HIV Medical Case Management Standard Semi-Annual Certification
(CAREWare Service # 1100)

Client ID: _____ **Case Manager:** _____

Date: __/___/_____ Person Completing Form: _____

Demographics – Demographics screen in CAREWare

Legal first name: _____

Legal last name: _____ **Preferred name:** _____

Has client received a new AIDS diagnosis in the last six months?
☐ No
☐ Yes*, Date of AIDS diagnosis __/__/____
*Change HIV status on Demographics screen in CAREWare and get documentation from medical provider

Care Status Tracking

Date of last visit with HIV medical care provider: ___/___/_____

Date of last Viral Load test: ___/___/_____ **Result:** _____
Enter labs in CAREWare on Encounters/Labs screen

Date of last CD4 test: ___/___/_____ **Result:** _____
Enter labs in CAREWare on Encounters/Labs screen

Has client been taking meds?
☐ Taking meds
☐ Refused/not taking prescribed meds
☐ Not recommended at this time

Client meets the HRSA definition for "in care"? ☐ yes ☐ no
Indicate care status on CAREWare service entry

Client is considered in care if

- *Client has seen his or her HIV medical provider in the last six months, OR*
- *Client has had labs drawn in the last six months, OR*
- *Client is taking HIV meds*

HIV Primary Care – Annual Review/Annual screen in CAREWare

☐ Publicly-funded clinic or health department (this includes **Positive Health Care**)
☐ Private practice
☐ No primary source of care
☐ Emergency room
☐ Hospital outpatient center (this includes **The Horizon Program** and **Virology Treatment Center**)
☐ Other: _____

Provider Information

Provider Type	Provider Name	Phone	Wants Referral?	Release?
Primary Care Physician			Yes No	Yes No
HIV Specialist*			Yes No	Yes No
Other Specialist			Yes No	Yes No
Dentist			Yes No	Yes No
Nutritionist/Dietitian			Yes No	Yes No
Mental Health Counselor			Yes No	Yes No
Substance Counselor			Yes No	Yes No
Pharmacy			Yes No	Yes No
Optometrist			Yes No	Yes No

*** recorded on Medical and Insurance screen in CAREWare**

Insurance Screening

Insurance Type - Annual Review/Annual screen in CAREWare
(indicate one primary and check all that apply)

☐ Primary	☐ Private Insurance
☐ Primary	☐ Medicare Part A/B (Hospital/Outpatient coverage)
	☐ Medicare Part D (Prescription coverage)
	☐ Full Low-Income Subsidy
☐ Primary	☐ Medicaid (MaineCare)
☐ Primary	☐ Other Public - Veterans Benefits, etc.
☐ Primary	☐ High Risk Insurance Pool
☐ Primary	☐ Other: _____
☐ Primary	☐ No insurance/ADAP only

Additional Information – Medical and Insurance screen in CAREWare

Private Insurance/COBRA/High Risk Insurance Pool

Plan Name:		Plan #:	

Medicare

Medicare #:			
Part D Plan Name:		Part D Plan #:	

MaineCare

MaineCare Type:	☐ Full benefit ☐ Limited benefit HIV waiver ☐ Emergency only ☐ Other: _____	MaineCare #:	
Review Date:			
If coverage pending, date of application:			

ADAP – Do NOT change ADAP info in CAREWare. Contact ADAP to make changes.

ADAP ID:	

Household Information – Annual Review/Annual screen in CAREWare

Housing/Living Arrangement:

☐ Stable/permanent
☐ Non-permanent/temporary housing
☐ Unstable housing
☐ Other: _____

Additional Household/Housing Information

Marital Status: ☐ Single ☐ Married ☐ Other: _____
(widowed, divorced, separated, partnered, other)

Legal household members (i.e. dependent spouse, child):

Name	Relationship	Age	Dependent?	Aware of HIV Status?	Release on File?
			Yes No	Yes No	Yes No
			Yes No	Yes No	Yes No
			Yes No	Yes No	Yes No
			Yes No	Yes No	Yes No

If client reports no income for household, CM must complete box below:

Client has not received income since _____

Client does not expect to receive any income until _____

Client has applied for:
☐ SSD/SSI
☐ Other assistance: _____

Client currently pays rent and/or utilities by: _____

Client gets food, hygiene items, and household supplies by: _____

Household Size and Income – Annual Review/Annual screen in CAREWare

Legal household size: _____

Income must be verified for all members of the legal household.

Income Source	Annual Amount	Date of Verifying Document*
Earned Income (wages, salaries, overtime, commissions, fees, tips, severance and bonuses, before any payroll deductions; net income from self-employment; all regular pay, special pay and allowances for members of the Armed Forces.)		
Unemployment		
Supplemental Security Income (SSI)		
Social Security Disability Income (SSDI)		
Veteran's disability pay		
Private disability insurance		
Worker's compensation		
Temporary Assistance for Needy Families (TANF)		
General assistance		
Social Security Retirement before deductions		
Veteran's pension before deductions		
Pension from a former job before deductions		
Child support		
Alimony or other spousal support		
Trust/endowment/investments		
Rental property		
Other:		
Total Annual Household Income:	**$**	

* **Verifying documents must be attached for all members of legal household.**

Acceptable forms of verification include:

- Social Security award letter
- Copy of Social Security check
- W2 tax forms
- Year-end 1099 forms
- Federal income tax return
- Pay stubs (must be 4 consecutive weeks)
- Bank statement
- DHHS statement

Client agreement (initial each area and sign below)

_____ I understand that my case manager has to complete this form with me every six months for me to receive HIV medical case management services.

_____ I understand that some of this information is entered into a computer database. Information about me and the services I receive are entered into this secured database and reported to the federal government. I understand that my information has to be reported for me to receive HIV medical case management services funded by Ryan White.

_____ I understand the Client Rights and Responsibilities. I know my rights and responsibilities. I have a copy to take home.

_____ I understand the Notice of Privacy Practices. I know my privacy rights. I know when my information can be given to others. I have a copy to take home.

_____ I understand the Grievance Policy. I know how to file a complaint and what to expect. I have a copy to take home.

_____ I understand that my household income has to be less than 500% of the Federal Poverty Level for me to receive HIV medical case management services in Maine.

_____ I understand that the federal government requires proof of all income. I understand that I have to report any change in income, from any source, within 10 business days of the change.

_____ All information I shared with my case manager for this form is true.

I want to receive HIV medical case management services for the next six months.

Client Signature: _____ Date: _____

Case Manager Signature: _____ Date: _____