do you currently have a regular place to go for your HIV medical care? [ ] Yes [ ] No

**IF YES,**

- How long have you been in care?
  - Less than a year [ ] 1 - 2 years [ ] 2 - 3 years [ ] 3 Years or More

**HIV Care Provider Information**
- [ ] No Provider
- [ ] Don't know

| NAME: _________________________________ | PHONE: __________________ |
| TYPE OF PHYSICIAN (i.e., Infectious Disease, General Practitioner, Nurse Practitioner): __________________ |
| ADDRESS: ____________________________ | HOSPITAL/CLINIC AFFILIATION: __________________ |

**IF NO,**

- Why are you not seeing a medical care provider for your HIV?
DATE OF LAST HIV-RELATED MEDICAL APPOINTMENT? / / 

IN THE LAST 6 MONTHS, HAVE YOU HAD A ONE-ON-ONE CONVERSATION WITH A HEALTHCARE PROVIDER ABOUT WAYS TO PROTECT YOURSELF OR YOUR PARTNERS FROM GETTING HIV OR OTHER SEXUALLY TRANSMITTED DISEASES?  □ No  □ Yes  □ Don’t Know

DATE OF MOST RECENT CD4 COUNT:  / /  VALUE:  

DATE OF MOST RECENT VIRAL LOAD:  /  /  VALUE:  

### HIV Medication and Readiness Assessment

HAVE YOU RECEIVED COUNSELING ABOUT TAKING HIV MEDICATIONS OVER LAST YEAR: □ Yes  □ No

From whom: ________________________________

DO YOU HAVE ANY CONCERNS ABOUT BEING PRESCRIBED HIV MEDICATIONS: □ Yes  □ No

Notes: _______________________________________________ __________________________________________

HOW WOULD YOU ASSESS YOUR KNOWLEDGE OF HIV MEDICATIONS AND HOW THEY AFFECT HIV:

□ Little of no understanding of HIV medications or how they work
□ Some understanding of meds but not how they affect HIV
□ Understand all meds and how they affect HIV

DATE YOU LAST TOOK HIV MEDICATIONS: / / (please include date if you don’t currently take HIV meds, but did in past)

ARE YOU CURRENTLY PRESCRIBED MEDICATIONS FOR HIV: □ Yes  □ No

<table>
<thead>
<tr>
<th>IF YES, TYPE OF ANTIRETROVIRAL THERAPY:</th>
<th>□ Dual  □ HAART  □ None  □ Salvage  □ Single  □ Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you feel that you have difficulty taking your HIV medications on time? By “on time” we mean no more than two hours before or after the time your doctor told you to take it.</td>
<td></td>
</tr>
<tr>
<td>□ Never (4) □ Rarely (3) □ Most of the time (2) □ All of the time (1)</td>
<td></td>
</tr>
<tr>
<td>On average, how many days PER WEEK would you say that you missed at least one dose of your HIV medications?</td>
<td></td>
</tr>
<tr>
<td>□ Everyday (1) □ 4-6 days/week (2) □ 2-3 days/week (3) □ Less than once a week (5) □ Never (6)</td>
<td></td>
</tr>
<tr>
<td>When was the last time you missed at least one dose of your HIV medications?</td>
<td></td>
</tr>
<tr>
<td>□ Within the past week (1) □ 1-2 weeks ago (2) □ 3-4 weeks ago (3) □ Between 1 and 3 months ago (4) □ More than 3 months ago (5) □ Never (6)</td>
<td></td>
</tr>
<tr>
<td>INDEX SCORE: ________ ( &gt; 10 = good adherence / ≤ 10 = poor adherence)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IF NO, REASON NOT ON HAART:</th>
<th>□ Client Refused  □ HAART payment assistance unavailable</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Intolerance due to side effects  □ Not medically indicated</td>
<td></td>
</tr>
<tr>
<td>□ Not ready (as determined by clinician)  □ Other reason ____________</td>
<td></td>
</tr>
<tr>
<td>□ Unknown</td>
<td></td>
</tr>
</tbody>
</table>

### General Health Assessment

IN GENERAL, WOULD YOU SAY YOUR HEALTH IS: □ Excellent  □ Very good  □ Good  □ Fair  □ Poor

HAVE YOU HAD A DIAGNOSIS OF STD IN LAST YEAR: □ Yes  □ No

IF YES, DO YOU NEED PARTNER NOTIFICATION ASSISTANCE NEEDED: □ Yes  □ No

HAVE YOU HAD A DENTAL VISIT IN THE LAST YEAR: □ Yes  □ No

HAVE YOU HAD A NUTRITIONAL COUNSELING VISIT IN LAST YEAR: □ Yes  □ No

OVER THE LAST MONTH, HAVE YOU HAD PROBLEMS EATING OR PROBLEMS WITH WEIGHT LOSS?

