Wyoming Department of Health, HIV Services

HIV SERVICES APPLICATION FOR ASSISTANCE

2015 CLIENT APPLICATION, ASSESSMENT, SERVICE CARE PLAN & ACUITY SCALE

Last Name	**First Name**	**Middle Name**	**Maiden Name (if applicable)**

Soundex #:	**Social Security Number:**	**Date of Birth**

Physical Address	**City**	**State**	**Zip**
Mailing Address, if different	**City**	**State**	**Zip**

How long have you lived at your present address? _____
How long have you lived in Wyoming? _____
Please list other states you have resided in the past 2 years. _____

Gender	**Gender at Birth**	**Relationship Status**	**Veteran**	**Citizen/resident**
□Male □Female	□Male □Female	□Single □Married/partnered □Separated □Divorced □Widowed	□No □Yes Discharge type _____ ***If yes, must complete the veteran's eligibility and verification form.***	□US Citizen □Permanent Resident □Undocumented □Other _____ Country of Birth: _____

Race	**Ethnicity**	**Hispanic Subgroup**	**Asian Subgroup**	**Native Hawaiian Pacific Islander Subgroup**
□White □Asian □African American □ Native Hawaiian/ Pacific Islander □American Indian/ Alaskan Native	□Hispanic □Non-Hispanic	□Mexican, Mexican American, Chicano/a □Puerto Rican □Cuban □Another Hispanic/Latino /a or Spanish Origin	□Asian Indian □Chinese □Filipino □Japanese □Korean □Vietnamese □Other Asian	□Native Hawaiian □Guamanian or Chamorro □Samoan □Other Pacific Islander

How may we contact you?

Home Phone Message OK?	☐ Yes ☐ No ☐ Yes ☐ No	( ) _____- _____
Cell Phone Message OK?	☐ Yes ☐ No ☐ Yes ☐ No	( ) _____- _____
Work Phone Message OK?	☐ Yes ☐ No ☐ Yes ☐ No	( ) _____- _____ x _____
Mail	☐ Yes ☐ No	

Emergency Contact (Must be someone who is NOT living in your home)	
Name:	**Relationship:**
Telephone number:	**Aware of HIV status?** ☐ Yes ☐ No

In what language are you most comfortable communicating? _____

Are you receiving case management services (including medical) from any other agency?
☐ Yes ☐ No *Provide name, agency, and telephone number*: _____

_____

Are you receiving any services from any other social service agency? ☐ Yes ☐ No
Provide names, agencies, telephone numbers, and services received: _____

_____

Use the following question to help begin a dialogue with the client and identify his/her priorities and needs. Based on the response, the order in which you complete the remainder of this assessment will vary.

What brought you in to see me today? _____

MEDICAL, ADHERENCE, AND INSURANCE

The following questions relate to health care, including regular access to medical care and medications, insurance information, and adherence to prescribed medications.

Do you have a doctor or other provider you see for medical needs, including HIV-related needs?
☐ Yes ☐ No

If the client does not have a doctor, skip to section below about barriers to medical care and make a supported referral to primary care.

Complete provider information below.

Provider	Name	Address and Phone	Date of Last Visit (month/year)
Primary Care			
HIV Specialist			
Dentist			
Ophthalmologist			
Other (OB/GYN, home health provider, etc.): _____			
Other (OB/GYN, home health provider, etc.): _____			
Pharmacy		Fax:	N/A

When were you diagnosed with HIV? ___/___/___ State of diagnosis? _____

Do you have an AIDS diagnosis? ☐ Yes ☐ No ☐ Unknown Date of diagnosis: ___/___/___
How are you feeling today? Do you have any particular health concerns? ☐ Yes ☐ No
Inquire about health-related symptoms, including opportunistic infections, the client may be experiencing. Note below.

Health Concerns:

Have you talked to a doctor about these health concerns? ☐ Yes ☐ No
If no, do you plan to? ☐ Yes ☐ No

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

How often do you see your doctor? _____

If the client does not see a doctor regularly (at least twice a year), or misses appointments, make appropriate supported referrals and attempt to determine barriers to getting or keeping appointments (e.g., difficulty remembering appointments, lack of transportation or childcare, language, housing situation, etc.). Note barriers in the box below.

Barriers to Accessing Health Care:

Are you taking medications to treat HIV? ☐ Yes ☐ No
Are you taking any other medications? ☐ Yes ☐ No
If yes, what medications do you take and how often do you take them? *(Complete table below.)*

Medications	
Medication	**Dosage (e.g., 1x/day, 2x/day, not sure, etc.)**

If additional space is needed, please attach a separate page.

Do you experience any side effects from your medications? ☐ Yes ☐ No
Do you discuss these side effects with your health care provider? ☐ Yes ☐ No
How do you manage these side effects? What does your doctor say about managing them?

Notes on Side Effects:

How are you doing with taking your HIV and other medications?
How often do you miss a dose?
☐ NEVER ☐ SOMETIMES ☐ 1 TIME PER WEEK ☐ 2-3 TIMES PER WEEK ☐ >4 TIMES PER WEEK

What do you think causes you to miss doses?

Barriers to Adherence:

If the client misses doses, attempt to determine barriers to taking medications as prescribed (e.g., difficulty remembering to take medications, difficulty obtaining medications, insurance problems, side effects as noted above). Explain the importance to treatment and appointment adherence. Encourage the client to contact his/her medical provider to discuss barriers and obtain adherence support.

