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| **Section 1: Identifying Information** |
| Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_  Last First M  Social Security No: \_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Clt is homeless nearest cross-streets of location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Hrs clt could be found at location: \_\_\_\_\_\_\_\_\_\_  Any additional information to locate clt: \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  OK to send Mail?  Y  N Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_ OK to Leave Msg?  Y N  Assigned Gender at Birth: M F  Sexual Orientation: Homosexual Heterosexual Bisexual  Gender Identity: Transsexual Transgender M->F F->M  Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bilingual English &: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Interview conducted in: English Spanish Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship Status:  Married Single Domestic Partner Divorced Widowed Separated  Significant Other  **Emergency Contacts:**  Primary: Secondary:  Name: Name:  Relationship: Relationship:  Phone: Phone:  Aware of HIV Status: Y N Aware of HIV Status: Y N  Ok to leave messages: Y N Ok to leave messages: Y N  **Clt Referred By**:  Union Station:  Grand View:  Alliance For Housing and Healing:  Casa De Las Amigas:  Door Of Hope:  Center For Health Justice:  Other:  Clt reached through outreach event: Y N |
| **Section II: Legal Assessment** |
| **Arrests:** YN **Incarcerations**: Y N  When**:** When:  Where: Where:  Reason: Reason:  **Parole**: Y N  **Probation**: Y N  Name: Name:  Address: Address:  Phone: Phone:  Aware of status: Y N Aware of status: Y N  **Clt convicted of sexual offense**: Y N  **DPOA/5 Wishes For Healthcare Completed**: Y N Declines  Copy in clt file: Y N  **DCFS Report:** Y N **Guardian of Minor Children**: Y N  Name:  Address:  Phone:    **APS Report:** Y N **Conservator/Guardian**: Y N  Name:  Address:  Phone:  **CLT NEEDS REFERRAL TO LEGAL ASSISTNACE**: |
| **Section III: Financial Assessment** |
| **Financial Source**:  Employment $/hr: SSI/SSDI $/mth: GR $/mth:  TANIF $/mth: Unemployment $/mth: Other:  **Is clt employed**: Y N  Employer:  Address:  Phone:  Clt is unemployed limited income received through:  **Monthly Expenses**:  Housing $: Utilities $: Telephone $:  Food $: Transportation $: Other: |
| **Section IV: Benefits Assessment** |
| **Does clt have medical insurance**: Y N  **If yes, specify**: Medi-Cal Medicare Healthy Way LA ADAP Private Insurance  **Clt receives medical care at (specify):**  County Clinic Community Clinic Hospital Outpatient Clinic/Department  Solo/Group Private Practice (not HMO) HMO Other:  **Primary MD**:  **Infectious Disease MD**:  **Clt does not have medical insurance, clt will be referred to**:  **Is clt a Veteran of United States military**: Y N  If yes, was VA referral provided: Y N Clt Denied  **Clt needs referral for the following additional benefits**:  Transportation Housing IHSS Mental Health Support Groups  Substance Abuse Recovery Employment Education RN Risk-Reduction Support Groups Partner Testing Food ADAP |
| **Section V: Social History** |
| **Race:** (choose all that apply)  Caucasian  Black/African American Asian Native American/Alaskan Native Native Hawaiian/Pacific Islander Other:  **Latino/Hispanic:** **Y** **N Ethnicity:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Highest Level of Education:**  None Grade 1-8 Grade 9-11 Grade 12/GED Some College/AA/Tech Bachelor’s Degree Graduate Degree  **Birth Place**: Country\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Length of time in the USA**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Are you a resident of LA County**: Y N  **Housing/Living Arrangements:** (choose one)  Permanent Non-permanent (homeless, transient, transitional) Institution (residential, health care, correctional) Other:  **If homeless:** (choose one)  Staying with friends or relatives Shelter Transitional housing Living Outside/Sleeping Outdoors Other:  **Primary HIV Exposure Category:** (choose all that apply)  Mother with/at risk for HIV infection Transfusion Heterosexual contact Men who have sex with men Injection drug use Hemophilla/coagulation disorder Other:  **Dependent Children:**  *Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* *Male* *Female DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_* **HIV+** **Y** **N**  *Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* *Male* *Female DOB:\_\_\_\_/\_\_\_\_/\_\_\_\_\_* **HIV+****Y** **N**  *Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male Female DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_* **HIV+ Y N**  *Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male Female DOB:\_\_\_\_/\_\_\_\_/\_\_\_\_\_* **HIV+Y N** |