□ Experiencing some problems eating, may have weight or abdominal problems
□ Many problems eating, may have advanced signs of wasting syndrome or other physical signs of eating problems
□ Not experiencing any weight problems or problems eating

PRIMARY CARE SOURCE: □ Private Practice  □ HMO  □ Comm. Health Ctr.  □ Hospital Clinic
□ Other Clinic  □ Emergency Room  □ Other  □ None

RW ASSESSMENT FORM FINAL 03.15.2010
IS YOUR HIV PROVIDER ALSO GENERAL PRIMARY CARE PROVIDER? □ Yes □ No (if no, complete provider info)

| PRIMARY CARE PROVIDER NAME: __________________________ | □ None □ Don’t know |
| PHONE: __________________________ |
| TYPE OF PHYSICIAN (i.e., Infectious Disease, General Practitioner, Nurse Practitioner): __________________________ |
| ADDRESS: __________________________ | HOSPITAL/CLINIC AFFILIATION: __________________________ |

DATE OF LAST MEDICAL APPOINTMENT: ___/___/____

MEDICAL CONDITIONS THAT A DOCTOR, NURSE, OR OTHER MEDICAL PROVIDER HAS TOLD YOU THAT YOU HAVE:

- □ No Health History
- □ Endocarditis/Infection of Heart Valve
- □ Hepatitis C
- □ Other permanent numbness
- □ Arthritis
- □ Epilepsy
- □ Hypertension
- □ Paralysis
- □ Asthma/Emphysema
- □ Glaucoma
- □ Liver Disease
- □ Tuberculosis
- □ Diabetes
- □ Heart Disease
- □ Obesity
- □ Stroke
- □ Cancer (Please specify type): __________________________
- □ Other __________________________

Pregnancy Assessment: complete if pregnant currently or in last 6 months

ARE YOU RECEIVING OR HAVE YOU RECEIVED PRENATAL CARE: □ Yes □ No □ Refused

IF YES, WEEK ENTERED PRENATAL CARE: __________________________

ESTIMATED CONCEPTION DATE: ___/___/_____ □ Don’t Know  EXPECTED DUE DATE: ___/___/_____ □ Don’t Know

PREGNANCY OUTCOME: □ Pregnant □ Miscarriage □ Still Birth □ Pregnancy Terminated □ Refused

DELIVERY TYPE: □ Planned Caesarian Section □ Emergency Caesarian Section □ Vaginal Delivery □ Not Applicable

ANTIRETROVIRALS PRESCRIBED? □ Yes □ No □ Don’t Know □ Refused

Legal History

- DEFAULT TO LAST ASSESSMENT (NO CHANGE)

CRIMINAL BACKGROUND: □ Yes □ No □ Unknown □ Refused

IF YES, CHECK ALL THAT APPLY:
- □ Felony conviction(s)
- □ Misdemeanor conviction(s)
- □ Been in jail  Date of most recent release ___/___/____
- □ Been in prison  Date of most recent release ___/___/____  IL Inmate Number: ____________ □ NON-IL Prison □ Refused

Currently under:
- □ Electronic Monitoring (house arrest)
- □ Work Release Programs
- □ Special Program Units
- □ Substance Abuse Centers
- □ Adult Correctional Centers (ATC)
- □ Mandatory Supervision
- □ Work Camps/Boot Camps
- □ Reentry Centers
- □ Life Skills Centers

Parole Officer (optional, if coordination desired): __________________________ Phone: __________________________

- □ Been Arrested  Court date(s) ___/___/____
- □ Required to register as sex offender: (circle one) adults  children
- □ Other __________________________
### Substance Use Assessment

<table>
<thead>
<tr>
<th>Type(s) of Drugs</th>
<th>Number of Days Used in Past 30 Days</th>
<th># Years Used</th>
<th>Route of Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Cigarettes</td>
<td></td>
<td>____________</td>
<td>_______</td>
</tr>
<tr>
<td>☐ Alcohol – any use at all</td>
<td></td>
<td>_______</td>
<td>___ ___ ___</td>
</tr>
<tr>
<td>☐ Alcohol to Intoxication</td>
<td></td>
<td>____________</td>
<td>_______</td>
</tr>
<tr>
<td>☐ Heroin</td>
<td></td>
<td>____________</td>
<td>_______</td>
</tr>
<tr>
<td>☐ Methadone</td>
<td></td>
<td>____________</td>
<td>_______</td>
</tr>
<tr>
<td>☐ Other Opiates/Analgesics</td>
<td></td>
<td>____________</td>
<td>_______</td>
</tr>
<tr>
<td>☐ Cocaine or Crack</td>
<td></td>
<td>____________</td>
<td>_______</td>
</tr>
<tr>
<td>☐ Amphetamines/Speed</td>
<td></td>
<td>____________</td>
<td>_______</td>
</tr>
<tr>
<td>☐ Marijuana/Hash</td>
<td></td>
<td>____________</td>
<td>_______</td>
</tr>
<tr>
<td>☐ Hallucinogens / LSD/Mushrooms</td>
<td></td>
<td>____________</td>
<td>_______</td>
</tr>
<tr>
<td>☐ Inhalants/Poppers</td>
<td></td>
<td>____________</td>
<td>_______</td>
</tr>
<tr>
<td>☐ More than 1 substance in 1 day (incl. alcohol)</td>
<td></td>
<td>____________</td>
<td>_______</td>
</tr>
<tr>
<td>☐ Refused</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**How many times in your life have you been treated for . . . ?** *(if none, code 0; if refused, code 77; if don’t know, code 88)*

