Brief Intake – Assessment *Sample Cobra Version 6-06*

CLIENT ID # _____ **INTAKE DATE** _____
Referral Date _____ **Referred by:** _____
(Referred to Case Management Program)

Last Name _____ First Name _____ M.I. ___

Does client prefer to be referred to by any other name? _____

Date of Birth _____ Age _____ Social Security# _____

Medicaid #_____

Street/Apt. Number _____ City _____

State _____ ZIP _____ County _____

Phone (___) _____ Cell phone (___) _____

Emergency Contact Number (___) _____ Name/Relationship _____

Is Emergency Contact aware of client's HIV status? _____ Yes _____ No

Client can be contacted (check all that apply) _____ At Home _____ By Mail _____ By Phone
Is discretion required? _____

PRESENTING PROBLEM/IMMEDIATE CASE MANAGEMENT SERVICE NEEDS:

_____
_____
_____
_____
_____
_____
_____
_____
_____

NON-MEDICAL SERVICE PROVIDERS:

(i.e. Advocacy, Intensive Case Management, Housing, Food, Support Groups)

Agency	*Contact Person*	*Phone*	*Service*

Are case management services provided through another agency? ☐ **Yes** ☐ **No**

GENDER: ☐ **Female** ☐ **Male**
☐ **Transgender-ID as Female** ☐ **Transgender-ID as Male**

Ethnicity: Hispanic? ☐ Yes, specify: _____ ☐ No

Race: ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Pacific Islander
☐ White ☐ American Indian or Alaska Native ☐ Other: _____

Relationship Status: ☐ Single ☐ Single-living w/partner ☐ Married ☐ Divorced
☐ Separated ☐ Widowed

Person describes self as: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Transgender

Primary language spoken: _____

English: **Read**? ☐ Yes ☐ No **Write?** ☐ Yes ☐ No

Other Language: _____ **Read**? ☐ Yes ☐ No **Write?** ☐ Yes ☐ No

Does the client have difficulty understanding English? ☐ **Yes** ☐ **No**
Does the client have difficulty using English to navigate the health and social service systems? ☐ **Yes** ☐ **No**

Citizenship/Immigration Status: _____

Is the client an undocumented U.S. resident? ☐ **Yes** ☐ **No**
Does the client have pending immigration issues? ☐ **Yes** ☐ **No**

Living Situation:
- ☐ On street ☐ Shelter ☐ Transitional ☐ Group Home ☐ Drug Treatment Residence
- ☐ SRO- Specify: ☐ 28 Day ☐ Permanent
- ☐ Rental ☐ Own Home
- ☐ Other _____

Living Arrangement:
- ☐ Relations/Friends ☐ Alone
- ☐ Temporary ☐ Permanent

Does the client have **temporary, unsafe**, and/or **inadequate** housing? ☐ **Yes** ☐ **No**

HOUSEHOLD COMPOSITION

Number of people in household (including client): _____

(*Ethnicity below refers to **Hispanic/Non-Hispanic**. Racial categories are White, Black/African American, Asian, American Indian/Alaskan Native, Native Hawaiian/Pacific Islander, or Some Other Race)*

Adults

Name (*for URS incude Ethnicity and Race*)	Relationship	HIV Status (+ , - , or unknown)	Age	Aware of Client's HIV+ Status? (Y/N/NA)

Children

Name (*for URS include Ethnicity and Race*)	Relationship	DOB	Sex		School Grade	Aware of Client's HIV+ Status? (Y/N)	Own HIV Status +, - , Unk	If HIV+ Aware of own Status?
		/ /	M	F				
		/ /	M	F				
		/ /	M	F				
		/ /	M	F				
		/ /	M	F				

LIVING OUTSIDE OF HOUSEHOLD (partners, children, other close supports)

Name (*for URS include Ethnicity and Race*)	Relationship	HIV Status (+ , - , or unknown)	Age	Aware of Client's HIV+ Status ? (Y/N)	Whereabouts

Do household members, children or close supports have needs that impact client's ability to access or maintain treatment or care? ☐ **Yes** ☐ **No**
Are there disclosure issues that can be assisted by case management? ☐ **Yes** ☐ **No**
Does the client have a functioning support system? ☐ **Yes** ☐ **No**

