Interior AIDS Association

HIV Client Services Intake

Client # _____(to be assigned by Case Manager)

Personal Information:

Client name: _____ Date: _____

Social Security Number: _____ DOB: _____

Alaska Resident: □ Caucasian □ African American □ Pacific Islander □ American Indian/Alaska Native □ Asian □ Multiracial: _____

Ethnicity: □ Hispanic □ Non- Hispanic

Sexual Orientation: □ Heterosexual □ Homosexual □ Bisexual □ Transgendered

Current Address: _____

Phone Number: _____ Home _____Cell

Mailing Address: _____

Household:

Do you have children living in your household? □ YES □ NO

Name	**Age**	**Date of Birth**	**Gender**	**Custody**	**Live with**	Other info

Who else lives in the household? (Include spouses, partners, roommates, relatives)

Name	**Age**	**Gender**	**Relationship**	**Additional info**

Primary language of household/family: _____
Secondary language: _____

Does someone come into the home to help with any of the following?
□ Cleaning □ Childcare □ Medical Care/Medication □ Other: _____
Is there any important information we should know, that would help us assist your household?

Emergency Contact Information

Name: _____ Phone: _____
Does this person know your HIV status? □ YES □ NO

Social Support:

Supportive Social Network: Rate the network using 1 = weak to 5 = strong
Immediate family _____ Family _____ Friends _____ Work _____ School _____
Community _____ Religious _____ Neighbors _____

Community Resources/Referral

Local Agency
□ Adult Public assistance
□ SSI/SSDI/SSA
□ Medicaid/CAMA
□ Medicare
□ Interim Assistance
□ Native/tribal
□ Veteran Benefits
□ WIC
□ Fairbanks Community Health

Residential
□ Rent/Own Home
□ Shelter
□ Homeless
□ living with family
□ living with friend's

Disability
□ Physical _____%
□ mental Health Diagnosis

Legal
□ Court ordered Services
□ on Probation
□ on Parole
□ On Pre-Release
□ Mandatory Monitoring
□ Protective Services

If you are receiving financial assistance: **Amount Received $ _____**

Contact information for Agency contacts:

Name of caseworker	Agency	Phone Number

Comments:

_____
_____
_____

Housing Situation

My living situation is: □ Temporary □ Permanent □ Sub-Standard
I have: □ Electricity □ Running Water □ Water Storage
I do laundry: □ At Home □ Laundromat □ other
I Shower: □ at Home □ Laundromat □ Other
I heat my home with: □ Fuel Oil □ Propane □ Natural Gas
My monthly rent is: $ _____
My rent is 50% or more of my income □ YES □ NO
Comments:
_____
_____

Education Information

□ High School/GED □ College Degree _____
I can communicate in English: □ verbally □ In Writing
Vocational Writing: _____
Interested in attending GED/High School/college? _____

Employment Information

Currently Employed: □ YES □ NO Income: $ _____ □ Weekly □ Hourly
Employer: _____ Phone: _____
Address: _____
Knows HIV Status: □ YES □ NO Length of time employed: _____
Messages at work: □ YES □ NO Are you: □ Seasonal □ Part time □ Full time

Military Information

□ Never Served □ Enlisted/Drafted □ Branch of Service: _____
□ Combat: □ YES □ NO Year of Discharge: _____
Type of Discharge: □ Honorable □ Other than Honorable □ Dishonorable □ Medical _____

Insurance Information

What type of insurance do you have? □ None Insurance # _____

Private/Employer □ Current □ Pending □ Will Apply

Medicaid/Medicare/CAMA □ Current □ Pending □ Will Apply

VA Benefits □ Current □ Pending □ Will Apply

AK Native Health Care □ Current □ Pending □ Will Apply

ADAP □ Current □ Pending □ Will Apply

ACHIA □ Current □ Pending □ Will Apply

Premium Amount $ _____ □ monthly □ Quarterly □ Yearly

Do you have Co-Pays? □ YES □ NO If Yes, Amount $ _____

Does your insurance cover: □ Vision □ Dental □ Medication □ Mental Health

Medical Information

Physician Name: _____ Phone: _____

Address: _____ Date of Diagnosis: _____

Other Specialist: _____ Phone: _____

Current CD4 Count: _____ Current Viral Load: _____

Current Medications: _____

How often do you see your doctor? _____

Last dental Visit: _____ Last Vision Appointment: _____

Are you currently using pain management medication? □ YES □ NO

Do you self-medicate with recreational or over the counter drugs? □ YES □ NO

Do you have a Borough ID card? □ NO □ YES, Expiration _____

Do you understand what your doctor says about your health? □ YES □ NO

Other medical conditions:

_____
_____
_____

Substance Abuse/Use Information

Do you smoke? □ YES □ NO

Do you drink alcohol? □ YES □ NO

Have you ever been to a detox program, or residential treatment program? □ YES □ NO

If yes, when? _____

Where? _____

Are you currently using drugs? □ YES □ NO

If yes, what drugs: _____

How much do you use? _____

When did you last use? _____

Have you ever used needles to inject drugs? □ YES □ NO

Do you think your drug use will interfere with your medication schedule? □ YES □ NO

If yes, how? _____

Do you want a referral to a drug treatment program? □ YES □ NO

Do you want a referral to a harm reduction program for active users? □ YES □ NO

Are you having problems remaining drug free or sober? □ YES □ NO

Do you want a referral to an outpatient support group? □ YES □ NO

Nutritional Information

Current weight: _____ Current Height: _____

Appetite: □ Good □ Fair □ Poor, explain: _____

Recently: □ Gained weight □ Lost weight Amount: _____

Experiencing: □ Nausea □ Diarrhea Worse when: _____

Sleep Pattern/Habits Concentration and Mood

Numbers of hours you sleep: _____ Time of sleep: _____

□ Normal sleep □ Sleep to little □ Sleep to much

□ Too little energy □ Normal energy □ Too much energy

Do you find it: □ Difficult to concentrate □ Easy to concentrate?

Are you: □ thinking too much □ easily distracted

How has HIV affected your mood?

□ had little effect □ Caused depression □ Caused suicidal thoughts

Have you ever been treated for suicide in the past? □ YES □ NO

If yes, when? _____

Transportation

Do you have a car? □ YES □ NO

If yes, is vehicle insured: □ YES □ NO

Is transportation a problem for you? □ YES □ NO

If yes, when? _____

Do you have a bus pass? □ YES □ NO

Do you use Van Tran? □ YES □ NO

How do you get to the doctor, shopping, errands, etc.?

_____

Activities of Daily Living

Which of the following can you do without assistance?

□ Spend time with friends □ Sports/Exercise □ Dancing □ Classes/Education

□ Stay at home □ Hobbies □ Time with family □ Go to casinos

□ Listen to music □ watch movies/TV □ Go out/social gatherings

Do you need assistance with any of the following?

□ Daily household chores □ Daily personal hygiene □ Braille □ Transportation

□ Mobility/Walking □ Reading □ Hearing and/or American Sign Language □ Translation

Do you have any of the following?

□ Glasses/Contacts □ Hearing Aid □ Walker □ Cane □ History of falling

□ Wheelchair □ Memory Loss □ Crutches

Risk Assessment

□ Unprotected sex □ Intravenous Drug use □ Fights □ Drug use/Abuse □ Trade sex for drugs

□ Illegal weapons □ Gambling □ Share needles □ Gang involvement □ Drunk behavior

□ Drug dealing □ multiple partners

Prevention Measures

□ Mutual Masturbation □ Willing to use a condom □ Oral sex □ Willing to use lubrication

□ Be the receiver □ Have less partners □ Needle Exchange □ Partner Communication

□ Drug/Alcohol Treatment

Client Signature: _____

Agency Representative Signature: _____

Case Manager/Client Services or Director Only

Client Referrals:

_____
_____
_____
_____
_____

Intervention:

_____
_____
_____
_____
_____

Service Plan

□ Case management □ Medical/Medication

□ Nutrition □ Environment/Housing

□ Advocacy □ Dental

□ Vision □ Employment

□ Education □ Mental/Emotional Health

□ Transportation □ Emergency assistance: _____

□ risk reduction □ other _____

Documentation

□ Signed Release

□ Care Plan Signed

□ Confidentiality Waiver signed

□ Clients Rights Signed

□ Verification of HIV Status

□ Client Orientation Signed

□ Grievance Procedures Signed