Alcohol abuse ___ ___ ___ Drug abuse ___ ___ ___

**How much would you say you have spent during the past 30 days on:**

- Alcohol $__________
- Cigarettes $__________
- Drugs $__________
  - ☐ Refused
  - ☐ Don’t Know

**Do you take steps to reduce the risks of alcohol or substance use?**  ☐ Yes ☐ No

**Do your friends, family, or legal system believe you have a problem with drug or alcohol use?**  ☐ Yes ☐ No

**Do you believe you have problems with drug or alcohol use?**  ☐ Yes ☐ No

**If yes, how many days in the past 30 days have you experienced drug or alcohol problems?**  ___ ___ ___

**How troubled or bothered have you been in the past 30 days by these alcohol problems?** *(check one)*

- ☐ Not at all
- ☐ Slightly
- ☐ Moderately
- ☐ Considerably
- ☐ Extremely
- ☐ Refused
- ☐ Don’t Know

**How important to you now is treatment for these alcohol problems?**

- ☐ Not at all
- ☐ Slightly
- ☐ Moderately
- ☐ Considerably
- ☐ Extremely
- ☐ Refused
- ☐ Don’t Know

**How troubled or bothered have you been in the past 30 days by these drug problems?**

- ☐ Not at all
- ☐ Slightly
- ☐ Moderately
- ☐ Considerably
- ☐ Extremely
- ☐ Refused
- ☐ Don’t Know

**How important to you now is treatment for these drug problems?**

- ☐ Not at all
- ☐ Slightly
- ☐ Moderately
- ☐ Considerably
- ☐ Extremely
- ☐ Refused
- ☐ Don’t Know

### Mental Health Screener

**During the past 3 months, how much have you been bothered by emotional problems such as feeling anxious, depressed or irritable?**

- ☐ Not at all
- ☐ Slightly
- ☐ Moderately
- ☐ Quite a lot
- ☐ Extremely

**During the past 3 months, how much did personal or emotional problems keep you from doing your usual work, school or other daily activities?**

- ☐ Not at all
- ☐ Very little
- ☐ Somewhat
- ☐ Quite a lot
- ☐ Could not do daily activities

**In the past 3 months, have you considered harming yourself or others?**

- ☐ Yes
- ☐ No
- ☐ Refused

**During the past 3 months, were you ever on medication/antidepressants for depression or nerve problems?**

- ☐ Yes
- ☐ No
- ☐ Don’t Know
- ☐ Refused
During the past 3 months, was there ever a time when you felt sad, blue, or depressed for 2 weeks or more in a row?
☐ Yes  ☐ No  ☐ Don’t Know  ☐ Refused

During the past 3 months, was there ever a time lasting 2 weeks or more when you lost interest in most things like hobbies, work, or activities that usually give you pleasure?
☐ Yes  ☐ No  ☐ Don’t Know  ☐ Refused

During the past 3 months, did you ever have a period lasting 1 month or longer when most of the time you felt worried and anxious?
☐ Yes  ☐ No  ☐ Don’t Know  ☐ Refused

During the past 3 months, did you have a spell or an attack when all of a sudden you felt frightened, anxious, or very uneasy when most people would not be afraid or anxious?
☐ Yes  ☐ No  ☐ Don’t Know  ☐ Refused

Is there any history of mental illness in your family?
☐ Yes  ☐ No  ☐ Refused

Have you ever been hospitalized for a psychiatric condition? ☐ Yes  ☐ No  ☐ Refused
If yes, how many times? _____ Name of hospital (most recent) __________ Dates of hospitalization: ____/____/______

Have you ever taken medication for psychiatric or emotional problems on a daily basis? ☐ Yes  ☐ No  ☐ Unsure
Please explain: ________________________________

