# HIV Medical Case Management Standard Comprehensive Assessment
# (CAREWare Service # 1300)

**Client Name/ID:**________________________ **Case Manager:** ____________________________________

**Date of Assessment:** __/___/_____ **Person Completing Assessment:** _____________________

**Assessment type:**
☐ Annual assessment, ongoing client
☐ New client, never received services before (intake)
☐ Client returning after one year or more (reintake)

## Client Statement of Need

**Which problems would you most like help with right now?**

______________________________________________________________________

______________________________________________________________________

**How do you think these problems can be resolved?**

______________________________________________________________________

______________________________________________________________________

**What resources do you have for solving these problems?**

______________________________________________________________________

______________________________________________________________________

## 1. Access

**Do you need interpretation/translation?** ☐ Yes ☐ No

______________________________________________________________________

**Do you need help completing paperwork related to your HIV care (insurance forms, certifications, etc)?**
☐ Yes ☐ No

______________________________________________________________________

**Do you need help accessing services due to a disability?** ☐ Yes ☐ No

______________________________________________________________________

## 2. Housing

**What is your current living situation?**

| | | | |
|---|---|---|---|
| ☐ Rented room, apartment or house | ☐ Emergency shelter | ☐ Foster care | ☐ Substance abuse facility |
| ☐ Owned house or condo | ☐ Hotel/Motel | ☐ Transitional housing | ☐ Correctional facility |
| ☐ Staying with family or friends | ☐ Permanent housing for formerly homeless persons (Shelter+, SRO) | ☐ Hospital/medical facility | ☐ Psychiatric facility |
| ☐ Place not meant for human habitation (eg: vehicle, abandoned building, bus/train station, outside) | | ☐ Other | |

**Do you have any housing concerns?**

______________________________________________

______________________________________________

**Are you living in a safe environment?** ☐ Yes ☐ No

______________________________________________

## 3. Food/Nutrition

**How is your appetite?** ______________________________

**Have you had any significant weight loss or gain?** ☐ Yes ☐ No

______________________________________________

**Do you have any problems that make it difficult to eat?**

______________________________________________

**Do you have enough money for food?** ☐ Yes ☐ No

**Are there any places you go to get food assistance?** ☐ Yes ☐ No

______________________________________________

## 4. Transportation/Home Care

**Do you have any concerns about transportation?** ☐ Yes ☐ No

______________________________________________

**How do you get to your medical appointments?**

______________________________________________

**How reliable is your transportation?**

______________________________________________________________________

**How do you manage your daily activities? Any difficulties? (dressing, bathing, toileting, walking, feeding, cooking, cleaning, shopping)**

______________________________________________________________________

______________________________________________________________________

**Do you need assistance with any of these tasks?** ☐ Yes ☐ No

______________________________________________________________________

## 5. Education/Employment/Financial Support

**New clients only (draw line through this box for existing clients)**

**Education history:** ____________________________________________

**Current Employment Status:**

☐ Full-Time Employment ☐ Part-Time Employment ☐ Unemployed ☐ Disabled
☐ Full-Time Student ☐ Part-Time Student ☐ Volunteer/Cmmty work ☐ Other

**Do you want to make any changes in your work or school situation? If unemployed: Do you want to return to school or work?** ☐ Yes ☐ No