What is your T-cell (CD4) count? _____ DON'T KNOW Date of last lab: _____/_____
What is your viral load? _____ DON'T KNOW Date of last lab: _____/_____

What other forms of treatment (e.g., acupuncture, herbal therapy, hormone therapy), if any, do you receive? Who provides this treatment? Do you talk to your doctor about each of these treatments? *Note below.*

Review why CD4 counts and viral loads are important as they relate to transmission and overall health.

Other Treatments:

The Wyoming Department of Health recommends that all HIV-infected persons see an oral health professional at least twice a year.

Have you seen a dentist in the last year? ☐ Yes ☐ No ☐ DON'T KNOW
If yes, when: _____

Do you have any oral health/dental needs? ☐ Yes ☐ No ☐ DON'T KNOW
If yes, what: _____

_____

_____

The Wyoming Department of Health recommends that all HIV-infected persons be vaccinated for Hepatitis A & B as well as screened for Hepatitis B &C.

Have you been vaccinated against hepatitis A or B? ☐ Yes ☐ No ☐ DON'T KNOW
Do you have a copy of your vaccination records? ☐ Yes ☐ No ☐ DON'T KNOW
Date of vaccination #1: _____
Date of vaccination #2: _____
Date of vaccination #3: _____

Would you like to be vaccinated against hepatitis A or B? ☐ Yes ☐ No ☐ DON'T KNOW

Have you ever been screened for hepatitis C? ☐ Yes ☐ No Date: _____
If yes, have you ever been diagnosed with hepatitis C? ☐ Yes ☐ No DATE: _____
If yes, do you currently receive treatment for hepatitis C? ☐ Yes ☐ No
If no, would you like to be screened for hepatitis C? ☐ Yes ☐ No

The Wyoming Department of Health recommends that all HIV-infected persons be screened for Tuberculosis at least once since diagnosis or if risks warrant screening.

Have you been screened for Tuberculosis? ☐ Yes ☐ No ☐ DON'T KNOW
Date of screening: _____
Results: _____

Would you like to be screened for Tuberculosis? ☐ Yes ☐ No ☐ DON'T KNOW

Have you ever been treated for Tuberculosis? ☐ Yes ☐ No Date: _____

Is there a chance that you or your partner might be pregnant or thinking about getting pregnant?
☐ Yes ☐ No

If yes, are you in prenatal care? ☐ Yes ☐ No
Does your prenatal care provider know that you have HIV? ☐ Yes ☐ No

If the client wishes to be vaccinated or screened for hepatitis, or if the client has hepatitis C, screened for Tuberculosis, needs to see an oral health provider or is pregnant but not in care, provide a supported referral to a medical provider. Integrated counseling, testing, and referral programs offer hepatitis vaccination and screening services, in addition to TB, STD screening and HIV testing.

Notes:

Do you smoke cigarettes or use other tobacco products? ☐ Yes ☐ No
How much do you usually smoke or use? _____
Do you ever think about quitting? ☐ Yes ☐ No
Would you like help with that? ☐ Yes ☐ No

If the client wants to stop using tobacco, options include providing a supported referral to the client's medical provider or contacting the American Cancer Society to find support groups, smoking cessation classes, or counselors who can work with the client over the telephone.

Notes:

Have you ever applied for health insurance? ☐ Yes
Is health insurance offered through your employer? ☐ Yes ☐ No
Do you have any health insurance? ☐ Yes ☐ No ***If yes, complete table below and provide a copy of the front and back of the insurance card.***

Insurance			
Insurance	**Policy Number**	**Effective Date**	**Contact Person**
Medicaid		/ /	
Medicare			
Private Insurance Name: _____			

Other: _____			
Dental: _____			

Are you the primary insured under the listed policies? ☐ Yes ☐ No

If no, fill out the following regarding the primary insured.

Name: _____ Date of Birth: _____ SSN: _____

Address: _____ City: _____ State: _____

Phone Number: _____ Employer: _____

If the client does not have health insurance, work with the client to complete the appropriate applications.

Note any insurance concerns below. Include barriers to accessing health insurance.

Insurance Concerns:

Summary of Need: Medical, Adherence, and Insurance		
Level of Need	**Description**	**Score** check one (✓)
NONE	No need for assistance in this category. No barriers to medical care or adherence including insurance. Stable, ongoing medical care.	☐ **1 POINT**
LOW	Needs referral and/or guidance for care of medical- or insurance-related issues but otherwise stable and client will follow up with supported referral.	☐ **2 POINTS**
MODERATE TO HIGH	Referral needed immediately with monitored follow up for medical- and/or insurance-related issues. Multiple barriers to care that need to be addressed.	☐ **3 POINTS**
HIGHEST (CRISIS)	Medical emergency and/or intensive, complicated care requires involving close monitoring and intensive follow up.	☐ **4 POINTS**
	Enter Score For This Section Here →	

Problem(s) Identified:	
Goal(s)	
Date	**Timeline:**
Outcome: (date / /)	

FINANCIAL, HOUSING, AND LEGAL

Did you file a tax return to for 2014? ☐ Yes ☐ No

(IF YES, THE CLIENT MUST PROVIDE A COMPLETE COPY)

If not, why? _____

Are you working? ☐ Yes ☐ No
If yes, current level of employment: ☐ FULL TIME ☐ PART TIME ☐ TEMPORAY/SEASONAL
Occupation: _____ Monthly income from employment: $_____

*****COMPLETE THE HOUSEHOLD INCOME STATEMENT*****

*All income is considered for income calculations and eligibility.

How are you doing with meeting your monthly expenses? Would you like help working out a budget?