Current Mental Health Assessment
☐ DEFAULT TO LAST ASSESSMENT (NO CHANGE)

Are you currently seeing a mental health professional?
☐ Yes ☐ No (skip to domestic violence section) ☐ Refused (skip to domestic violence section)

Provider name_____________________________Provider phone________________________

Provider type (therapist, counselor, psychiatrist, social worker, psychologist, Other______________________)

How often do you meet with your mental health professional? ______________________________

Have you been able to follow through with doctors and counseling appointments?
☐ Yes ☐ No
If no, please explain: ________________________________

Are you currently on medications for mental health issues? ☐ Yes  ☐ No (skip to mental health history section)

Current Medications: ______________________________

Have you been able to follow through with taking the prescriptions?
☐ Yes  ☐ No

What is the treatment for:
☐ Schizophrenia  ☐ Depression  ☐ Bipolar Disorder  ☐ Personality Disorder  ☐ Anxiety Disorder
☐ Others: ___________________________
☐ Was treated, but does not know diagnosis, but their symptoms are: ______________________________

Domestic Violence Assessment

SPECIAL NOTE: Please remember to notify your client before you being this series of questions if you are a mandated reporter in the State of Illinois and the possible consequences of their sharing this information with you. If you are a mandated reporter, notify your client BEFORE YOU BEGIN THE ASSESSMENT, and ask them if they choose to decline this assessment. If they decline this assessment, please indicate so and skip to the next Intake section. Please remember also that this assessment is only for the purposes of service need planning and referral making. It is not intended for any legal or client tracking purposes.
CLIENT DECLINES THIS ASSESSMENT: □ YES □ NO

Have you experienced anger that has caused you to want to hurt someone?
- □ Yes and a state agency became involved due to signs of potential abuse
- □ Yes and need help finding an appropriate release
- □ Yes but was able to control anger and no harm was done
- □ No
- □ Refused

Have you experienced domestic violence or abuse in past or present relationships? □ Yes □ No □ Refused
If yes, when did the experience occur?
- □ Currently experiencing domestic violence or abuse
- □ A history of violence within last 3 months
- □ A history of violence more than 6-12 months ago
- □ A history of violence more than one year ago

Have you ever perpetuated violence toward a partner, child or others? □ Yes □ No □ Refused

**Additional Assessed Service Needs**

**TRANSPORTATION**
- □ Able to meet transportation needs at this time
- □ Able to use public transportation, but need occasional help paying for it
- □ Have car or access to car but need occasional help paying for gas
- □ Need referrals to clinic/hospital van services
- □ Need assistance applying for RTA reduced fare card
- □ No means of transportation via self, friends/family, public transportation, van services, etc

**FOOD**
- □ Able to meet food needs at this time
- □ Need referrals to food banks or for home delivered meals
- □ Need assistance applying for Public Aid (Link Card)
- □ Not able to access food pantries or Public Aid and need emergency food assistance (vouchers)

**NUTRITIONAL COUNSELING**
- □ No need for nutritional intervention
- □ Request assistance in improving nutrition, consider referral for nutrition education
- □ No understanding of good nutrition, referral for nutrition counseling is needed

**HOUSING**
- □ Stably housed with no additional needs at this time
- □ Currently receiving ongoing housing assistance or in a supportive housing program
- □ Need referral to lower-cost housing options
- □ Current housing in danger and need financial assistance for rent, mortgage, and/or utilities

**OTHER SERVICE NEEDS**
- □ Support Groups
- □ Rehabilitation/Job education
- □ Cultural or linguistic services
- □ Assistance managing monthly bills
- □ Dental Care □ YES- Minor □ YES – Major
- □ Legal Services (For HIV discrimination and entitlements)
- □ Eye Care
Program Eligibility

Emergency Food Assistance Eligibility:

- Client affirms that they do not receive assistance from Public Aid (Link Card)
- Client affirms that they are not receiving food from Vital Bridges
- Client affirms that they are not able to access local food pantries

Clients must meet \textbf{ALL} of the above eligibility criteria to receive emergency food voucher assistance.

Client is eligible for emergency food assistance: \( \square \) \textbf{YES} \( \square \) \textbf{NO}

Client requests food services \( \square \) \textbf{YES} \( \square \) \textbf{NO}

CTA/PACE/METRA Services:

- Client’s income is at or below 50\% of the area median income to be eligible.
- Client affirms that he/she has no family or friends that can transport him/her to appointments
- Client affirms that there are no clinic/hospital van services available
- Client affirms that he/she does not have an RTA reduced fare card and is not eligible
- Client affirms that he/she does not have an active medical card

Clients must meet \textbf{ALL} of the above eligibility criteria to receive CTA/Metra/PACE transportation assistance.

