Case Number _____

# RYAN WHITE PART B

## Medical Case Management Assessment

Date of Assessment: _____ ☐ Initial Assessment ☐ Annual Assessment
Case Manager: _____ Contact Phone: _____Agency:_____

## I: Personal Information

Last Name: _____ First: _____ Middle: _____

Preferred Name: _____ Preferred Pronouns: _____

Date of Birth (MM/DD/YYYY): _____

Current Gender: ☐ Male ☐ Female ☐ Non-Binary
☐ Transgender (Male to Female) ☐ Transgender (Female to Male) ☐ Transgender (Unknown)

Race:
☐ White ☐ Black/African American ☐ American Indian or Alaskan Native ☐ Asian_____
☐ Native Hawaiian/Pacific Islander_____ ☐ Unknown ☐ More Than One Race

Ethnicity:
☐ Hispanic/Latino(a) _____ ☐ Non-Hispanic

Address: _____

City: _____ Zip Code: _____ County: _____

Best way to be contacted (check all that apply):
☐ By Mail ☐ Labeled ☐ Not Labeled
☐ Home Visit
☐ By Phone ☐ Text ☐ Voicemail Primary #: Secondary #:
☐ By E-mail:_____
☐ By Patient Portal

Emergency Contact Name:_____ Phone: _____
Relationship: _____ Aware of Status: ☐ Yes ☐ No

## II: HIV Care

### Viral Suppression

What was your last viral load? ☐ Client not able to answer; ☐ Able to answer 2000 (load)
What was your last CD4 count? ☐ Client not able to answer; ☐ Able to answer _____ (count)
Does client understand the meaning of viral load and CD4 count? ☐ Yes ☐ No

_____

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## Adherence

Is client currently taking antiretroviral medications? ☐ Yes ☐ No
If yes, list medications or ☐ print list from EMR. If applicable, answer questions below:

| Medication Name | Route of Administration |
|---|---|
| | |
| | |
| | |
| | |
| | |

Have you missed recent doses of antiretroviral medications? ☐ Yes ☐ No
If yes, how many? _____
What is usually the reason for missing doses? _____
Are there any barriers preventing you from taking your medication? ☐ Yes ☐ No
If yes, what are the barriers? _____
Does anybody help you or remind you to take your medications? ☐ Yes ☐ No
Do you ever have problems affording your medication? ☐ Yes ☐ No
Do you ever have any problems picking up your medications from the pharmacy or getting them delivered to your home? ☐ Yes ☐ No
Do you understand how to take your medication as prescribed? ☐ Yes ☐ No
Do you have difficulty reading the label on your medication bottle? ☐ Yes ☐ No
Do you have trouble swallowing pills? ☐ Yes ☐ No
Do you ever have side effects or other problems when you take your medication? ☐ Yes ☐ No
If so, what side effects? _____
Do you have any other concerns about your health that we have not discussed yet? ☐ Yes ☐ No
_____

*Healthcare Fatigue*

Do you get exhausted mentally or physically from going to the doctor? ☐ Yes ☐ No
If yes, which of the following apply:

- ☐ experience lack of sleep before your appointment
- ☐ stress or worry about appointment (outcome, frequency, cost, transportation)
- ☐ experience a rise in blood pressure prior to appointment
- ☐ other: _____

## Acuity

| **Area of functioning: Knowledge of Medication** | | | **Acuity Score:** 0 |
|---|---|---|---|
| Intensive Need (3) | Moderate Need (2) | Basic Need (1) | Self-Management (0) |
| ☐ Client has no knowledge of what medication they are taking, how to take them or their purpose. | ☐ Client knows they are taking medications but is unable to elaborate. Needs assistance with refills. | ☐ Client knows what medication they are taking, how to take them and purpose. Needs assistance with refills. | ☐ Client knows what medication they are taking, how to take them, their purpose and can refill them without assistance. |

