Client Name:

Client Number:

Intake Form Date: Click here to enter text. Worker

Date of initial contact/referral:
☐New Client ☐Reopen ☐Update

Referral Source Click here to enter text.

Contact Information:

Name:
First Last Middle

Date of Birth: Social Security Number:

Mailing address:

City: Zip: County:

Phone: Home: Other: (work, cell, partner)

(If discretion is necessary, please put a "D" at the end of the number)

Communication method to be used for follow-up, confidentiality considerations;

Phone: 1) Identify if calling from agency? ☐Yes ☐No
2) Identify ourselves by first name only? ☐Yes ☐No
3) Leave a message on answering machine/voice mail? ☐Yes ☐No
4) Leave a message with person answering the phone? ☐Yes ☐No
5) Other persons in household and confidentiality considerations:

Mail: 1) Client Services MAIL ONLY (anonymous envelope)? ☐Yes ☐No
2. NO MAIL CONTACT AT ALL? ☐

Emergency Contact

Name:
Address:

Relationship:

Client Name:

Client Number:

Phone: Home: Other: (work, cell, partner)
Is discretion necessary: Yes ☐ No ☐

URS Requirements

Gender: ☐Male ☐Female ☐Transgender ☐Unknown

Race: (Check all that apply)

☐American Indian or Alaskan Native ☐Native Hawaiian or other Pacific Islander
☐Asian ☐Unknown/not reported
☐Black or African American ☐White
☐Other:

Ethnicity: (If applicable, check in addition to race)
☐African Born
☐Arab or Chaldean
☐Hispanic/Latino/a

Self Reported HIV Status:
☐HIV+ (non-AIDS) ☐HIV Negative
☐HIV+ (AIDS status not known) ☐Infant/Indeterminate
☐CDC Defined AIDS ☐HIV status unknown

HIV+ Date: ☐Est. AIDS Date: ☐ Est.

Primary risk factors: (Check all that apply)
☐Men who have sex with men (MSM)
☐Injection drug user (IDU)
☐Hemophilia/coagulation blood disorder
☐Heterosexual contact
☐Receipt of blood, blood components, or tissue
☐Perinatal transmission
☐Other
☐Undetermined/unknown/risk not identified or reported

Source of medical insurance:
☐Private insurance Company name:
☐Medicaid
☐Medicare
☐Other public insurance Name:

Client Name:

Client Number:

☐No health insurance
☐Other insurance Name:
☐Unknown/not reported

Primary Source of HIV Medical Care:

☐Emergency Room ☐publicly funded clinic or health department
☐Hospital outpatient center ☐No primary source of HIV medical care
☐Other _____ ☐Private practice ☐Unknown/not reported

Housing status:

☐Permanently Housed
☐Non-permanently Housed (includes homeless)
☐Institution
☐Unknown/unreported
☐Other:
Household size: (number in household) Gross Annual Household Income $

Financial Information:

Gross Monthly Household Income:

Work Status: ☐Full-time ☐Part-time ☐Unemployed☐Disabled ☐Sick leave

☐Other: _____

Medical/Health:

Primary Doctor: Name: Phone

☐*Needs Primary Doctor* **Date last seen?**

Medical Provider: Name: Phone:

☐*Needs Infectious Disease Doctor* **Date last seen?**

OB/GYN Doctor: (If female) Name: Phone:

☐*Needs OB/GYN Doctor*

Other Medical Providers:

Self-Reported CD4 count of unknown as of

Self-Reported Viral Load of as of

Client Name:

Client Number:

Co-Infection/Other significant diagnoses? (Please specify):

Medication status (Anti-retroviral Therapy):

☐On medication ☐New to medication ☐Never taken ARV medication
☐Other:

Immediate Health Care Needs:

☐Emergency Treatment ☐Urgent/in crisis

☐Infectious Disease Physician ☐Primary Care Physician

☐Medical Insurance ☐Access to Medications

☐Other:

Other Presenting Problem(s):

☐Food ☐Mental Health
☐HIV Education ☐Social Support
☐Homeless ☐Substance use/abuse
☐Housing ☐Transportation
☐Legal ☐Other:

Summary of Services Provided:

Are you interested in Case Management services at this time? ☐Y ☐N
Referral and meets the requirements for EIS (Early Intervention Services)? ☐Y ☐N
Referral and meet the requirements for Care Coordination? ☐Y ☐N
To ensure you are receiving quality HIV/AIDS medical care, may we contact you again in six months?
☐Y ☐N
☐Referral for Case Management (complete assessment in 7 days)
☐Information and Referral only (complete URS only)
☐Rationale for Services:

_____ _____

Client Advocate Signature Date

Client Name:

Client Number:

Planned next appointment with client (date/time/location/who):