Client is eligible: \( \square \) \textbf{YES} \( \square \) \textbf{NO}

Client requests fare cards \( \square \) \textbf{YES} \( \square \) \textbf{NO}

Taxi Services:

- \*Client’s income is at or below 50\% of the area median income to be eligible.
- \*Client affirms that he/she has no other transportation resources available to them.
- \*Client affirms that he/she does not have an active medical card.
- \*Client affirms that he/she does not have an RTA reduced fare card and is not eligible.
- Client has demonstrated difficulty ambulating (i.e. cannot climb stairs, cannot walk more than 20 feet)
- Client has a documented physical disability that impedes safe access to public transportation.
- Client affirms that public transportation does not serve point of origin or destination.
- Client affirms that he/she is traveling with two or more infants or toddlers.

\*Client must meet \textbf{ALL} of the first four eligibility criteria and at least one of the remaining four eligibility criteria in order to be eligible to receive taxi transportation assistance.

Client is eligible: \( \square \) \textbf{YES} \( \square \) \textbf{NO}

Client requests taxi services \( \square \) \textbf{YES} \( \square \) \textbf{NO}

**PROGRAM ENROLLMENT CHANGE INFORMATION:** \( \square \) DEFAULT TO LAST ASSESSMENT (NO CHANGE)

**DISCHARGE INFORMATION:** EFFECTIVE DATE OF DISCHARGE: ____/____/____

REASON FOR DISCHARGE: \( \square \) Administrative discharge \( \square \) Assisted living/nursing home placement \( \square \) Death \( \square \) DCFS placement
\( \square \) Incarceration \( \square \) Ineligible \( \square \) Moved out of EMA \( \square \) No services needed \( \square \) Refused services \( \square \) Whereabouts unknown

**TRANSFER INFORMATION:** EFFECTIVE DATE ____/____/____ NEW PROGRAM: \( \square \) DRS \( \square \) CORRECTIONS \( \square \) CHHP \( \square \) SHP \( \square \) PACPI

NEW CASE MANAGER _____________________ AGENCY ________________________________

I have participated in the completion of this document for planning of my care. I certify that all information provided is accurate and truthful to the best of my knowledge. I understand that I may deemed ineligible for services based on some of the responses to these questions.

__________________________________   _____/____/____
Client or Legal Guardian signature   Date

__________________________________   _____/____/____
Case Manager   Date

\*At intake ONLY, acceptable documentation of serostatus, Photo ID, and proof of residency must be provided by the client and recorded in the client case management record.
Ryan White Initial Assessment Checklist
(To be completed at intake for all Ryan White clients)

<table>
<thead>
<tr>
<th>Forms/Documentation</th>
<th>Date Completed/Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Screening Form (received from AFC)</td>
<td>____________</td>
</tr>
<tr>
<td>Consent to Enroll in Central Database (AFC form)</td>
<td>____________</td>
</tr>
<tr>
<td>Consent to Participate in Case Management (AFC form)</td>
<td>____________</td>
</tr>
<tr>
<td>AFC Consent to Release Information (AFC form)</td>
<td>____________</td>
</tr>
<tr>
<td>Case Intake Form (pages 1-4) (AFC form)</td>
<td>____________</td>
</tr>
<tr>
<td>Medical Assessment to Physician (AFC form) Date Sent:</td>
<td>____________</td>
</tr>
<tr>
<td>Date Received:</td>
<td>____________</td>
</tr>
<tr>
<td>Client Photo ID (Drivers License/State ID)</td>
<td>____________</td>
</tr>
<tr>
<td>Client Rights and Responsibilities (Agency Form)</td>
<td>____________</td>
</tr>
<tr>
<td>Client Grievance Policy (Agency Form)</td>
<td>____________</td>
</tr>
<tr>
<td>HIPAA Policy (when applicable) (Agency Form)</td>
<td>____________</td>
</tr>
</tbody>
</table>

Client Proof of Residency
- Utility bill with client name and current address
- Driver’s license or state ID with current address
- Documents issued by the state or federal government (i.e. a motor vehicle registration form, a current Illinois voter registration card, or a current Medicaid card)
- Current rental or lease agreement with client name

Client Proof of Income
- Current pay stubs – 1 month’s worth
- Most recent W2 forms
- Unemployment Benefits Statements
- Most recent SSI benefits statement
- For clients with no income, a verification letter must be completed, signed and dated by client and cm

Client Proof of HIV Status
- Client’s name must be on any of the following:
  - Medical Assessment with diagnosis identified
  - Official lab result with any detectable viral load
  - Positive ELISA & Western Blot
  - Positive Serology assay
  - Positive DNA PCR assay