| **Area of functioning: Medication Adherence** | | | | **Acuity Score**: 0 | | | |
|---|---|---|---|---|---|---|---|
| Intensive Need (3) | | Moderate Need (2) | | Basic Need (1) | | Self-Management (0) | |
| ☐ | Client reports missing doses of scheduled medication daily and is experiencing on-going barriers to adherence and has a viral load of more than 200; | ☐ | Client reports missing doses of scheduled medication weekly and is experiencing on-going barriers to adherence and has a viral load of more than 200; | ☐ | Client is adherent to ARV medication regimen but may need assistance from MCM to maintain optimum adherence. | ☐ | Client is adherent to ARV medication regimen and has a viral load of less than 200; |
| ☐ | Client refuses to follow prescribed ARV medication regiment and has a viral load of more than 200; | ☐ | Client reports choosing to engage in alternative/herbal drug and is medically stable; | | | ☐ | Reports missing no more than one (1) dose in a 30 day period. |
| ☐ | Client chooses herbal/alternative drug therapies despite negative health outcomes; | ☐ | Client is just starting ARV medication regimen; | | | | |
| ☐ | Not on ARV | ☐ | Client's long-term ARV medication regimen does not appear to be effective. | | | | |
| **Area of functioning: HIV Care Adherence** | | | | **Acuity Score**: 0 | | | |
| Intensive Need (3) | | Moderate Need (2) | | Basic Need (1) | | Self-Management (0) | |
| ☐ | Client has missed 2 or more consecutive HIV medical appointments in the last 6 months; | ☐ | Client has missed 1 or 2 (non-consecutive) HIV medical appointments in the last 6 months but has been seen by member of HIV medical team. | ☐ | Client needs assistance or reminders with scheduling or keeping medical appointments. | ☐ | Client does not require any assistance or reminders to schedule or keep medical appointments. |
| ☐ | Client has not been seen by HIV medical team in the last 6 months; | ☐ | Client requests accompaniment to medical appointments from MCM or other member of the care team. | | | ☐ | Client has attended all scheduled HIV medical appointments in the last 12 months as indicated by HIV medical provider. |
| ☐ | Client has significant challenges (limited language, cognitive ability, mental health, etc.) and requires ongoing accompaniment or assistance with medical appointments. | ☐ | Client needs a referral to access a culturally competent service provider (e.g. LBGTQ, linguistically appropriate, etc.) | | | | |

### HIV Knowledge, Education and Health Literacy

Highest grade/degree of education completed: _____
Language(s) spoken fluently: _____ Preferred Language: _____
Read English? ☐ Yes ☐ No Read (other)? ☐ Yes (specify) _____ ☐ No
Write in English? ☐ Yes ☐ No Write (other)? ☐ Yes (specify) _____ ☐ No
Describe any health literacy needs:

## Acuity

| **Area of functioning: Health Literacy** | | | **Acuity Score**: 0 |
|---|---|---|---|
| Intensive Need (3) | Moderate Need (2) | Basic Need (1) | Self-Management (0) |
| ☐ Case Manager observes that the client is cognitively impaired and needs assistance to understand all health and/or prescription information. | ☐ Case Manager observes that the client cannot translate basic written health and/or prescription information, needs assistance. | ☐ Case Manager observes that the client can read and comprehend very basic health and/or prescription information with assistance occasionally. | ☐ Case Manager observes that the client understands health and/or prescription information with no assistance. |

# III: Social/ Economic Barriers

### Support/Activities of Daily Living

Who is Client's primary source of social/emotional support? _____

If you become unable to care for yourself, is there someone to help you? ☐ Yes ☐ No
If yes, Name: _____ Phone: _____
If no, who could you ask to help? _____

Does client have any ambulatory restrictions? ☐ Yes ☐ No
If yes, please check and explain as needed:

☐ Toilet _____ ☐ Eating _____ ☐ Using Telephone _____
☐ Bathing _____ ☐ Meal Preparation _____ ☐ Ambulation _____
☐ Dressing _____ ☐ Driving _____ ☐ Shopping

Is client aware of community resources in the area? ☐ Yes ☐ No

Does client have any sensory impairment? ☐ None ☐ Sight ☐ Hearing ☐ Speech

### Financial Stability

Does the client have any outstanding debts that could affect rent or utilities? ☐ Yes ☐ No
Is the client/household income sufficient to meet the basic needs? ☐ Yes ☐ No
Is the client in need of assistance with a benefits appeal? ☐ Yes ☐ No

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If additional assistance is needed, please complete the information below:

| Monthly Income | | Monthly Expenses | |
|---|---|---|---|
| _____ | Job | _____ | Rent/Mortgage |
| _____ | Social Security Disability (SSDI) | _____ | Car Payment |
| _____ | Supplemental Security Income (SSI) | _____ | Insurance |
| _____ | Food Stamps | _____ | Transportation |
| _____ | Unemployment Compensation | _____ | Healthcare/Medications |
| _____ | Veterans Admin. Benefits | _____ | Utilities (Gas, Water, Energy) |
| _____ | Private Disability Benefits | _____ | Phone |
| _____ | SSI/SSD for Child | _____ | TV/Cable/Dish/Internet |
| _____ | Family/Friend | _____ | Food |
| _____ | Other Assets _____ | _____ | Other _____ |