Financial Issues:

Are you interested in assistance finding employment? ☐ Yes ☐ No ☐ Not Sure

Do you do any community or volunteer work? ☐ Yes ☐ No

Are you interested in doing any community or volunteer work? ☐ Yes ☐ No

If yes, describe briefly: _____

If the client reports no income, income verification form must be completed and accompanied with a letter of explanation from the client explaining how he/she is able to live with zero income/cash assistance.

What is the highest level of formal education that you have completed?

☐ DID NOT COMPLETE HIGH SCHOOL
☐ HIGH SCHOOL DIPLOMA / GED
☐ SOME COLLEGE OR COLLEGE DEGREE
☐ SOME GRADUATE SCHOOL / GRADUATE DEGREE

Are you interested in going back to school? ☐ Yes ☐ No

Employment, Community/Volunteer, or Educational Needs:

Housing Status		
Current Housing (check all that apply)	**Currently living with:**	**Aware of HIV status?**
☐ None (living on street, in vehicle, etc.)	☐ Alone	☐ Yes ☐ No
☐ Subsidized housing ☐ Public Housing ☐ Section 8 ☐ Other:_____	☐ Friends/roommate	☐ Yes ☐ No
☐ Temporary house/apartment (Staying with family/friends)	☐ Spouse/lover/partner	☐ Yes ☐ No
☐ Permanent house/apartment ☐ Own ☐ Rent	☐ Children	☐ Yes ☐ No
☐ Shelter	☐ Parents	☐ Yes ☐ No
☐ Jail / Prison / Community Corrections Facility	☐ Relatives	☐ Yes ☐ No
☐ Residential Program	☐ Other:_____	☐ Yes ☐ No
☐ Hospice/chronic care		
☐ Psychiatric Facility. Release date:_____	Monthly rent (if applicable): $ _____	
☐ Doubled Up		
☐ Recovery housing	Landlord's name and telephone number:	
☐ Domestic Violence Situation	_____	
☐ Other _____		

Is your current housing affordable? ☐ Yes ☐ No EXPLAIN: _____
Is your current housing safe and stable? ☐ Yes ☐ No EXPLAIN: _____

Please List All Individuals Living In Your Home				
Name (First and Last)	**Date of Birth**	**Sex**	**Race/Ethnicity**	**Aware of HIV Status?**
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

If the client is homeless or living in housing that is not considered affordable, safe, or stable, help the client access shelter, transitional housing, or permanent housing and/or offer the client a referral to a housing advocate, a client advocate, or a legal services program, as appropriate.

Describe any housing concerns in the box below (e.g., adequacy of current housing situation, housing subsidy status, satisfaction w/ housing situation, status of rent or utility payments, history or danger of eviction).

Housing Concerns:

Do you have any legal issues, such as a history of arrests and incarcerations, probation/supervision, or parole? *Note any legal issues in the box below.*

Probation: ☐ Yes ☐ No Probation officer: _____
Phone: (_____) _____

Parole: ☐ Yes ☐ No Parole officer: _____
Phone: (_____) _____

Pending court case: ☐ Yes ☐ No If yes, for what issue? _____
Date due in court: _____/_____/_____

Open warrants: ☐ Yes ☐ No If yes, for what issue? _____

Do you have a lawyer? ☐ Yes ☐ No Lawyer name: _____
Phone: (_____) _____

Other legal issues: _____

Do you need assistance with any of the following? *Check all that apply.*

☐ WILL
☐ HEALTH CARE PROXY
☐ POWER OF ATTORNEY
☐ GUARDIANSHIP
☐ OTHER: _____

*Clients may find legal assistance at wyomingbar.org

Do you need any assistance with immigration issues? ☐ Yes ☐ No

If the client needs legal assistance, provide a supported referral to a legal services program.

Legal and Immigration Issues:

Summary of Need: Financial		
Level of Need	**Description**	**Score** check one (✓)
NONE	No need for assistance in this category. Steady income and/or employed, able to meet financial obligations.	☐ **1 POINT**
LOW	Steady income but in jeopardy or has occasional need for financial assistance. May be employed part time, seasonally, or temporarily.	☐ **2 POINTS**
MODERATE TO HIGH	No income and/or minimally employed/unemployed, benefits have been denied and unfamiliar with application process.	☐ **3 POINTS**
HIGHEST (CRISIS)	Need for emergency financial assistance or referral to representative payee.	☐ **4 POINTS**
	Enter Score For This Section Here →	

Problem(s) Identified:	
Goal(s)	
Date	**Timeline:**
Outcome: (date / /)	

Summary of Need: Housing		
Level of Need	**Description**	**Score** check one (✓)
NONE	No need for assistance in this category. Stable and satisfactory housing.	☐ **1 POINT**
LOW	Housing is currently stable but may be in jeopardy or client needs assistance with housing.	☐ **2 POINTS**
MODERATE TO HIGH	Temporary housing or eviction imminent and will need housing placement.	☐ **3 POINTS**
HIGHEST (CRISIS)	Homeless, recently evicted, home uninhabitable, and/or needs assisted living facility.	☐ **4 POINTS**
	Enter Score For This Section Here →	

Problem(s) Identified:	
Goal(s)	
Date	**Timeline:**
Outcome: (date / /)	

Summary of Need: Legal		
Level of Need	**Description**	**Score** check one (✓)
NONE	No need for assistance in this category. No recent or current legal problems.	☐ **1 POINT**
LOW	Needs assistance completing standard legal documents or has minor recent legal problems.	☐ **2 POINTS**
MODERATE TO HIGH	Involved in serious legal matters. Has assistance managing legal issues and needs.	☐ **3 POINTS**
HIGHEST (CRISIS)	Immediate crisis involving legal matters.	☐ **4 POINTS**
	Enter Score For This Section Here →	