Client Rights and Responsibilities (Agency Form) ____________
Client Grievance Policy (Agency Form) ____________
HIPAA Policy (when applicable) (Agency Form) ____________
The CASE ASSESSMENT FORM is to be submitted via the AIDS Foundation of Chicago client database (CLIENTTRACK) when enrolling a new or reopened client receiving Ryan White Medical or Supportive/DRS/Corrections/PACPI-funded case management services (DO NOT COMPLETE THIS FORM FOR CHHP/SHP CASES). All information fields MUST be completed and accurate. Case managers are encouraged to contact AFC Program Staff prior to intake to verify that the client is not receiving services at another case management agency in the Northeastern Illinois HIV/AIDS Case Management Cooperative. Case intake forms cannot be entered into the client database if the client is currently enrolled at another Cooperative agency.

CASE INTAKE FORM MUST HAVE THE FOLLOWING INFORMATION. Although not all fields are required in the database, any field that is on the Intake Form in print should be entered into the database.

CASE REASSESSMENT FORMS MUST HAVE THE FOLLOWING INFORMATION. Although not all fields are required in the database, any field that is on the Reassessment Form in print should be entered into the database. When identified, you may select the option to Default to Last Assessment, this means there has been no change in this area for this client since last assessment and will populate the fields in that section with the information from your previous assessment (if, and only if, there is one in the database).

Referral Information:

INTAKE DATE - Date that case manager began providing case management services.

CLIENT ID # - This is an open field that allows providers to enter any client ID that is helpful for identifying the client. Preferred ID’s are: IDPH Patient Code Numbers, and DRS ID’s. Please refer to the Direct Entry Training Manual for the creation of these ID’s.

AGENCY - Name of case management agency that is completing the Case Intake Form.

CASE MANAGER - Name of assigned case manager who will be the Ryan White/DRS/Corrections/PACPI-funded case manager.

SOURCE OF REFERRAL - Indicate type of agency or source that referred the client to your agency (or to AFC) for case management services. This should NOT be AFC, but rather who first referred the client to the system.

REFERRAL DATE - The date this individual was referred for case management services.

REFERRAL SOURCE - Name of individual who referred this case to your program.

AFFILIATION - Name of agency that the REFERRAL SOURCE is employed/affiliated with.

PHONE NUMBER - Phone number of the REFERRAL SOURCE.

Client Profile:

CLIENT NAME - Name that will be enrolled in the central registry at AFC. Last Name, First Name, Middle Initial.
DATE OF BIRTH (DOB) - Enter numerical entries only in an eight digit format. (Month/Date/Year) Example - 07/29/1948.

CLIENT SS# - This information is vital to avoid duplication of services and assure that changes are being made later to the correct client. If a client has no social security number, please indicate that in the database.

CURRENT GENDER - Place a check mark in the area of Male (M), Female (F), Unknown is based on the client’s self report.

GENDER AT BIRTH - Place a check mark in the area of Male (M), Female (F), Unknown is based on the client’s self report.

RELATIONSHIP STATUS – Place a check mark on the line beside the most applicable status: divorced, married, separated, widowed, engaged, partnered, single, or unknown.

CONTACT INFORMATION:
STREET ADDRESS - House number and street where client lives. If client is homeless write “Homeless.” If additional information is known about client location it can be written after “Homeless” with a hyphen, for example “Homeless – North Side,” “Homeless – North and Damen.”

CITY - City or town that the house address is located in. If the client is homeless, write in the city where the client primarily resides.

COUNTY - MUST reside in the Part A EMA (Cook, DuPage, DeKalb, Grundy, Kane, Kendall, Lake, McHenry, or Will County). If the client is homeless, write in the county where the client primarily resides.

ZIP - Zip code of the house address. If the client is homeless and a zip code can be determined, include it.

MAILING ADDRESS: - Enter as above if information is different than STREET ADDRESS.

OKAY TO SEND MAIL? - Indicate if the client is willing to have mail sent to this address.

HOME PHONE/MOBILE PHONE/WORK PHONE/EMAIL ADDRESS – Enter the contact information the client provides for contacting them.

MESSAGE/EMAIL TYPE – Indicate if the client is comfortable with ANY messages being left, only DISCREET messages, or if the client prefers no messages (NONE)

ETHNICITY – Indicate whether the individual identifies as being of Hispanic or Latino origin or not.

RACE - Ask the individual which race(s) they identify with. An individual may be both Hispanic/Latino and another identified race. Clients may choose as many races as apply.