PRIMARY INSURANCE

Indicate all that apply:

☐ Medicaid: Number with Sequence # _____ (_____)
Is there an exception – 35? ☐ Yes ☐ No
Is there a spend-down? ☐ Yes, in the amount of _____ ☐ No
☐ Medicaid Managed Care ☐ Medicare ☐ Private Insurance ☐ HMO/Managed Care
☐ ADAP PLUS ☐ Self Pay ☐ Military ☐ Other: _____

SECONDARY INSURANCE ☐ **None or** ☐ **Yes, (check below)**

☐ Medicaid Managed Care ☐ Medicare ☐ Private Insurance ☐ HMO/Managed Care
☐ ADAP PLUS ☐ Self Pay ☐ Military ☐ Other: _____

Effective Date of Secondary Insurance: _____
HASA Phone # *(NYC only)* _____ **HASA Worker** _____

Does the client need assistance with insurance for medical care? ☐ **Yes** ☐ **No**

HIV STATUS/ HIV RISK History

When was client diagnosed with HIV? _____

Does the client have an AIDS diagnosis? ☐ **Yes** ☐ **No** When diagnosed? _____

Where can proof of HIV status be obtained? _____

Does client know how he/she was infected? Describe:_____
Has client experienced following in past 3 months: Recent STD ☐ Yes ☐ No Incarceration ☐ Yes ☐ No
Sex Work ☐ **Yes** ☐ **No** Refused ☐ **Yes** ☐ **No** Not Asked ☐ **Yes** ☐ **No**

MEDICAL

A. ***Primary Medical Care***

Provider Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Main Phone: _____

Case Manager/Social Worker: _____ Phone: _____

Primary Physician: _____ Phone: _____

Recent Hospitalizations: _____

Last time saw doctor: _____ CD_4 Count: _____Date: _____
Viral Load:_____Date: _____
Is client restricted to use of a specific medical provider/facility? ☐ Yes ☐ No

B. *OB-GYN Care*

Is client pregnant? ☐ Yes ☐ No ☐ N/A If yes, is client receiving prenatal care? ☐ Yes ☐ No
If yes, is client on anti-retroviral protocol? ☐ Yes ☐ No

Date of last Pap Smear: _____ Results: _____

OB/GYN Clinician: _____ Phone: _____

C. *TB Status*

Last PPD: _____ Result: ☐ (+) Pos ☐ Pos (under Tx) ☐ (-) Neg ☐ Unknown

If PPD (+), date of last chest x-ray: _____ Chest x-ray results: _____

Has client ever been told they have active TB disease? ☐ Yes ☐ No

If yes, when? _____ By whom? _____

Has client ever been on TB medication? ☐ Yes ☐ No If yes, when? _____

Is client currently taking TB meds? ☐ Yes ☐ No If yes, identify meds _____

_____

If yes, any problems taking meds? _____

Do client's partners or members of their household need TB testing? ☐ Yes ☐ No

Comments: _____

_____

D. *Other Medical Conditions*

_____

_____

_____

_____

E. *Pharmacy* (Specify): _____

_____

Is client restricted to use of a pharmacy? ☐ Yes ☐ No

See ***Medications*** next page.

Does the client have difficulty keeping appointments or problems taking medications? ☐ **Yes** ☐ **No**
Does the client need other services related to accessing HIV treatment and care? ☐ **Yes** ☐ **No**
Are there unmet needs for other medical or health conditions (including pregnancy)? ☐ **Yes** ☐ **No**
Are there debilitating symptoms requiring assistance (i.e., homecare, home delivered meals)? ☐ **Yes** ☐ **No**

F. *Medications* (List all taken currently, e.g., HIV, TB, HCV, Psychotropics, etc.):

ANTIRETROVIRAL MEDICATIONS

Protease Inhibitors (PI)	**Date Started**	**Dosage/Frequency**
Agenerase (amprenavir, APV)		
Aptivus (tipranavir, TPV)		
Crixivan (idinavir, IDV)		
Invirase (saquinavir, SQV- hard gel cap)		
Kaletra (lopinavir/ritonavir, LPV/r)		
Lexiva (fosamprenavir, FPV)		
Norvir (ritonavir, RTV)		
Reyataz (atazanavir, ATV)		
Viracept (nelfinavir, NFV)		

