# Transitional Planning Intake/ Assessment /Action Form



**Demographics:**

Agency Name: _____ Referral Source:_____ Date: _____

Client Name:_____ AKA: _____

Client Code: _____DIN/Facility ID #: _____

Facility / County: _____/_____

DOB: _ _ / _ _ / _ _ _ _ Gender Identity: □ Male □ Female
□ Transgender: Female to Male □ Transgender: Male to Female

Social Security #: __ __ __ /__ __/__ __ __ __ Primary Language Spoken: _____

Race: _____ Ethnicity: _____ Veteran Status: _____

May I contact you in the facility? Yes:____ No: ___

How should I identify myself at call-out? _____

**Parole Information:**

In-Facility Parole Officer: _____Telephone #: _____

Board Date: _____ Release Date: _____

Notes:

_____

_____

Are there other caseworkers in-facility, pre-release counselors, mental health staff, etc. involved in your case?

_____

_____

**HIV Status:**

| **HIV Status:** (Check One) | | **Date of Diagnosis :** _____ |
|---|---|---|
| ☐ **HIV Positive, Not AIDS** | ☐ **HIV Positive, CDC Defined AIDS** | ☐ **HIV Positive, AIDS Status Unknown** |

**Substance Use History:**

What is your drug(s) of choice: _____

Do you think your history of drug and/or alcohol use is a problem? Yes ____ No ____
If yes, describe: _____

What situations cause you to use? _____

Have you ever been in a treatment setting for drug and/or alcohol abuse? Yes ____ No ____
If yes, where and when? _____

Is drug and/or alcohol treatment mandated by Parole? Yes ___ No ___ Unknown ___

Do you want treatment for drug and/or alcohol abuse? Yes ___ No ___

If yes, would you like to a referral?_____

If in recovery, what would help prevent relapse?_____

**Mental Health History:**

History of mental illness? _____ Diagnosis? _____
Previous Treatment? _____ Where? _____
Current Treatment? _____

Do you take medications for mental health issues? If yes, please list.
_____
_____

Do you have any current or past thoughts of hurting yourself or others? If yes, please describe.
_____
_____

If you see a mental health counselor, psychologist, social worker, Office of Mental Health or Department of Mental Hygiene staff, have you discussed this with them?
_____

If yes, then what referrals have been made?_____

Is there a Trauma History (e.g., violence, rape, incest, accident, etc.)?_____

**Risk Assessment:**

Do you share works? _____

Do you practice safer sex? _____

Do you need assistance with disclosing your HIV status? _____

What do you think your risk(s) will be upon release?_____

**Harm Reduction Plan:**

_____

_____

_____

**Community Medical Care History:**

Primary Physician: _____ Phone: _____

Infectious Disease Physician: _____ Phone: _____

Usual site of medical care: _____

Do you want to reestablish care?_____

Date of last outpatient visit: _____

Reason: _____

**Other Medical Issues:**

- **Hepatitis C Status** (check one): □Positive □ Negative □ Unknown
  Previously treated? _____ Current treatment? _____ If current, date started: _____

- **TB Status** (check one): □ Positive □ Negative □Unknown Date of Last TB Skin Test: _____
  Previously treated? _____ Current treatment? _____ If current, date started: _____

- **History of STDs**? _____
- **Gynecological Issues**? _____

**Current Medications:**

| Medications | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |

**Family Issues: *(check all that apply)***

□ Single □ Partnered □Married □ Divorced □Widowed □Children; How many? _____
Do you have concerns about children, parental rights, custody, etc? _____

If yes, do you have any plans to reunite with family after release?_____

What assistance do you need? _____
Significant other's HIV status: _____ Is your significant other aware of your status? _____

Is family aware of HIV status: Yes __ No __; If NO, what are your plans to tell them?
_____

Were there any problems with your living situation/relationships *(e.g., domestic violence, fear, drug use, etc.)* before your incarceration?
_____
_____

**Housing:**

Where do you plan on living after release?_____ With whom?_____

Do they know your HIV status? _____ If no, will you tell them? _____

Did you have any problems with past housing services? For example, Section 8/Subsidized/ Municipal Housing ? If yes, Explain: _____

Do you have a conviction history for: Arson ___ Sex Offense ___ Felony Drug Conviction_____ and/or Violent Crime _____?

Do you have a preference for housing? _____

Do you have any disabilities that would require special housing placement?_____

If I need to contact you, may I call you at your residence when you return home? _____

If yes, how should I identify myself when I call? _____

**Person to contact upon release:**

Name:_____ Phone: _____

Address: _____

Person's relationship to you: _____

Does this person know your status? _____ Will you be living with this person?_____

If no, will you tell them?_____ How will you tell them?_____

Would you like assistance from the Partner Notification program? _____

**History of Previous Social Services, (if appropriate):**

Services and providers used prior to incarceration related to HIV and other needs:
*Please place a check mark (✓) in the first column to signify client's request to re-connect to service.*

| (✓) | Agency | Service | Contact Person/ Phone | Date(s) of Service |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Immediate Service Needs:**

Indicate below the appropriate Entitlements, Documentation, and Referrals that are needed:

**Referrals Needed: *(Check All That Apply)***

- ❑ **Housing Referral**
- ❑ **Entitlements Referral:** (Specify)_____
- ❑ **Substance Abuse Referral**
- ❑ **Escort/Transportation Referral**
- ❑ **Domestic Violence Referral**
- ❑ **Medical Referral**
- ❑ **Drug/Alcohol Treatment Referral**
- ❑ **Mental Health/Support Group Referral**
- ❑ **Case Management Referral**
- ❑ **Partner Notification Referral**
- ❑ **Family Reunification Referral**
- ❑ **Legal Assistance Referral**

| **Documents** | Place a (✓) *if item is* **Needed** | Place a *(✓) if item is* **Not Needed** | **Who is Responsible?** |
|---|---|---|---|
| CMS/M11Q | | | |
| ADAP Card | | | |
| Birth Certificate | | | |
| Social Security Card | | | |
| SSI Application | | | |
| Public Assist. /Medicaid Card | | | |
| INS (Green) Card | | | |
| Other: _____ | | | |

## Psychosocial Issues Identified During Assessment Requiring Action

| Issue (s) Identified | Action Taken | Date Completed |
|---|---|---|
| Harm Reduction | | |
| Partner Notification | | |
| Domestic Violence | | |
| Substance Use Prevention | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Faith Affiliation:**

- **Do you have a religious affiliation? If yes, what is it?** _____
- **Have you been connected to an in-facility faith leader?** _____
- **Do you have a connection established to a faith leader(s) in your home community?**

  _____
- **If No, do want to establish a connection?** _____

_____ _____

Client's Signature Date

_____ _____

Transitional Planner's Signature Date