| **Section VI: Mental Health HX** |
| **Current Treatment Status:**  Not applicable In treatment Waiting list for treatment Refused treatment Completed treatment Pre-treatment process Dropped out of treatment No active treatment Resumed treatment Resumed treatment Other Unknown  **Current Psychiatrist:** **Y** **N**  Name:  Aware of status: Y N  Client signed consent for communication: Y N  **Current Psychiatric Medications**: Y N  Meds:  If taking, adherent: Y N  Barriers to adherence:  **Current Psychiatric Diagnosis**:  **Current Therapist**: Y N  Name:  Aware of Stat**us**: Y N  Client-signed consent for communication: Y N  **Past Psychiatric Hospitalizations**: Y N  **Is the clt experiencing any of the following issues**: (check all that apply)  Anxiety issues Depression issues AIDS related dementia issues Death and dying issues  Body image issues Disclosure issues Confidentiality issues Partner notification issues  **Therapist/Support Group/Other Mental Health Support/Referral Needed**: Y N  **Section VII: Substance Use HX** |
| **Current use/abuse**: Y N  If yes, how often (daily, weekly etc.) & how much (ounce, gram, etc):  **Substance(s) of choice**:  Alcohol Cannabis Heroin Crack/Cocaine Meth/Speed Prescription Caffeine  Nicotine Inhalant GHB/Ecstacy/Ketamine Hallucinogens Other:  **Current Treatment Status**: **If actively using, practicing harm reduction**: Y N  Inpatient: Y N  Outpatient: Y N  **In need of detox or treatment program**: Y N  **Referral to outpatient**: Y N  Comments: |
| **Section VIII: Risk Factors** |
| **Does the clt present any of the following risk factors**: (check all that apply)  Needle sharing Sex work Unprotected sex with women Unprotected sex with men  Sex with HIV+ individual Sex with IDU  Comments:  **Provided clt with harm reduction strategies**: Y N |
| **Section IX: Current Mental Status Examination (MSE)** |
| **Appearance:**  Grooming: Neat/Clean Disheveled/Dirty  Hygiene: Clean Malodorous  Age: Looks older than age Looks younger than age  **Eye Contact:**  Appropriate Minimal Erratic None  **Behavior/Motor Activity:**  Relaxed Restless Pacing Sedate Threatening Catatonic Posturing Tremors/Tics Appropriate to situation Inappropriate to situation Other:  **Attitude:**  CalmPleasant Cooperative Resistant Defensive Evasive Guarded Suspicious  Demanding Manipulative Withdrawn Hostile Other:  **Speech:**  Slow Slurred Increased quantity Rapid Soft Decreased quantity Clear  Loud Mumbled Other:  **Mood:**  Normal Euphoric Elevated Depressed Angry Irritable Agitated Anxious  Apathetic Pleasant Unpleasant Neutral Fearful Elated Sad Other:  **Affect:**  Broad Restricted Blunted Flat Labile Appropriate to situation Inappropriate  Other:  **Orientation:**  Person Place Time Situation  **Attention:**  Normal Hyper Vigilant Distractible  **Concentration:**  Good Fair Poor  **Memory:**  Immediate: Good Fair Poor  Recent: Good Fair Poor  Remote: Good Fair Poor  **Thought Content:**  Ideas of reference Grandiosity Phobias Obsession/Compulsions Delusions  Depersonalization Suicidal Ideation Homicidal Ideations Preoccupied  Other:  **Thought Process:**  Normal Slow/Inhibited Rapid/Racing Circumstantial Tangential Blocking Flight of ideas Paranoid Loos Association Other:  **Perception:**  Hallucination: Y N  If yes, specify: Auditory Visual Olfactory Gustatory Tactile Somatic  **Insight:**  Good Fair Poor  **Impulse Control:**  Good Fair Poor |
| **Section X: Summary/Follow Up On Previously Identified Concerns** |
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| **Section XI: Plan/Identification Of Potential Problems Or Concerns.** |
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| **Section XII: Signature**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Peer Care Navigator Social Worker Date |

*This publication is part of a series of manuals that describe models of care that are included in the HRSA SPNS Initiative* Building a Medical Home for HIV Homeless Populations*. Learn more at* <http://cahpp.org/project/medheart/models-of-care>