Non Nucleoside Reverse Transcriptase Inhibitors (nNRTI)	**Date Started**	**Dosage/Frequency**
Rescriptor (delavirdine, DLV)		
Sustiva (efavirenz, EFV)		
Viramune (nevirapine, NVP)		

Nucleos*ide*/nucleo*tide* Reverse Transcriptase Inhibitors (NRTI)	**Date Started**	**Dosage/Frequency**
Combivir (zidovudine + lamivudine, AZT + 3TC)		
Emtriva (emtricitabine, FTC)		
Epivir (lamivudine, 3TC)		
Epzicom (abacavir + lamivudine, ABC + 3TC)		
Hivid (zalcitabine, ddC)		
Retrovir (zidovudine, AZT or ZDV)		
Trizivir (abacavir + zidovudine + lamivudine, ABC + AZT + 3TC)		
Truvada (tenofovir + emtricitabine, TDF + FTC)		
VIDEX (didanosine, ddI)		
VIDEX EC (didanosine:delayed-release capsules, ddI)		
Viread (tenofovir DF, TDF)		
Zerit (stavudine, d4T)		
Zerit XR (stavudine:delayed-release, d4T)		
Ziagen (abacavir, ABC)		

Entry / Fusion Inhibitors	**DateStarted**	**Dosage/Frequency**
Fuzeon (enfuvirtide, ENF)		

OTHER MEDICATIONS (psychotropics, cardiac, analgesics, insulin and related drugs, antifungals, antibiotics, herbal remedies, vitamins/minerals, bronchodilator/respiratory inhalants, medications to treat wasting, hepatitis C, opportunistic infections, etc.)

Drug Name	***Reason Prescribed***	***Drug Name***	***Reason Prescribed***

Medications list updated 3/13/06

TOTAL MONTHLY HOUSEHOLD INCOME SOURCE & BENEFITS

Employment	_____	**HIV/AIDS Service Administration**	_____
Social Security	_____	**Short Term Disability**	_____
SSI	_____	**Survivor Benefits**	_____
SSD	_____	**Rent Supplement**	_____
Child Support	_____	**Veteran's Assistance**	_____
Public Assistance	_____	**Pension**	_____
Disability Insurance	_____	**Long Term Disability**	_____
Alimony	_____	**Unemployment Insurance**	_____
Workman's Compensation	_____	**Food Stamps**	_____
Other:	_____		

Total Personal Monthly Income: _____

Additional monthly income from household members: _____

Total monthly household income: _____ Annual household income (for URS) : _____
(Monthly income x12)

Does the client have a regular source of income? ☐ **Yes** ☐ **No**
Does client have difficulty meeting monthly expenses? ☐ **Yes** ☐ **No**
Is the client linked to all income sources they are eligible for? ☐ **Yes** ☐ **No**
Does the client need assistance/advocacy in accessing entitlements? ☐ **Yes** ☐ **No**

HISTORY OF INCARCERATION

Has client been released from a correctional facility in the last 12 months?

☐ Yes, when _____ ☐ No

How long incarcerated? _____ days/weeks/months/years

Is client currently on parole/probation? ☐ Yes ☐ No

If yes, name of Parole/Probation Officer: _____ phone: (___)_____

Reason for incarceration: _____

Comments: _____

_____

_____

If recently incarcerated, does client need to be reconnected to health or human services? ☐ **Yes** ☐ **No** ☐ **NA**
Are there continuing legal needs to be addressed before client is ready for services? ☐ **Yes** ☐ **No** ☐ **NA**