Total Income: $ 0.00 _____ Total Expenses: $ 0.00 _____

## Acuity

| **Area of functioning: Financial Stability** | | | | | | | **Acuity Score**: 0 |
|---|---|---|---|---|---|---|---|
| Intensive Need (3) | | Moderate Need (2) | | Basic Need (1) | | Self-Management (0) | |
| ☐ | Client requires but does not receive public benefits and/or has pending applications for benefits; | ☐ | Client's income is inadequate to meet basic needs at the end of every month for 3 or more months in a 6 month period; | ☐ | Client's income occasionally (no more than 2 times in a 6 month period) inadequate to meet basic needs; | ☐ | Client has steady income and manages all financial obligations; |
| ☐ | Client has immediate need for financial assistance, no income or benefits established and no identified source of financial support; | ☐ | Client's expenses exceed income; | ☐ | Client requests support with benefits applications or other means to increase and manage income; | ☐ | Client receives benefits and requires no assistance with maintaining benefits. |
| ☐ | Client's application for benefits has been denied or is under appeal; | ☐ | Client is in stable housing but may need occasional financial assistance with housing and/or utilities; | ☐ | Client requests assistance with budgeting. | | |
| ☐ | Client needs referral to a representative payee. | ☐ | Client currently uses a representative payee. | | | | |

## Housing

☐ Lives with family/friends ☐ Homeless ☐ Homeless Shelter ☐ Rent ☐ Own
☐ Transitional ☐ Other: _____

Is housing stable? ☐ Yes ☐ No Is client satisfied with living conditions? ☐ Yes ☐ No

Are there any barriers to housing? _____

Are there any safety concerns or needed repairs? ☐ Yes ☐ No
If yes, has client taken action? What was the outcome? _____

Is client at risk of losing housing? ☐ Yes ☐ No
How long has client been at current address? _____

Is client receiving a housing subsidy? ☐ Yes ☐ No
If yes, list subsidy source: _____

If client is homeless, are there any waiting lists for housing programs? ☐ Yes ☐ No ☐ N/A
If so, specify which programs: _____

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## Acuity

| **Area of functioning: Housing** | | | | **Acuity Score**: 0 | | | |
|---|---|---|---|---|---|---|---|
| Intensive Need (3) | | Moderate Need (2) | | Basic Need (1) | | Self-Management (0) | |
| ☐ | Current living situation has major health or safety hazards or limits the client's ability to care for themselves; | ☐ | Client has difficulties managing ADLs (e.g., navigating stairs, showering) in current living situation; | ☐ | Client lives in permanent or stable safe housing but needs short-term rent or utility assistance to remain housed; | ☐ | Client has stable and affordable housing that meets client's needs. |
| ☐ | Client is expected to be released from incarceration in the next 3 months or was released from incarceration within the last 6 months; | ☐ | Client has chronic challenges maintaining housing; | ☐ | Client is currently working with MCM to maintain housing subsidy. | | |
| ☐ | Client has no working utilities or running water; | ☐ | Client is in stable housing but may need occasional financial assistance with housing and/or utilities. | | | | |
| ☐ | Client is not in stable housing, is homeless or is living in temporary housing/shelter. | | | | | | |

## Food Security

Are you able to buy food for the month? ☐ Yes ☐ No

How are food needs met? ☐ Provides for self ☐ Food Stamps ☐ Family/Friends assist