Problem(s) Identified:	
Goal(s)	
Date	**Timeline:**
Outcome: (date / /)	

NUTRITION AND OTHER BASIC NEEDS

Tell me how you are meeting your nutritional needs. Do you need assistance with any of the following:

Obtaining enough nutritious food to eat? ☐ Yes ☐ No
Preparing food/cooking? ☐ Yes ☐ No
Grocery shopping? ☐ Yes ☐ No
Food storage? ☐ Yes ☐ No

Do you receive or use any of the following types of food assistance? *If yes, indicate from where and how often where applicable.*

Food Assistance			
Assistance type	**Receive/Use?**	**How often?**	**From where?**
Food stamps	☐ Yes ☐ No		
Food pantry	☐ Yes ☐ No		
Home delivered meals	☐ Yes ☐ No		
Congregate meals	☐ Yes ☐ No		
Other _____	☐ Yes ☐ No		

Do you have any dietary limitations or food allergies? ☐ Yes ☐ No
Do you have any problems eating due to medications? ☐ Yes ☐ No
Have you ever seen a nutritionist/registered dietician? ☐ Yes ☐ No
Would you like to see a nutritionist/registered dietician? ☐ Yes ☐ No
How is your appetite? _____

If the client needs any assistance related to nutrition, help the client access the resources that will meet his or her needs.

Food and Nutrition Concerns:

Do you need any assistance with "activities of daily living," e.g., bathing, dressing, using the bathroom, or eating? ☐ Yes ☐ No

Do you need any assistance with housekeeping, laundry, shopping, remembering appointments, or using the telephone? ☐ Yes ☐ No

Do you have adequate clothing? ☐ Yes ☐ No
Do you have any other basic needs? ☐ Yes ☐ No

Basic Needs:

If the client needs any assistance related to activities of daily living or other activities that help the client live independently, offer a supported referral to home health care.

Summary of Need: Nutrition and Other Basic Needs		
Level of Need	**Description**	**Score** check one (✓)
NONE	No need for assistance in this category. Food, clothing, and other daily living items available.	☐ **1 POINT**
LOW	Needs occasional assistance in accessing assistance programs such as nutrition services or other services related to basic needs.	☐ **2 POINTS**
MODERATE TO HIGH	Routinely needs assistance in accessing assistance programs such as nutrition services or other services related to basic needs.	☐ **3 POINTS**
HIGHEST (CRISIS)	Has no access to food and/or basic needs not met. Unable to perform daily living activities.	☐ **4 POINTS**
	Enter Score For This Section Here →	

Problem(s) Identified:	
Goal(s)	
Date	**Timeline:**
Outcome: (date / /)	

TRANSPORTATION

How do you get to your medical or support service visits?

- ☐ PUBLIC TRANSPORTATION
- ☐ TAXI
- ☐ OWN VEHICLE
- ☐ RIDE FROM FAMILY MEMBER OR FRIEND
- ☐ RIDE FROM PROGRAM VOLUNTEER
- ☐ WALK
- ☐ OTHER _____

Ask if client has or is eligible for a discounted pass for public transportation.

Do you have difficulty arranging transportation? ☐ Yes ☐ No

If yes, why? _____

Note any transportation barriers or concerns in the box below:

Transportation Concerns:

If the client is unable to travel to medical or support service providers for appointments, help the client access transportation resources that meet the client's needs.

Summary of Need: Transportation		
Level of Need	**Description**	**Score** check one (✓)
NONE	No need for assistance in this category. Consistent transportation available.	☐ **1 POINT**
LOW	Needs occasional assistance in accessing transportation or finances for transportation.	☐ **2 POINTS**
MODERATE TO HIGH	Routinely needs assistance in accessing transportation. Unaware of transportation services.	☐ **3 POINTS**
HIGHEST (CRISIS)	Has very limited access to transportation which is a factor in current crisis or lack of regularly receiving care.	☐ **4 POINTS**
	Enter Score For This Section Here →	

Problem(s) Identified:	
Goal(s)	
Date	**Timeline:**
Outcome: (date / /)	

MENTAL HEALTH

Explain that the following questions are asked of all clients in order to assess a client's need for and interest in a referral for mental health care and support.

How are you feeling emotionally these days?
Have you ever received mental health treatment or counseling? ☐ Yes ☐ No
Have you ever been hospitalized for mental health treatment? ☐ Yes ☐ No
Do you currently receive mental health treatment or counseling? ☐ Yes ☐ No
Provider: _____ Telephone number: _____

Are you currently taking any medications to treat a mental health condition? ☐ Yes ☐ No
Condition? _____Medications _____

How do you manage difficult feelings or situations?

