CLIENT INTAKE

For all Ryan White Services including coordinated support

(INSTRUCTIONS: This form must be updated every 6 months. Complete all information. Use "N/A" for information that does not apply and "UNK" for information not obtained.)

Intake date:___/__/__ 6 mo. update:__/__/___ 12 mo. update: __/__/__ 18 mo. update: __/__/__ or more often: __/__/__

Service Site_____Case Manager_____

CLIENT INFORMATION:

Client Name:_____ Nickname:_____ Telephone#:_____

O.k. to call? Yes☐ No☐ Leave message? Yes☐ No☐ Workphone#:_____ O.k. to call? Yes☐ No☐

Address:_____ Apt#:_____ Town:_____ ZIP:_____

Social Security#:_____ DOB:_____ Age(optional):____

Marital Status: Single ☐, Married ☐, Separated ☐, Divorced ☐, Lives with Significant Other ☐.

U.S. Citizen: Yes☐, No☐. Place of birth:_____ How long in the US?_____

Immigration status: Documented ☐, Undocumented ☐, N/A ☐. Other info_____

What does client use for ID? CT Driver's License☐, State Non-Driver Picture ID☐, Other☐, None☐.

Does client have his/her own transportation? Yes☐ No☐

Primary Language Spoken:_____ Read: ☐ Secondary Language Spoken:_____ Read: ☐

CLIENT CHARACTERISTICS

*Gender:	Male ☐, Female ☐, Transgender ☐, Unknown/Unreported ☐.
*Hispanic/Latino/a ethnicity:	Hispanic or Latino/a ☐, Non-Hispanic and Non-Latino/a ☐, Unknown/Unreported ☐.
*Self-reported Race:	White ☐, Black/African American ☐, Asian ☐, Native Hawaiian/Pacific Islander ☐, American Indian/ or Alaskan Native ☐, More than one race ☐, Unknown/unreported ☐.
Transmission Category:	Men who have sex with men (MSM) ☐, Injection Drug Users (IDU) ☐, MSM and IDU ☐, Heterosexual Contact ☐, Perinatal ☐, Transfusion ☐, Other (specify)_____
*HIV Status:	HIV + (not AIDS) ☐, HIV + (AIDS status unknown) ☐, CDC Defined AIDS ☐, HIV – (affected) ☐, Unknown/ Unreported (affected) ☐.
Education:	(K-8) ☐, High School (circle last grade completed) 9, 10, 11, 12 GED ☐, AA/AS ☐, BA/BS ☐, MA/MS ☐, Ph.D ☐, Other (specify)_____

LIVING ARRANGEMENT (check one)

*Shelter ☐, Streets (no regular nighttime residence)☐, Transitional Housing/living program ☐,

Medical facility (hospital, nursing home, rehabilitation center) ☐, Substance Use Treatment Program ☐,

Mental Health Treatment Program ☐, Prison/jail ☐, Living with family or friends ☐,

Rental housing ☐: Monthly rent:$_____ Subsidy:$ _____ Client's Portion:$ _____

What utilities is client responsible to pay?_____

Is client housed in a facility/program? If yes, please enter name of facility/program:_____

Contact Person for facility/program:_____ Telephone#_____

HOUSEHOLD COMPOSITION (list all except Client)

Name	Age	Relationship to Client	Aware of HIV status?
1.			☐
2.			☐
3.			☐
4.			☐

*information from this line will be used for the RDR

5.			☐
6.			☐

SUPPORT NETWORK OUTSIDE OF HOUSEHOLD:

Name	Relationship to Client	Aware of HIV status?	Telephone#
1.		☐	
2.		☐	
(List emergency contacts below)			
1.		☐	
2.		☐	

HEALTH INSURANCE/MEDICAL COVERAGE (check one)

*Medicare ☐, Title XIX (Medicaid) ☐, CADAP ☐, CIAPAP (CT Insurance for AIDS Patients) ☐, Veterans Administration ☐, Other Public ☐, Employer Health Plan ☐, Other Private ☐, Other ☐, Unknown/unreported ☐, No Insurance ☐.

Name of Insurance Co._____ Managed Care Co._____

Client ID#_____ Group#_____

Authorization Telephone#_____ Insur. Case Manager_____

Have you made a copy of client's insurance card? Yes☐ No☐

Is client a veteran? Yes☐ No☐ **Did client serve before '80 or serve for > 24 consecutive months? Yes☐ No☐

Is client eligible for VA medical care? Yes☐ No☐

EMPLOYMENT

Employer:_____ Address:_____

Occupation:_____ Employed how long:_____ Full-time(F) ☐ or Part-time(P) ☐

FINANCIAL/BENEFIT INFORMATION

Please checkmark all sources of income:

- ☐ Employment
- ☐ Family Member(s) Income (Work and Other)
- ☐ Unemployment Compensation
- ☐ Workers Compensation
- ☐ Social Security Disability Insurance (SSDI)
- ☐ Pension
- ☐ Supplementary Security Income
- ☐ SAGA (State Administered General Assistance)
- ☐ TANF (Temporary Aid to Needy Families)
- ☐ State Supplement for the Disabled
- ☐ Food Stamps
- ☐ WIC
- ☐ Other (specify source)_____

Pending Benefits (List date of application):

- ☐ CADAP_____
- ☐ Title XIX_____
- ☐ Unemployment Compensation_____
- ☐ Workers Compensation_____
- ☐ Social Security Disability_____
- ☐ Pension_____
- ☐ Supplemental Security Income_____
- ☐ SAGA (State Administered General Assistance) _____
- ☐ TANF (Temporary Aid to Needy Families)_____
- ☐ State Supplement for the Disabled_____
- ☐ WIC_____
- ☐ Food Stamps_____
- ☐ Other_____

*information from this line will be used for the RDR, **If yes, client needs to provide a written denial from VA to use Ryan White money for medical services

ELIGIBILITY WORKSHEET(use for eligibility determination)

I. Indicate household/family source(s) of income, frequency, and amount:
(complete for all items checked on section III, page 1; please attach documentation)

SOURCE(S) OF INCOME	SPECIFY HOUSEHOLD MEMBER	INCOME($)	WEEKLY(W); BIWEEKLY(B); MONTHLY(M)	ANNUAL AMOUNT($)
Client work income	Client			
Family member(s) work income				
Unemployment Compensation				
Workers Compensation				
Social Security Disability Insurance (SSDI)				
Pension				
Supplementary Security Income				
SAGA (State Administrd Gen'l Assistance)				
TANF (Temporary Aid to Needy Families)				
State Supplement for the Disabled				
Other(specify)				
Total:		$	Total:	$

II. Indicate any medical out-of-pocket expenses that should be taken into account as adjustments in determining income(e.g. copayment, insurance premiums, deductibles, etc):

TYPE OF EXPENSE	DATE PAID	OUT-OF-POCKET EXPENSE($)
	_____/_____/_____	
	_____/_____/_____	
	_____/_____/_____	
	_____/_____/_____	
TOTAL OUT-OF-POCKET EXPENSES:		$

medical expenses taken into account must be within a 12-month period of time and can only be used to calculate and pay for future RW bills.

III. Subtract II from the total of I above and indicate adjusted income: $_____

IV. What is family /household size?(# of people): _____

V. Eligibility Determination:
What is 300% of the poverty level for this household/family size? $_____
(Compare this with III (adjusted income):
If adjusted income is less, then the client is eligible for RW funds:
☐Eligible ☐ Ineligible Date_____

VI. Household Income (has to be completed):
Equal to or below FPL ☐, 101-200% FPL ☐, 201-300% FPL ☐, 301 – 400% FPL ☐, Greater than 400

Other Information:

Has client ever had another Case Manager? Yes☐, No☐. When /Who/Agency:_____

_____

MENTAL HEALTH

Is client currently involved in mental health treatment (counseling, therapy, psychiatry)? Yes☐ No☐

Has client ever been involved in mental health treatment? Yes☐ No☐

Date (list most recent)	In-Patient	Out-Patient	Provider/Facility	Contact Name	Telephone#
	☐	☐			
	☐	☐			

SUBSTANCE USE

Is client currently involved in substance treatment? Yes☐ No☐

Has client ever been involved in substance treatment? Yes☐ No☐ Reason client stopped treatment_____

Date (list most recent)	In-Patient	Out-Patient	Provider/Facility	Contact Name	Telephone#
	☐	☐			
	☐	☐			

SERVICE PROVIDERS

Type of Provider	Name	Telephone#
Primary Care Physician:		
Other physicians:		
Infectious Disease Specialist:		
Dentist:		
Pharmacy:		

MEDICAL INFORMATION

If HIV+, where did client first test HIV +:_____ When?_____

Is client currently being treated for conditions besides HIV? Yes☐ No☐ If yes, what condition(s)_____

Current Medications: _____

_____

Has client recently started or stopped taking medications? Yes ☐ No☐. Explain:_____

_____

Drug/Food Allergies: _____

OTHER

Religion/spirituality (optional):_____Child Welfare System Status:_____

Is client involved with the legal system in any way? Yes☐ No☐

If yes, please explain: (please list contact person(s) and phone)_____

If client is an immigrant, what is the client's country of origin:_____

What is the reason for immigration?_____ Does the client have fear of deportation?_____

Is client knowledgeable about his/her diagnosis? Yes☐ No☐. Comments:_____

Current state of Client's health (optional):_____

CAREGIVER/CHILDREN'S NEEDS (For children/adolescents, attach additional pages if needed):

_____

_____