______________________________________________________________________

______________________________________________________________________

**How would you describe your financial situation?**

______________________________________________________________________

______________________________________________________________________

**Does anyone assist you with managing your money?** ☐ Yes ☐ No

______________________________________________________________________

**Where do you go for help?**

______________________________________________________________________

______________________________________________________________________

**Have you had trouble accessing benefits?**

______________________________________________________________________

______________________________________________________________________

## 6. Treatment Adherence

**New clients only (draw line through this box for existing clients)**

**Medical History:** ______________________________

______________________________

______________________________

**Are there any barriers to seeing your PCP?**

______________________________

______________________________

**Are there any barriers to seeing your HIV specialist?**

______________________________

______________________________

**Are you having your labs drawn at least every six months?**

______________________________

______________________________

**Are you having any problems with your health insurance?**

______________________________

______________________________

**How would you describe your health?** ______________________________

______________________________

**What are your current health concerns?** ______________________________

______________________________

______________________________

______________________________

**Have you spoken to a medical provider about these concerns?** ☐ Yes ☐ No ☐ NA

______________________________

**Would you like help speaking with your medical provider or a referral?** ☐ Yes ☐ No

______________________________

**Do you have any problems keeping up with any of your medications, like what to take and when?**

______________________________

______________________________

______________________________

*If considering starting/re-starting HIV medications:*
**What strategies might help you with your medication routine?**

*If taking HIV medications:*
**Have you had any concerns about your HIV medications?** ☐ Yes ☐ No

**Do you speak with your medical provider when you have medication concerns?** ☐ Yes ☐ No

**Have you had any concerns about missed doses?** ☐ Yes ☐ No

**What tools are you using to keep on track with your meds?**

**Do you use any complimentary therapies or nutritional supplements?** ☐ Yes ☐ No

**If yes: Have you talked to your doctor about these therapies/supplements?** ☐ Yes ☐ No

## 7. Dental Care

**When was the last time you saw a dentist?**

**Do you have any dental concerns?** ☐ Yes ☐ No

**Are you aware of dental assistance that may be available?** ☐ Yes ☐ No

**Do you need help connecting with a dentist or a referral?** ☐ Yes ☐ No

## 8. Mental Health/Social Support

**New clients only (draw line through this box for existing clients)**

**Tell me about your social supports.** (family, friends, spiritual network, pets*, support groups)

___

*If pets, discuss health risks

**How are your relationships with your family, children, partner(s)?**

___

**What things do you do to "take care of yourself"?** (stress relief, hobbies, exercise, religious beliefs/traditions)

___

**Do you feel like you have a good support system?** (stress relief, hobbies, exercise, religious beliefs/traditions)
☐ Yes ☐ No

___

**Do you have enough support around HIV issues?**

___

___

**Have you received mental health services in the past? If so, why?**

___

___

___

**Have you/are you taking medications for your mood, emotions, or nerves?**
(anti-depressants, tranquilizers, etc) ☐ Yes ☐ No

___

**Are you currently getting counseling?** ☐ Yes ☐ No

___

___

**Have you had any thoughts of wanting to harm yourself or anyone else?** ☐ Yes ☐ No

___

___

**Have you ever been in a violent or abusive situation? (domestic violence, sexual abuse, rape)**
☐ Yes ☐ No

___

___

**Do you currently feel safe?** ☐ Yes ☐ No ___

**Are there things you are doing that may put you or others at risk for HIV/STDs?**

**Do you know some ways to reduce your risk?**

## 9. Substance Use

**Are you interested in help with quitting smoking?** ☐ Yes ☐ No ☐ NA

**How have alcohol and/or drugs affected your life?**

**What is your history of alcohol and drug use in the past 12 months?***

**If none, skip to Section 11 and draw a line through the remainder of this section*

**Have you shared needles, syringes, or works, or back-loaded or front-loaded a syringe in the last 12 months?** ☐ Yes* ☐ No

**If yes, consider for Partner Services*

**If yes: Do you share with the same people regularly?** ☐ Yes ☐ No

**Have your injecting partner(s) been aware of your HIV status?** ☐ Yes ☐ No*

**If no, consider for Partner Services*

**Have you been aware of your injecting partner(s)'s HIV and/or Hep C status?**
☐ Yes ☐ No*

**If no, consider referral for Hepatitis C testing*

**Have you been in treatment for substance use?** (treatment programs: in-pt, out-pt, support groups; relapses, challenges) ☐ Yes ☐ No