Notes:

If client does not currently receive mental health treatment, ask the following questions:

1. Do you ever feel anxious, depressed, or confused? ☐ Yes ☐ No
2. Do you ever find yourself feeling sad, or hopeless? ☐ Yes ☐ No
3. Do you find yourself worrying so much that it keeps you from doing activities you would like to do? ☐ Yes ☐ No
4. Do you find it difficult to enjoy yourself when engaging in activities you have enjoyed in the past? ☐ Yes ☐ No
5. Do you have any significant difficulties sleeping? ☐ Yes ☐ No
6. Do you often find yourself reliving bad experiences from the past (flashbacks, feeling as if you are re-experiencing the event?) ☐ Yes ☐ No
7. Have you ever thought about hurting yourself or others? ☐ Yes ☐ No

Would you like to speak with a mental health counselor or therapist for any reason? ☐ Yes ☐ No

Are you interested in becoming a Peer Navigator? ☐ Yes ☐ No
Are you interested in speaking with a Peer Navigator? ☐ Yes ☐ No

If the client answers "yes" to items 1, 6, or 7, offer to make a referral for a more thorough mental health assessment. If the client answers "yes" to two or more of the remaining items, or if the client states that s/he would like to speak with a mental health counselor, offer to make a supported referral. Record any notes about mental health treatment in the box below, if applicable. Note willingness and any barriers to receiving mental health care:

Notes on Mental Health Treatment, Including Barriers to Mental Health Care (if applicable):

Summary of Need: Mental Health		
Level of Need	**Description**	**Score** check one (✓)
NONE	No need for assistance in this category. No indication of mental health problems.	☐ **1 POINT**
LOW	History of some problems. Needs emotional support or counseling referral but otherwise functioning.	☐ **2 POINTS**
MODERATE TO HIGH	Referral and follow-up needed due to acute crises or mental health episode or severe stress in relationships.	☐ **3 POINTS**
HIGHEST (CRISIS)	Danger to self; needs immediate psychiatric evaluation/assessment.	☐ **4 POINTS**
	Enter Score For This Section Here →	

Problem(s) Identified:	
Goal(s)	
Date	**Timeline:**
Outcome: (date / /)	

SUPPORT SYSTEM AND RELATIONSHIPS

Is there a person you can count on to care about you regardless of what is happening to you? ☐ Yes ☐ No
Do you have a significant other? ☐ Yes ☐ No
Does your significant other know about your HIV status? ☐ Yes ☐ No
Is your significant other ☐ Male ☐ Female ☐ Transgender

If at any time you decide that you want to notify past or present sex or drug use partners that they may have been exposed to HIV and should get tested, I can help you with that. There are people who can notify them without revealing your identity.
Is this something you might be interested in doing? ☐ Yes ☐ No
Would you like help telling other family members or friends? ☐ Yes ☐ No

If the client requests help disclosing HIV status, discuss options with the client that may include, but are not limited to: contacting Wyoming Department of Health Communicable Disease Field Epidemiologists, asking the client if s/he would like information about counseling and testing services (including locations, hours, and contact information), offering a supported referral to a peer support provider who could help the client negotiate disclosure issues, or offering to work with the client on preparing and having conversations about disclosure.

Notes, including barriers to disclosure:

CHILDREN

Do you have children? ☐ Yes ☐ No

If yes, complete the table below. Include all children, including those not living with the client.

Children				
Name	**Date of Birth**	**Relationship**	**Aware of HIV Status?**	**Living with Client?**
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

In the box below, note the relationship with children and any DFS involvement or custody issues:

Notes:

Do you think that your children or other family members might need services related to HIV or other issues? ☐ Yes ☐ No

If yes, describe. _____

PETS

Do you have any pets? ☐ Yes ☐ No

How does your pet affect your daily life? _____

SPIRITUALITY

Are you connected to any spiritual or religious support? ☐ Yes ☐ No

Are you interested in connecting with any spiritual or religious communities or any other type of spiritual or religious support? ☐ Yes ☐ No

Notes:

SUPPORT GROUPS

Are you receiving information about any support groups? ☐ Yes ☐ No *If yes, check all that apply below:*

- ☐ Hospital-based
- ☐ Faith-based
- ☐ Narcotics Anonymous (NA)/Alcoholics Anonymous (AA)
- ☐ AIDS service organization/community-based
- ☐ Other: _____

If no, are you interested in attending a support group? ☐ Yes ☐ No
If yes, what type? _____

SAFETY OF SELF AND OTHERS

Tell the client that the following questions are asked of everyone. ("Because violence is so common, I ask all my clients about their experiences with partner violence.") Discuss confidentiality and its limits.

Do you feel safe at home? ☐ Yes ☐ No

Is anyone hurting you, threatening you, or making you feel afraid? ☐ Yes ☐ No

Follow-up: If yes, is this person a current or former partner? A family member? ☐ Yes ☐ No
A co-worker? Someone else?

Have you ever felt afraid or unsafe because of the way your partner, or some other person, has spoken to you or treated you? ☐ Yes ☐ No

Prompts: Has your partner ever physically hurt or threatened you in any way? ☐ Yes ☐ No
Has your partner ever tried to control any of your daily activities? ☐ Yes ☐ No

Has your partner ever forced you to have sex when you didn't want to? ☐ Yes ☐ No

Has your partner ever refused to practice safe sex when you wanted to? ☐ Yes ☐ No

Have you ever been, or are you currently concerned about harming your partner or someone close to you? ☐ Yes ☐ No

Follow-up: Have you or your partner ever had domestic abuse charges filed? ☐ Yes ☐ No
Have you ever filed for/been issued a restraining order? ☐ Yes ☐ No

Would you like to talk to someone about these issues? ☐ Yes ☐ No ☐ DON'T KNOW
Currently working with another provider: _____

If there is an indication of potential or current domestic violence, review options for supported referrals with the client. Options include domestic violence services, rape crisis centers, and mental health services. Become knowledgeable about your agency's crisis intervention policy for appropriate protocols.