☐ Utilizes food bank(s)/pantry community ☐ Other: _____

Does client have any dietary restrictions? ☐ Yes ☐ No If yes, describe: _____

Does client need any additional education? ☐ Yes ☐ No If yes, explain: _____

## Acuity

| **Area of functioning: Food Security** | | | | **Acuity Score**: 0 | | | |
|---|---|---|---|---|---|---|---|
| Intensive Need (3) | | Moderate Need (2) | | Basic Need (1) | | Self-Management (0) | |
| ☐ | Relies on food pantries, soup kitchens or other community food resources on a weekly basis; | ☐ | Relies on food pantries, soup kitchens or other community food resources 1x per month or more; | ☐ | Relies on food pantries, soup kitchens or other community food resources at less than 1x per month; | ☐ | All food needs are met and/or MCM assistance is not needed to access food. |
| ☐ | Needs a referral to and/or an application to obtain access to community food resources (e.g., food pantries, soup kitchens, etc.); | ☐ | Needs assistance to access community food resources (e.g., translation services, coordinating transportation, transporting food packages, etc.); | ☐ | Receives food related benefits to meet nutritional needs for self or household. | | |
| ☐ | Needs referral to obtain food related benefits (e.g., SNAP, WIC, etc.); | ☐ | Needs assistance completing applications to maintain current food related benefits; | | | | |
| ☐ | Is ineligible to obtain food related benefits (e.g., SNAP, WIC, etc.). | ☐ | Relies on access to an agency food program and/or assistance from MCM to obtain adequate food. | | | | |

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## Transportation Access

How are transportation needs being met?

☐ Own Vehicle ☐ Family or Friends ☐ Cab ☐ Volunteers/Peer
☐ DSS transportation (Medicaid) ☐ Public Transportation ☐ Local Transportation Services
☐ Other: _____

Any barriers or disabilities that present challenges with using public transportation? ☐ Yes ☐ No

_____

Has not having transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? ☐ Yes ☐ No

### Acuity

| **Area of functioning: Transportation** | | | | **Acuity Score**: 0 | |
|---|---|---|---|---|---|
| Intensive Need (3) | | Moderate Need (2) | | Basic Need (1) | Self-Management (0) |
| ☐ | Client has no access to public or private transportation (e.g., lives in an area not served by public transportation, has no resources available for transportation options, is required to travel long distances to access medical appointments); | ☐ | Client has frequent access needs for transportation; | ☐ Client needs occasional, infrequent transportation assistance for HIV related needs; | ☐ Client is fully self-sufficient and has available and reliable transportation; and has no physical disabilities limiting access to transportation. |
| ☐ | Client has difficulty accessing transportation due to physical disabilities. | ☐ | Client is unable to understand bus/train schedules or how to manage bus/train transfers. | | |

## Health Insurance and Access

☐ Medicaid
☐ Medicare Part: ☐ A ☐ B ☐ D
☐ HMAP Subprogram: ☐ UMAP ☐ SPAP ☐ ICAP ☐ PCAP
☐ VA Benefits
☐ Private Insurance Specify: ☐ Individual ☐ Group (through employer) ☐ COBRA

☐ Client does NOT have any form of medical insurance at this time.
Reason: _____
Discussed enrollment into the following:
Health Care Program (ACA): ☐ Yes ☐ No
HMAP/PCAP: ☐ Yes ☐ No

## Acuity

| **Area of functioning: Insurance** | | | | | | | **Acuity Score**: 0 |
|---|---|---|---|---|---|---|---|
| Intensive Need (3) | | Moderate Need (2) | | Basic Need (1) | | Self-Management (0) | |
| ☐ | Client is without medical coverage adequate to provide minimal access to care; | ☐ | Client needs assistance to complete applications for health benefits (Medicaid, HMAP, etc.); | ☐ | Client has medical insurance, but insurance is inadequate to obtain care; | ☐ | Client is self-insured with adequate coverage to provide access to the full continuum of clinical care including dental and medication services. Client may only need occasional information or periodic review for renewal eligibility. |
| ☐ | Client is unable to pay for care through other sources and needs immediate medical assistance. | ☐ | Client needs directions and assistance compiling and completing health benefit documentation or application materials; | ☐ | Client needs assistance in meeting deductibles, co-payments and/or spend-down requirements; | | |
| | | ☐ | Client's application(s) for health benefits is pending. | ☐ | Client needs significant active advocacy with insurance representative to resolve billing disputes. | | |

# IV: Behavioral Health and Safety Planning

### Mental Health

Have you ever received mental health treatment or counseling? ☐ Yes ☐ No

Have you ever been hospitalized for mental health treatment? ☐ Yes ☐ No

Currently receiving mental health or psychiatric treatment (i.e., individual or group treatment, family counseling, psychiatric care)? ☐ Yes ☐ No If yes, frequency: _____

If yes, treatment provider(s)

| Name | Address | Phone | Fax | Email |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

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*Mental Health Medications* ☐ Print List from EMR

| Name of Medication | Currently or Previously Taken (C/P) | Frequency | Side Effects |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Has client experienced any significant losses/ traumatic events? ☐ Yes ☐ No

Has client ever been victim of a crime? ☐ Yes ☐ No
Does client have a history of past suicidal or homicidal attempts? ☐ Yes ☐ No
Does client have current suicidal ideation? ☐ Yes ☐ No
If yes, does client have a plan?