______________________________________________________________________

______________________________________________________________________

**Are you interested in a referral for treatment?** ☐ Yes ☐ No

______________________________________________________________________

## 10. Relationships

**(Partner(s)'s names should not be recorded)**

**Would you like to talk about sharing your status?**

______________________________________________________________________

______________________________________________________________________

**Are you currently in a relationship?** ☐ Yes ☐ No

______________________________________________________________________

**If yes: How long?** ____________________________________

**How do you define your relationship?**

______________________________________________________________________

**Have you been sexually active in the past 12 months?** ☐ Yes ☐ No

**If yes: How many sexual partners have you had in the past 12 months?** ____________________

**Have your partner(s) been aware of your HIV status?** ☐ All ☐ Some* ☐ None*

**Consider for Partner Services*

**Have you been aware of your partner(s)'s HIV status?** ☐ Yes ☐ No

______________________________________________________________________

**How are you protecting yourself and your partner(s) against the spread of HIV and STDs?**

______________________________________________________________________

______________________________________________________________________

**How often do you and/or your partner(s) use condoms?** ☐ Always ☐ Sometimes* ☐ Never*

______________________________________________________________________

**Consider referral to Partner Services*

**Have you been diagnosed with a sexually transmitted disease in the past 12 months?**
☐ Yes* ☐ No

______________________________________________________________________

**Consider referral Partner Services*

**Have you been vaccinated against Hepatitis A and B?** ☐ Yes ☐ No*
**Consider referring to free HAV/HBV vaccination sites*

**Are there things about reducing your/others' HIV and STD risk that you'd like to know more about?**
☐ Yes ☐ No

______________________________________________________________________

**Have you had sex while under the influence of alcohol and drugs in the past 12 months?**
☐ Yes ☐ No

______________________________________________________________________

## 11. Legal

**Do you need assistance with any of the following legal issues?**

Immigration ☐ Yes ☐ No
Guardianship ☐ Yes ☐ No
Last Will and Testament ☐ Yes ☐ No
Living Will ☐ Yes ☐ No
HealthCare Proxy ☐ Yes ☐ No
Power of Attorney ☐ Yes ☐ No

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

**Have you had any legal problems?** (civil charges, criminal convictions, pending court cases, probation or parole) ☐ Yes ☐ No

**If yes: Please describe:** ______________________________________________

______________________________________________________________________

**Prompt: Have you had any legal issues/concerns that might affect your housing?**

## 12 . Other

| Emergency Contacts | | | | |
|---|---|---|---|---|
| **Name** | **Relationship** | **Phone #** | **Aware of HIV Status?** | **Release on File?** |
| | | | Yes No | Yes No |
| | | | Yes No | Yes No |
| | | | Yes No | Yes No |
| | | | Yes No | Yes No |

**Is there anything you'd like to share that we haven't covered? (draw line through this box if not)**

_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

| Acuity Assessment | | | | | |
|---|---|---|---|---|---|
| Area | 0 pts | 1 pt | 2 pts | 3 pts | 4 pts |
| | Client identifies no needs in this area | Client identifies low needs in this area | Client identifies moderate needs in this area | Client identifies high needs in this area | Client is in crisis in this area |
| 1. Access | | | | | |
| 2. Housing | | | | | |
| 3. Food/Nutrition | | | | | |
| 4. Transportation/Home Care | | | | | |
| 5. Education/Employment/Financial Support | | | | | |
| 6. Treatment Adherence | | | | | |
| 7. Dental Care | | | | | |
| 8. Mental Health/Social Support | | | | | |
| 9. Substance Use | | | | | |
| 10. Relationships | | | | | |
| 11. Legal | | | | | |
| 12. Other | | | | | |

**Total Acuity Score: _____**

**Agreed frequency of contact: ___________________________________________**

**Guide to Scoring:**

**0 = Discharge**
**1-12 = Minimal assistance needed, assess for discharge as appropriate**
**13-24 = Moderate assistance needed**
**25-36 = Significant assistance needed**
**37-48 = Extensive assistance needed**