Notes:

Summary of Need: Support System and Relationships		
Level of Need	**Description**	**Score** check one (✓)
NONE	No need for assistance in this category. No indication of domestic violence. Client has satisfactory social support.	☐ **1 POINT**
LOW	Some problems or inadequate support. No indication of domestic violence. Needs emotional support or referral to supportive services.	☐ **2 POINTS**
MODERATE TO HIGH	Client isolated without social support or in unsupportive relationship. Potential indication of domestic violence. Needs referral, follow-up, and additional supportive services.	☐ **3 POINTS**
HIGHEST (CRISIS)	Client reports signs of potential or current domestic violence and needs immediate intervention.	☐ **4 POINTS**
	Enter Score For This Section Here →	

Problem(s) Identified:	
Goal(s)	
Date	**Timeline:**
Outcome: (date / /)	

SEXUAL HEALTH

Let the client know that there are some basic things about sexual health that the case manager discusses with all clients when doing an assessment. While this topic may be uncomfortable for some, it is important to acknowledge sexuality and sexual relationships as an important element of an individual's overall health and well-being. One aspect of this involves discussing the possible risks the client may (or may not) have and ways of reducing those risks. Ask the client to let you know if s/he feels uncomfortable or is unsure about a question. Ask the client if s/he has any questions before getting started.

Define other STDs as Chlamydia, Gonorrhea, Syphilis, Herpes, Trichomoniasis, and/or HPV.

Is there anyone you currently talk to about your sexual health, including reducing your risk of sexually transmitted diseases (STDs) or Hepatitis? ☐ Yes ☐ No *If yes, indicate below*:

☐ MEDICAL PROVIDER
☐ MEDICAL/NURSE CASE MANAGER
☐ SUPPORT GROUP
☐ OUTREACH /COMMUNITY HEALTH WORKER
☐ OTHER: _____
☐ PEER EDUCATOR
☐ MENTAL HEALTH COUNSELOR
☐ FAMILY PLANNING PROVIDER

Have you ever been diagnosed with an STD? ☐ Yes ☐ No ☐ DON'T KNOW
Have you ever been diagnosed with hepatitis? ☐ Yes ☐ No ☐ DON'T KNOW

Notes:

On a scale of one to ten, tell me how important it is to you to protect yourself and others from HIV, other STDs and hepatitis?

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

(1 – Not Important; 10 – Very Important)

Tell me more about that.

Let's talk about what you know or what you've heard about STDs and hepatitis.

Using fact sheets, pamphlets, or other handouts, review STDs and hepatitis A, B, and C, how they're transmitted, and their associated symptoms. Explain role: "I am not a doctor so I can't diagnose you but I can help you get the care you may need if you have concerns or refer to you a medical provider who can answer any questions you may have." Correct misperceptions and provide basic information not covered in the materials.

Do any of the symptoms we discussed seem like something you may be concerned about?
☐ Yes ☐ No ☐ DON'T KNOW

If yes, have you told your doctor? ☐ Yes ☐ No

If the client does have concerns but has not discussed them with a doctor, explore barriers to communication and explain why it is best for the doctor be aware of the symptoms. Provide information about health centers or clinics where the client can be screened and treated if necessary, as an alternative. Explain that it is possible to have an STD without having any symptoms and that some STDs can be transmitted even when using a condom.

Notes:

Can you tell me what you know or what you've heard about HIV transmission?

Allow time for client to talk about what they know, correct any misconceptions they may have, and provide basic information.

Can you tell me what kinds of things you do to reduce your risk of acquiring STDs and hepatitis?
If the client is co-infected with Hepatitis or has an STD, tailor the discussion accordingly.
Use the following types of questions to generate discussion:

- Are you sexually active?_____
- When you are sexually active, do you have sex with ☐ Males ☐ Females ☐ Both
- When you are sexually active, that kind of sex do you have? (check all that apply)
  ☐ Oral ☐ Vaginal ☐ Anal
- Do you have a primary sexual partner? _____
- Do you have sexual partners other than your primary partner? _____
- How often do you use condoms when you have sex? _____
- What is different about the times when you did something to reduce your risk compared to the times you did not?_____
- Do you use drugs or drink alcohol before, during, or in order to have sex?_____
- To your knowledge, have any of your current or past sexual partners injected drugs?_____
- How do you feel about that? _____

Also see section regarding needle use in the Alcohol and Drug Use section below.

Notes:

Can you tell me what kinds of things you do to reduce the risk of transmitting HIV to another person?

See questions above. Additional questions:

Do you disclose your HIV status to your partner(s)? Do you make choices about your partners based on your knowledge of their HIV status? Do you make choices about your sexual behavior with particular partners based on your knowledge of their HIV status? How would you describe these choices?

Notes:

Have there been times when you were concerned about your sexual decisions or that you felt your decisions were unhealthy for you?

What kinds of things do you think would help support you in order to make different decisions? *Consider impact of decisions on disease risk, relationships, employment, custody of children, etc. Assess potential need for and interest in clinical referral.*

Notes:

With information shared by client above, use a sexual risk hierarchy scale (or "safe sex menu") to discuss options and explore ways to reduce risk and harm. Consider broad context of the individual's life circumstances and decision-making processes. Discuss issues related to disclosure and review options for partner counseling and referral services. Discuss condom and lubricant use, and use sample male and female condoms and anatomical models to have the client demonstrate correct use. Explore barriers to engaging in less risky sexual behavior consistently (e.g., partner does not want to use condoms, alcohol or drug use during sex, concerns about disclosing HIV status, etc.). Validate the individual's statements that indicate any efforts to reduce risk and harm.