***Please follow agency plan of action.***

***If client is receiving a Mental Health assessment from a Provider/Behavioral Health Specialist, questions below do not need to be answered. If Medical Case Manager is assessing client's Mental Health, please answer the questions below.***

| | | | |
|---|---|---|---|
| Do you ever feel anxious, depressed, or confused? | ☐ Yes | ☐ No | ☐ Sometimes |
| Do you ever find yourself feeling sad or hopeless? | ☐ Yes | ☐ No | ☐ Sometimes |
| Do you ever find yourself worrying so much that it keeps you from doing activities you would like to do? | ☐ Yes | ☐ No | ☐ Sometimes |
| Do you find it difficult to enjoy yourself when engaging in activities you have enjoyed in the past? | ☐ Yes | ☐ No | ☐ Sometimes |
| Do you have any significant difficulties sleeping? | ☐ Yes | ☐ No | ☐ Sometimes |
| Do you often find yourself reliving bad experiences from the past (flashbacks, feelings as if you are re-experiencing the event)? | ☐ Yes | ☐ No | ☐ Sometimes |

## Acuity

| **Area of functioning: Mental Health Status** | | | | | | **Acuity Score**: 0 | |
|---|---|---|---|---|---|---|---|
| Intensive Need (3) | | Moderate Need (2) | | Basic Need (1) | | Self-Management (0) | |
| ☐ | Clinical diagnosis with no current mental health provider, no pending appointments, no desire and/or is resistant to seek treatment; | ☐ | Clinical diagnosis or otherwise engaged with a mental health provider, but inconsistent with appointment attendance and/or treatment adherence; | ☐ | Engaged with a mental health provider and is consistent with mental health treatment and/or appointments; | ☐ | No indication of need for clinical mental health assessment; |
| ☐ | Currently awaiting treatment or appointment with mental health professional; | ☐ | Referral to a new mental health professional in the past 6 months; | ☐ | Receives MCM support to make and keep appointments with mental health professional; | ☐ | No support needed to make and keep appointments with mental health professional; |
| ☐ | Consistent challenges with adherence to prescribed psychiatric medicines or treatment protocol; | ☐ | Moderate challenges with adherence to prescribed psychiatric medicines or treatment protocol (missed doses more than a few times a month); | ☐ | Some challenges with adherence to prescribed psychiatric medicines or treatment protocol (occasional missed doses). | ☐ | No challenges with adherence prescribed psychiatric medicines or treatment protocol. |
| ☐ | Indication of need for mental health support, clinical mental health assessment, and/or treatment and does not receive it; | ☐ | Needs referral to or help accessing a culturally competent mental health provider (e.g., LGBT, linguistically appropriate, etc.); | | | | |
| ☐ | Behavior relating to mental health status negatively impacts daily living, interactions with providers, and/or other social supports. | ☐ | MCM or other member of the care team is an integral part of mental health support (e.g., regular check-ins etc.) | | | | |

## Alcohol/Substance Use

Do you drink alcohol or use drugs (other than those prescribed by your doctor)? ☐ Yes ☐ No

If yes, do you worry about your use? ☐ Yes ☐ No

Have you ever been in a detox program? ☐ Yes ☐ No

Have you ever been in a residential facility for drug or alcohol use? ☐ Yes ☐ No

Are you on methadone maintenance/suboxone? ☐ Yes ☐ No

Would you like to meet with an alcohol/drug counselor? ☐ Yes ☐ No

Comments/additional information:

| Substance | Age of First use? | Date of last use? | Currently Using? (Y/N) | Problem for client? (Y/N) | Wants treatment |
|---|---|---|---|---|---|
| **Gambling** | | | | | |
| **Nicotine** | | | | | |
| **Alcohol** | | | | | |
| **Marijuana** | | | | | |
| **Speed/Meth** | | | | | |
| **Cocaine/crack** | | | | | |
| **Heroin** | | | | | |
| **Hallucinogens** | | | | | |
| **Rx Medications** | | | | | |
| **Other** | | | | | |