MENTAL HEALTH

Has client ever received mental health counseling? ☐ Yes ☐ No

Diagnosis: _____ When/How long: _____

Is client currently receiving mental health counseling? ☐ Yes ☐ No

Diagnosis: _____ When Began: _____

Clinician: _____ Phone: _____

Ever hospitalized for a psychiatric condition? ☐ Yes ☐ No

Most recent date: _____ Where? _____

Reason: _____

Is client currently receiving psychiatric treatment? ☐ Yes ☐ No

Psychiatrist: _____ Phone: _____

Does client mental health treatment include medications? ☐ Yes ☐ No

** Please list all psychotropic medications on Medication list – Page 6, Section F **

Client's assessment of mental health/emotional support needs: _____

_____

Comments: _____

_____

_____

Does client have a need for mental health services? ☐ **Yes** ☐ **No**
Does the client have difficulty keeping mental health appointments? ☐ **Yes** ☐ **No** ☐ **NA**
Does the client have difficulty taking psychotropic medication as prescribed? ☐ **Yes** ☐ **No** ☐ **NA**

DOMESTIC VIOLENCE

Has the client ever been in an abusive relationship? ☐ Yes ☐ No – If yes, explain _____

_____

_____

Does client feel safe in current living arrangement? ☐ Yes ☐ No - If no, explain: _____

_____

_____

Does the client report ever feeling afraid that they or a family member/partner would resort to physical force when interacting with a significant other OR his/her children? ☐ Yes ☐ No – If yes, explain: _____

_____

_____

Does the client have needs related to current, recent, or threat of domestic violence? ☐ **Yes** ☐ **No** ☐ **NA**

SUBSTANCE USE

Does client have a history of drug/alcohol use? ☐ Yes ☐ No
Is client currently using? ☐ Yes ☐ No
If Yes, how long? _____ days/weeks/months/years
Drug(s) of choice: _____

Method and Frequency of use: _____

_____

Is client currently in substance abuse treatment program? ☐ Yes ☐ No
If Yes, how often? _____ Per day/week/month/year

Program Name: _____

Contact Person: _____ Phone: _____

If not in treatment, is client interested in receiving SU treatment, syringe exchange, other supports?
☐ Yes ☐ No If yes, referred to: _____

Does client want assistance to quit smoking? ☐ Yes ☐ No

Is the client experiencing problems as a result of alcohol or drug use? ☐ **Yes** ☐ **No**
Is the client seeking treatment for alcohol or drug use? ☐ **Yes** ☐ **No**

BASIC HIV EDUCATION/HARM REDUCTION

Does client know how HIV is transmitted and prevention techniques? ☐ Yes ☐ No

Assess level of knowledge regarding: ☐ Basic HIV transmission ☐ Safer Sex/Use of Latex
☐ Needle/Works Sharing ☐ Effect of Drug/Alcohol Use on Risk

Referral to Prevention Services needed? ☐ Yes ☐ No – If yes, where? _____

Comments: _____

_____

_____

OTHER NEEDS

Does the client need assistance obtaining
Nutritious food? ☐ **Yes** ☐ **No**
Appropriate clothing? ☐ **Yes** ☐ **No**
Transportation? ☐ **Yes** ☐ **No**
Legal services? ☐ **Yes** ☐ **No**
Education/training/employment? ☐ **Yes** ☐ **No**

CASE DISPOSITION

Client ID#: _____ Client Name:_____

Case management recommended? ☐ Yes ☐ No

Model? ☐ Supportive CM ☐ Comprehensive CM

(Explain recommended model to client)

Case Management accepted? ☐ Supportive CM ☐ Comprehensive CM ☐ Declined

If not case management at program/agency, where referred? _____

- **CM Consent form signed?** ☐ Yes ☐ No
- **Given copy of "Client Rights"?** ☐ Yes ☐ No
- **Release of HIV Confidential Information form Signed?** ☐ Yes ☐ No

ASSIGNMENT:

Program: _____ Staff:_____ Date: _____

Program: _____ Staff:_____ Date: _____

Program: _____ Staff:_____ Date: _____

Documents requested for client to collect and return with:

_____

_____

_____

IMMEDIATE REFERRALS MADE: (include contact name)

Hospital/Clinic: _____ For: _____

Agency: _____ For: _____

Agency: _____ For: _____

Internal: _____ For: _____

Internal: _____ For: _____

Completed by**:** _____ Date: _____

Reviewed by**:** _____ Date: _____

SUMMARY PAGE

Summarize client status, presenting needs, and assessed needs. Elaborate on any questions in the shaded boxes indicating unmet needs.