If the client would like to discuss these issues with another provider or would like to explore these issues through peer support, offer to make a supported referral. If needs related to STD or hepatitis screening emerge, refer the client to a testing site or medical provider. If the client requests help with disclosure and other partner services, offer assistance as described in "Support System and Relationships."

Notes:

Summary of Need: Sexual Health		
Level of Need	**Description**	**Score** check one (✓)
NONE	No need for assistance in this category. No risky behavior reported and client has good understanding of risks.	☐ **1 POINT**
LOW	Some risky behavior reported and client has understanding of risks. Risk-reduction education reinforced.	☐ **2 POINTS**
MODERATE TO HIGH	Moderate risk and/or client has poor understanding of risks. Risk-reduction education needed. Clinical referral may be necessary.	☐ **3 POINTS**
HIGHEST (CRISIS)	Significant risk behavior and/or client has little/no understanding of risks. Risk-reduction education a priority. Clinical referral recommended.	☐ **4 POINTS**
	Enter Score For This Section Here →	

Problem(s) Identified:	
Goal(s)	
Date	**Timeline:**
Outcome: (date / /)	

ALCOHOL AND DRUG USE

Acknowledge that this is an area that many people feel uncomfortable discussing, but that it is important for the client to know how his/her alcohol or drug use may interact with his/her HIV medications and also how to use alcohol or drugs in a way that doesn't cause him/her or others harm. Having this awareness can help the client make better decisions about alcohol or drug use in general. Assure the client that it is ultimately his/her decision to continue, stop, or use drugs or alcohol safely but that knowing the implications of use can help prevent overdose or the compromising of health.

Do you drink alcohol or use (currently or historically) drugs?
☐ DRUGS ☐ ALCOHOL ☐ BOTH ☐ NEITHER
Tell me a little about that.

Notes:

Have you ever been in a detox program? ☐ Yes ☐ No
If yes, when? _____
Have you ever been in a residential treatment facility for drug or alcohol use? ☐ Yes ☐ No
If yes, when? _____

Are you on methadone maintenance? ☐ Yes ☐ No
Do you receive treatment with buprenorphine (suboxone or subutex)? ☐ Yes ☐ No

If client has been in treatment or is in recovery, ask about strategies that are, or have been, helpful.

Notes:

If client uses drugs, ask the following questions.

Do you use drugs not prescribed for you by a doctor? ☐ Yes ☐ No
If you use prescription drugs, do you take more than indicated? ☐ Yes ☐ No

Tell me about the drugs you use, e.g., sedatives (Valium, Xanax, Ativan, etc.); stimulants (speed, crystal meth, cocaine, Ritalin, etc.); opioids (heroin, morphine, methadone, codeine, OxyContin, etc.); hallucinogens/PCP (ecstasy, MDMA, LSD, angel dust, mushrooms, etc.); steroids; poppers; and/or marijuana. *Ask how client administers each drug identified, how much of each drug is used, and how frequently it is used.*

Notes:

Have you ever injected drugs? ☐ Yes ☐ No
Are you currently injecting drugs? ☐ Yes ☐ No
If client answers yes, ask the following questions:
Do you have access to clean needles? How do you get your needles and works?

Notes:

Do you or have you ever shared needles or works (cotton, cooker, spoon, water) with someone else?
☐ Yes ☐ No
Do you or have you ever cleaned your needles or works? ☐ Yes ☐ No
If yes, how often? ☐ Always ☐ Often ☐ Sometimes ☐ Rarely
What do you use to clean your needles or works? _____
Do you or have you ever bought needles/syringes from a pharmacy? ☐ Yes ☐ No

What are some of the things you do to take care of yourself while using?

Notes:

Explore any barriers identified by the client to using drugs safely (e.g., access to clean needles or other injecting equipment) and discuss risk reduction strategies. Inform the client that s/he can legally purchase needles and syringes in pharmacies. Using bleach kits and needles or substitutes, ask client to show how s/he cleans needles or works. Using information provided regarding drugs used, use fact sheets and other handouts to review effects of these drugs on the body and HIV treatment. Help client figure out how to take the drugs more safely (e.g., changing route of administration, staying hydrated while using ecstasy, avoiding use of Viagra with poppers or heart medication, etc.). Explore harm reduction strategies to address any negative impact of alcohol and/or drug use that the client may raise.

Harm Reduction Strategies:

Explain that the following four questions are being asked to help assess a client's need for and interest in substance use services.

If client uses drugs or drinks alcohol, ask the following questions.[1] One or more 'yes' responses indicates that the client may need a referral for a more comprehensive substance use assessment and/or substance use counseling. A client who answers "no" to all questions may still have needs related to substance use.

1. Have you ever felt you ought to cut down on your drinking or drug use? ☐ Yes ☐ No
2. Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No
3. Have you ever felt guilty about your drinking or drug use? ☐ Yes ☐ No
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves, get rid of a hangover, or as an eye opener? ☐ Yes ☐ No

Right now, how important is it to you to enter treatment for alcohol and/or drug use?
☐ NOT AT ALL ☐ SLIGHTLY ☐ MODERATELY ☐ CONSIDERABLY

Would you like to meet with an alcohol/drug use counselor? ☐ Yes ☐ No ☐ Not Sure

Inform the client that if at any time s/he decides to stop using drugs and/or alcohol, the case manager can make supported referrals to substance use services and support including, but not limited to detox, counseling, and support groups.