AMERICAN INDIAN/ALASKA NATIVE: American Indian or Alaskan is a person having origins in the original peoples of North and South America;

ASIAN: Asian is a person having origins in the peoples of the Far East, Southeast Asia, or the India subcontinent;

BLACK/AFRICAN AMERICAN: Black/African American is a person having origins in any of the black racial groups of Africa;

HAWAIIAN/PACIFIC ISLANDER: Hawaiian or other Pacific Islander is a person having origins in any of the original peoples of Hawaii, Guam or other Pacific Islands;
WHITE: White is a person having origins in any of the original peoples of Europe, the Middle East, or North Africa; OTHER: is an individual who does not identify with any of the above listed categories.

COUNTRY OF BIRTH (ORIGIN): Select the individuals’ country of birth.

PRIMARY LANGUAGE – Ask the client the languages they primarily use for communication.

LIMITED ENGLISH PROFICIENCY: Ask the client if they feel they have limited English proficiency. This is client self report.

Household Members
For each member of the household write the name of the member, the Date of Birth, the member’s gender, the member’s relation to the client, date of birth (or age if date of birth is unknown), race, and ethnicity. Use the categories from the client section for guidance. Example:

<table>
<thead>
<tr>
<th>NAME</th>
<th>DOB</th>
<th>GENDER</th>
<th>RELATIONSHIP</th>
<th>DEPENDANT</th>
<th>ETHNICITY</th>
<th>RACE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kid Client</td>
<td>1/25/2000</td>
<td>M</td>
<td>Son</td>
<td>Yes</td>
<td>Non-Hisp</td>
<td>Asian</td>
</tr>
<tr>
<td>Spouse Client</td>
<td>1/10/1970</td>
<td>F</td>
<td>Wife</td>
<td>No</td>
<td>Non-Hisp Hawaiian</td>
<td></td>
</tr>
</tbody>
</table>

Emergency Contacts
NAME: Name of the person(s) that the client would allow you to contact in case of an emergency.

RELATIONSHIP TO CLIENT: relationship to client. For example client’s mother would be “MOTHER”, client’s daughter “DAUGHTER”.

CONTACT AWARE CLIENT IS HIV+: Is the contact aware of clients HIV diagnosis?

PHONE: number for contact

LEAVE MSG?: Is the client comfortable with ANY message being left, DISCREET messages being left, or no message (NONE) being left with the contact.

Additional Demographics
HIGHEST EDUCATION LEVEL COMPLETED – Indicate highest level of education that the client successfully completed. Examples: if a client completed 10th grade, but did not graduate from high school, check “10th”. If a client completed some college, but did not get a degree, check “Post Secondary, No Degree”

VETERAN – Check if the client is a veteran. Indicate % disability status if known. If the client is a disabled veteran ask them “What is the percentage of disability they you have been assessed, if known?”

LIVING ARRANGEMENT CURRENT TYPE – Choose the housing situation that best describes the client’s current living situation. If none of the listed options apply, choose “other”. If the client’s living arrangement is not know, chose “unknown.” Also enter the date the client began living in the current situation.

Institutions
- Hospital (non-psychiatric facility)
- Institution
- Jail, correctional facility, prison or juvenile detention facility
- Psychiatric hospital or other psychiatric facility
- Substance abuse treatment facility or detox center
Transitional/Temporary
- Group or Foster Home
- Supportive Housing Unit
- Transitional Housing
- Hotel/Motel
- Temporarily with Friend
- Temporarily with Family

Homeless
- Shelter: Emergency shelter (including hotel, motel, or campground paid for with emergency shelter voucher)
- Street: Place not meant for human habitation (such as a vehicle, abandoned building, bus/train/subway station/airport, or outside)

Permanent housing
- Rental Unit
- SRO
- Homeownership
- Live with Friend
- Live with Family

Current Employment:
CURRENTLY EMPLOYED – indicated if the client is currently employed.
If employed, write the number of hours worked last week and check the appropriate employment tenure. Indicate if the client is looking for additional employment or increased hours.
If not employed, check the appropriate status and if the client is currently looking for work.

Income Sources:
INCOME STABILITY – Select the appropriate box to indicate the consistency of the client’s income

INCOME SOURCES and NON-CASH BENEFITS – For each income source or non-cash benefit the client has received in the last 30 days, record the amount received and any additional details about the income.

Insurance Sources:
INSURANCE SOURCES - For each source of third party liability for payment of primary medical costs indicate if medications are covered, the date coverage started, and if applicable the date coverage ended. If client does not have a source of payment, select ‘No Insurance’ as a Type of Insurance and enter the date the client from which the client has had no insurance and record how client receives medications if they are currently prescribed any medications.

HIV Medical Care Assessment:
HIV/AIDS STATUS - Indicate whether the client is HIV+. (Recall that any client who is not HIV+ is ineligible for Ryan White funded services). For HIV+ clients, please indicate the date of their HIV diagnosis.

TRANSMISSION CATEGORY: Indicate what the client identifies as the primary risk factor that exposed them to HIV infection.