## Acuity

| **Area of functioning: Substance Use Status** | | | | **Acuity Score**: 0 | | | |
|---|---|---|---|---|---|---|---|
| Intensive Need (3) | | Moderate Need (2) | | Basic Need (1) | | Self-Management (0) | |
| ☐ | Chronic daily drug or alcohol use or dependence that consistently interferes with adherence to HIV care and treatment and/or activities of daily living and expresses no desire for treatment (e.g., methadone, suboxone, detox, etc.) | ☐ | Current or recent drug or alcohol use or dependence that sometimes interferes with adherence to HIV care and/or daily living; | ☐ | Current or recent drug or alcohol use does not interfere with adherence to care, treatment, and/or activities of daily living but MCM assesses a need for additional support or regular check-in; | ☐ | Current or recent drug or alcohol use that does not interfere with adherence to care, treatment, or activities of daily living; |
| ☐ | Intermittent engagement in drug and alcohol treatment (e.g., methadone, suboxone, detox, etc.) | ☐ | Recently in residential or in-patient treatment for drug or alcohol use; | ☐ | Currently receiving treatment for drug and alcohol use in an out-patient setting; | ☐ | Receives sufficient supports around past substance use and/or no indication of need for additional support; |
| ☐ | Expresses a need or desire for drug or alcohol treatment (e.g., suboxone, methadone, detox, etc.) | ☐ | Currently on a wait list to receive treatment for substance use disorder; | ☐ | Currently engaging with a recovery support program/group (e.g., AA, NA, holistic recovery, etc.) | ☐ | No current or past issues with drug or alcohol use; |
| ☐ | Imminent harm associated with substance use and/or no engagement/interest in harm reduction practices (e.g., sharing needs, Narcan, etc.) | ☐ | Experiences harm associated with substance use with minimal ability to engage in harm reduction practices (e.g., sharing needles, Narcan, etc.) | ☐ | Experiences harm associated with substance use with some ability to engage in harm reduction practices (e.g., sharing needles, Narcan, etc.) | ☐ | No harm associated with current or past alcohol and drug use. Is able to engage in harm reduction practices (e.g., no needle sharing, carries narcan, etc.) |
| ☐ | Ongoing alcohol use in the context of liver disease (e.g., HIV/HCV co-infection etc.) | | | | | | |

## Domestic Violence/Intimate Partner Violence/Safety

Does the client report feeling unsafe at this time? ☐ Yes ☐ No

If yes, is the client currently in a program that is addressing the issue? ☐ Yes ☐ No

Provide comments below (observe any visible evidence that client may be at risk):

Have you ever been in a relationship (familial/intimate) where they have been hurt in some way or threatened? ☐ Yes ☐ No

If yes, please explain:

Have you ever been in a relationship (familial/intimate) where your money or personal belongings have been stolen, withheld or restricted? ☐ Yes ☐ No

If yes, please explain:

If applicable, do you know any resources available to address current needs? ☐ Yes ☐ No

---

Has someone physically harassed you (e.g., pushed, hit or was physically abusive) because of your HIV status? ☐ Yes ☐ No

Does anyone pressure you to do something illegal? ☐ Yes ☐ No

If yes, is someone profiting off of you? ☐ Yes ☐ No

### Acuity

| **Area of functioning: DV/IPV/Safety** | | | **Acuity Score**: 0 |
|---|---|---|---|
| Intensive Need (3) | Moderate Need (2) | Basic Need (1) | Self-Management (0) |
| ☐ Client is actively involved in any of the following:<br>- Domestic Violence<br>- Intimate Partner Violence<br>- Human Trafficking<br>- Life Threatening Situation | ☐ Client reported any of the following within the last year:<br>- Domestic Violence<br>- Intimate Partner Violence<br>- Human Trafficking<br>- Life Threatening Situation | ☐ Client reported history of the following which occurred > than 1 year ago:<br>- Domestic Violence<br>- Intimate Partner Violence<br>- Human Trafficking<br>- Life Threatening Situation | ☐ No reported history of the following:<br>- Domestic Violence<br>- Intimate Partner Violence<br>- Human Trafficking<br>- Life Threatening Situation |

## Risk Behaviors and Health Education Risk Reduction

Are you currently sexually active? ☐ Yes ☐ No

Would you like information about good sexual health? ☐ Yes ☐ No

How do you protect yourself from STI's and hepatitis? _____

How do you protect your partner from STI's and hepatitis? _____

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Are you currently in a relationship with a primary partner? ☐ Yes ☐ No