Summary of Need: Alcohol and Drug Use		
Level of Need	**Description**	**Score** check one (✓)
NONE	No need for assistance in this category. No indication of harm related to drug and/or alcohol use.	☐ **1 POINT**
LOW	History of harm related to drug and/or alcohol use but none currently. Client would benefit from monitoring of needs in this area.	☐ **2 POINTS**
MODERATE TO HIGH	Current harm related to drug and/or alcohol use and ready to seek help. Referral and follow-up to counseling/treatment needed. Need to explore harm reduction strategies.	☐ **3 POINTS**
HIGHEST (CRISIS)	Current harm related to drug and/or alcohol use, not ready to seek help, and/or does not recognize harms associated with use.	☐ **4 POINTS**
	Enter Score For This Section Here →	

Problem(s) Identified:	
Goal(s)	
Date	**Timeline:**
Outcome: (date / /)	

[1] JA Ewing "Detecting Alcoholism: The CAGE Questionnaire" *JAMA* 252: 1905-1907, 1984.

I hereby certify that all information provided by me on this application form, together with all supporting documentation, is true and correct to the best of my knowledge, information, and belief. I understand that if I deliberately omit or give false information I can be removed from the program, prosecuted under applicable state or federal law, or both.

Client or Legal Representative

_____ _____/_____/_____

Signature **Date**

_____

Printed Name

Case Manager

_____ _____/_____/_____

Signature **Date of Assessment**

_____

Printed Name

Initial Referrals & Follow-up Plan

LEVEL OF NEED SUMMARY

Section	Score (by 6-month assessment intervals)					
	Initial assessment	/ /	/ /	/ /	/ /	/ /
Medical, Adherence, and Insurance						
Financial						
Housing						
Legal						
Nutrition and Basic Needs						
Transportation						
Mental Health						
Support System and Relationships						
Sexual Health						
Alcohol and Drug Use						
Level of Case Management ***A* = *minimal*** *(10-19 pts)* ***B* = *moderate*** *(20-29 pts)* ***C* = *intensive*** *(30-40 pts)*						

* For Level of Case Management add all of the scores from the assessment form (10 score boxes total, minimum of 1 point (pt) each, maximum of 4 pts).

CERTIFICATION, AUTHORIZATION, AND CONSENT FOR PARTICIPATION

PLEASE READ EACH OF THE FOLLOWING STATEMENTS CAREFULLY, AND THEN PLACE YOUR INITIALS IN THE BOX TO THE LEFT OF EACH STATEMENT.

IF YOU HAVE ANY QUESTIONS, PLEASE ASK FOR CLARIFICATION BEFORE YOU INITIAL.

THIS APPLICATION IS A LEGAL DOCUMENT.

INITIALS	I understand that all information provided by and pertaining to me is confidential and may constitute Protected Health Information. All protected health information will be maintained in a confidential and secure manner.
INITIALS	I hereby certify that I am HIV positive and/or have a clinical diagnosis of AIDS.
INITIALS	I understand that the names of individuals with communicable diseases (including HIV disease and AIDS) are required by Wyoming law to be reported to the Wyoming Department of Health. I understand that the information I have provided on this application form will be shared with the Wyoming Department of Health's Communicable Disease Surveillance Program for the purposes of disease reporting in accordance with state law. I further understand that, if my name has not been previously reported to the Department, I may be contacted confidentially by a representative of the Department in order to accomplish complete case reporting and follow-up.
INITIALS	I understand that my client specific health, treatment and supportive service information is collected and maintained in the encrypted CAREWare database program which is operated and maintained by the Wyoming Department of Health. I further understand that this information can be compiled and used for reporting purposes, but it will be done so without revealing names or other information that would identify any specific client.
INITIALS	I hereby certify that I have disclosed on this application form **ALL** sources of household income, including all sources of insurance or other public assistance for which I and all other persons in my household are eligible. I further certify that I have no other undisclosed sources of monies or benefits which could be used to pay for the services I am requesting.
INITIALS	I understand that the assistance for which I am applying is dependent, in whole or in part, on state and/or federal appropriations and grant awards. Funding decisions made by the Wyoming Legislature, the U.S. Congress, the U.S. Department of Housing and Urban Development and/or the U.S. Department of Health and Human Services may result in the limitation or termination of any or all program services at any time.
INITIALS	I understand that the assistance programs for which I am applying serve as payers of last resort to provide necessary medical and supportive services which I would not otherwise be able to receive. **THE ASSISTANCE PROGRAMS FOR WHICH I AM APPLYING ARE NOT ENTITLEMENT BENEFIT PROGRAMS.**
INITIALS	I understand that payment for all goods and services under these programs can only be authorized by an agent of the Wyoming Department of Health, HIV Services Program. I further understand that, should I obtain goods or receive services which were not properly authorized, I will be solely liable for payment.
INITIALS	**I agree to notify my Case Manager(s) immediately of any changes in my address, telephone number(s), household or familial status, insurance coverage, and/or eligibility for other public assistance programs.**
INITIALS	I acknowledge that I have a responsibility to cooperate with all reasonable requests of my Case Manager(s) in carrying out his/her duties in relation to my treatment and my eligibility for the programs for which I am applying.
INITIALS	**SEPARATE PROGRAM ACKNOWLEDGEMENT** I understand that the Ryan White Part B, ADAP, Insurance Assistance Program, Early Intervention Services (EIS) Part C, and HOPWA programs are administered by the Wyoming Department of Health, based in Cheyenne. I understand that EIS clinics administered by contracted physicians do not share staff, location, management, cost sharing requirements, or daily operations with WDH. **I hereby acknowledge that, by affixing my initials in the box to the left, I am applying for assistance from separately funded programs and that I consent to the release and sharing of this application form with EIS provider staff, together with all supporting documentation.**