AIDS DIAGNOSED? Indicate whether the client is AIDS diagnosed by a primary care provider at any time. For AIDS diagnosed clients, please indicate the date of their AIDS diagnosis.
HOW WOULD YOU ASSESS YOUR KNOWLEDGE OF HOW HIV IMPACTS YOUR BODY? Record client’s self-identified comprehension of HIV disease. You may also ask, “Would you say that you have no understanding of HIV disease, very little or a lot of understanding on HIV disease and its impact on your body?” Map their responses appropriately.
HIV MEDICAL CARE INFORMATION

- **Medical care information:** Complete information on whether the client is in primary care for their HIV infection. Also note whether or not client is currently receiving medical care for their HIV, how long, and the date of last visit.
- **If client is in care:** Complete information on length of time in care.
- **If client is not in care:** Probe as to why the client is not currently in care? And consider making a referral for an HIV primary care provider.
- **Provider Information** – Please list the name and contact information of client’s HIV Primary Care Provider and hospital/clinic affiliation.
- **Date of Last HIV-Related Medical Appointment**
- **HIV/STD Prevention:** Ask the client if they have had an HIV and/or Sexually Transmitted Diseases prevention conversation with their health care provider in the last six months (prior to this intake date).
- **CD4:** Record the date and value of their most recent CD4 count
- **Viral load:** Record the date and value of their most recent viral load

**HIV Medication and Readiness Assessment**

Ask the client medication questions to help assess their need for any additional HIV medication adherence support. Please make sure you ask all relevant questions whether the client is on HIV medications or not.

**General Health Assessment**

Ask the client general health assessment questions and health related needs assessment questions. If the client has been diagnosed with an STD (sexually transmitted disease) in the last year, consider including STD prevention counseling as part of your service plan. If the client reports not having had a dental visit in the last year, consider making an oral health referral for the client. If the client reports no nutritional counseling visits in the last year AND has experienced problems with weight loss or eating consider making a nutritional counseling referral for the client.

**Pregnancy Assessment: complete if pregnant currently or in last 6 months**

Ask the client pregnancy questions related to any current pregnancies or any pregnancies the client has had in the last six months. Please be aware of the sensitive nature of the following questions, and assure the client that you are asking the questions regarding their health status, and their potential baby’s health status. Pregnancy outcome is asked to determine ALL possible pregnancy outcomes, and includes all viable health-related outcomes for pregnant clients.

**Legal History**

Check the appropriate boxes based on the client’s self-report. When possible, obtain documentation for the client file. If the client has any pending legal issues, is on parole, probation, or has upcoming court dates, the case manager will need to get appropriate consents from the client. Reassure the client that providing this information will not disqualify them from services.

**Mental Health Screener/Current Mental Health Assessment/ Mental Health History**

Please complete the screening assessment to determine if the client has any metal health issues that may or may not need to be addressed. Assess the last three months of mental health symptoms the client may have experienced.
Complete the assessment to determine the history of treatments the client may have undergone for any mental health related issues. If the client has a treatment history, indicate what they have been treated for. Check the client’s ability to follow through with taking prescriptions, and attending doctors and counseling appointments. Check if the client has ever been hospitalized for a psychiatric condition or not, how many times, and details of the hospitalization. Check if the client has ever taken medication for psychiatric or emotion problems, and if yes, details of the course of treatment.

**Domestic Violence Assessment**

SPECIAL NOTE: Please remember to notify your client before you being this series of questions if you are a mandate reporter and the possible consequences of their sharing this information with you. If you are a mandated reporter, notify your client BEFORE YOU BEGIN THE ASSESSMENT, and ask them if they choose to decline this assessment. If they decline this assessment, please indicate so and skip to the next Intake section. Please remember also that this assessment is only for the purposes of service need planning and referral making. It is not intended for any legal or client tracking purposes.

**Substance Use Assessment**

If the client has been treated for alcohol or drug abuse, fill in the number of times. If none, use 0, refused 77, don’t know 88. Indicate what drugs the client is currently using and how many years the client has been using any of these drugs. If client has never used the drug, leave blank. If client no longer uses drug, record number of year used and leave number of days blank. Reassure the client that providing this information will not disqualify them from services. This checklist is not intended to be used as a substance abuse assessment. Reassure the client that providing this information will not disqualify them from services.

**Additional Assessed Service Needs**

Assess the client for additional service needs or potential referrals regarding transportation, food services, nutritional counseling, housing, and other needs. This list of service is meant to be helpful and not necessarily exhaustive of all possible referrals.

**Program Eligibility**

Complete the checklists for Food Assistance, CTA/Metra/PACE Transportation, and Taxi services to determine client eligibility for these programs.