If yes, is your primary partner HIV positive? ☐ Yes ☐ No

Do you need information on PrEP? ☐ Yes ☐ No

Current HIV risk:

☐ IDU ☐ MSM ☐ Sex involving transgender ☐ Heterosexual contact

Any additional information on current risk:

_____

*If client is also injecting drugs:*

Does the client ever find themselves in a situation where they are sharing syringes or works? ☐ Yes ☐ No

Does the client know where they can get clean syringes, help practicing safer drug use through a syringe program, or purchase syringes at an ESAP pharmacy/hospital? ☐ Yes ☐ No

Summarize your discussion with the client about drug-related harm reduction methods:

## Acuity

| **Area of functioning: Risk Behavior** | | | | **Acuity Score**: 0 | |
|---|---|---|---|---|---|
| Intensive Need (3) | | Moderate Need (2) | | Basic Need (1) | Self-Management (0) |
| ☐ | Client practices significant *risky behavior* of any type more than 50% of the time; | ☐ | Client practices unsafe *risky behavior* of any type more than 20-50% of the time; | ☐ Client practices unsafe *risky behavior* occasionally, less than 20% of the time; | ☐ Client abstains from *risky behavior* by safer practices. |
| ☐ | Client reports recent history of STI's in the last 6 months; | ☐ | Client reports recent history of STI's in the last 6 to 12 months; | ☐ Client reports no recent history of STI's in the last 12 months; | ☐ Client reports no recent history of STI's in the last 24 months, |
| ☐ | Client has significant relationship barriers to safe behavior. | ☐ | Client has mild relationship barriers to safe behavior. | ☐ Client has no relationship barriers to safe behavior; | |

# V: Specialty Referrals

### Medical Needs/Co-Morbidities

How would you rate your general state of health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are there any other diagnosed health problems (hypertension, heart diseases, diabetes, hepatitis, etc.)? ☐ Yes ☐ No

If yes, list: _____

Do you have a primary care physician? ☐ Yes ☐ No

If yes: _____

Do you have any pain? ☐ Yes ☐ No

If yes:_____

Have you reported the pain to your physician or ID Clinic? ☐ Yes ☐ No

Any hospitalizations in the last year? ☐ Yes ☐ No

If yes, date, reasons, locations: _____

Case Number _____

*Oral Health*

Do you have dental insurance? ☐ Yes ☐ No

Do you receive dental care? ☐ Yes ☐ No Reason: _____

Name of Dentist: _____ Date of last appointment: _____

*Vision*

Does your insurance include vision? ☐ Yes ☐ No

Do you receive regular vision care? ☐ Yes ☐ No

Name of Optometrist: _____ Date of last appointment: _____

*Nutrition*

Ask client to describe appetite:

How many meals during the day? _____ Type of food (fast food, cook at home)? _____

Is client taking food supplements? ☐ Yes ☐ No If yes, add to medication section.

Has client experienced a significant weight change recently? ☐ Yes ☐ No

Explain any changes:

Does client need a referral to a nutritionist? ☐ Yes ☐ No

*Specialist*

| Type of Specialist | Agency | Current (C)/ Referral (R) |
|---|---|---|
| | | |
| | | |
| | | |

## Acuity

| **Area of functioning: Disease Comorbidities** | | | **Acuity Score**: 0 |
|---|---|---|---|
| Intensive Need (3) | Moderate Need (2) | Basic Need (1) | Self-Management (0) |
| ☐ Client has unmanaged acute or chronic comorbidities. | ☐ Client has on-going acute comorbidities or chronic comorbidities that are not well managed. | ☐ Client has on-going acute comorbidities or chronic comorbidities that are manageable with minimal medical assistance. | ☐ Client has no comorbidities; or client has well managed acute/chronic comorbidities and does not need assistance. |

| **Area of functioning: Dental Care** | | | | **Acuity Score**: 0 |
|---|---|---|---|---|
| Intensive Need (3) | | Moderate Need (2) | Basic Need (1) | Self-Management (0) |
| ☐ Client has no dental provider **and/or** reports current tooth or mouth pain and severe discomfort. | | ☐ Client has no dental provider **and** reports no dental problems. | ☐ Client has a regular dental provider **but** reports dental problems. | ☐ Client is currently in active dental care (has seen a dentist within the last six months) **and** reports no dental issues. |
| **Area of functioning: Vision** | | | | **Acuity Score**: 0 |
| Intensive Need (3) | | Moderate Need (2) | Basic Need (1) | Self-Management (0) |
| ☐ Client has no eye provider and reports vision problems. Client needs assistance with accessing an optometrist. | | ☐ Client has no eye provider and reports no vision problems. | ☐ Client reports vision problems and has an eye provider. | ☐ Client has no vision issues and sees an optometrist regularly. |

# VI: Stigma and Trust

## Confidentiality/Information Disclosure

Have you disclosed your HIV status to anyone at this time? ☐ Yes ☐ No

If yes, to whom have you disclosed your status? ☐ Partner ☐ Family ☐ Friends

Please describe your experience: _____

Have you been supported since you've been diagnosed? ☐ Yes ☐ No

If no, do you plan to disclose your status in the future? ☐ Yes ☐ No

What support and resources do you need to support you in this process?

Would you like information about becoming more comfortable with disclosing status to others? ☐ Yes ☐ No

## Stigma – Internalized/Externalized

Have you ever felt discriminated against because of your HIV status? ☐ Yes ☐ No

If yes, please explain:

_____

Since diagnosis, have you experienced any of the following:

☐ I feel guilty for being HIV positive and hide status.

☐ I feel certain friends, family and/or organizations (Churches, School, Community agencies, employer) will exclude me from events and activities if they learn of my diagnosis.

☐ I have been treated differently or less than since diagnosis.

☐ I hide my status from others for fear of being verbally insulted, physically harassed and/or physically assaulted.

In the past 12 months, did fears about someone learning your HIV status lead you to miss a dose of your HIV (antiretroviral treatment)? ☐ Yes ☐ No

Have you been able to advocate for yourself and/or educate others about discrimination towards yourself and individuals living with HIV? ☐ Yes ☐ No

Do you feel comfortable with the facilities where you receive HIV Care? ☐ Yes ☐ No

Case Number _____

# VII: Other/Competing Demands

## Religion/Spirituality

Does client identify as a religious or spiritual person? ☐ Yes ☐ No ☐ Unreported

Is client's faith support for them? ☐ Yes ☐ No

If yes, please provide any details client would like share:

## Legal

Does client have any legal issues, such as history of arrest and incarcerations, probation/supervision, or parole that might affect their ability to obtain work or housing? ☐ Yes ☐ No

If yes, please explain:

| Is client in need of assistance with: | | | |
|---|---|---|---|
| Health Care Proxy/Living Will? | ☐ Yes | ☐ No | _____ |
| Power of Attorney? | ☐ Yes | ☐ No | _____ |
| Immigration? | ☐ Yes | ☐ No | _____ |
| Permanency Planning? | ☐ Yes | ☐ No | _____ |
| Standby Guardianship? | ☐ Yes | ☐ No | _____ |
| Other? | ☐ Yes | ☐ No | _____ |

## Acuity

| **Area of functioning: Legal** | | | | **Acuity Score**: 0 | | | |
|---|---|---|---|---|---|---|---|
| Intensive Need (3) | | Moderate Need (2) | | Basic Need (1) | | Self-Management (0) | |
| ☐ | Client is experiencing a crisis involving legal matters; | ☐ | Client has current legal problems and/or on probation or parole and does not need assistance. | ☐ | Client wants assistance with completing legal related items (e.g., living will, last will, power of attorney, advanced directives). | ☐ | Client has no recent or current legal problems. |
| ☐ | Client is recently released from a correctional facility; | | | | | | |
| ☐ | Client has a current or extensive criminal history; | | | | | | |
| ☐ | Client needs legal services to access health benefits; | | | | | | |
| ☐ | Client has immigration-related legal issues. | | | | | | |

Total Acuity Score: 0

_____

Medical Case Manager

Date

# Acuity Scale Guidelines

| Score | Case Management Level | Score Considerations |
|---|---|---|
| 0-10 | Self-Management | • Medically stable without MCM assistance<br>• Able to manage supportive needs without assistance |
| 11-23 | Basic Case Management | • Medically stable with minimal MCM assistance<br>• Able to manage supportive needs with minimal or occasional assistance. |
| 24- 37 | Moderate Case Management | • At risk of becoming medically unstable without MCM assistance<br>• Support systems are not adequate to meet client's immediate needs without MCM assistance. |
| 38-51 | Intensive Case Management | • Medically unstable and in need of comprehensive MCM assistance OR cognitively or physically challenged.<br>• Has no support system in place and unable to manage supportive needs without MCM assistance. |

Summary (Optional):