Comprehensive Case Management Reassessment

Reassessment Date: _____ Date of previous Assessment/Reassessment: _____

Name: _____ Client ID # _____

Address: _____

_____

If Reassessment early or late explain: _____

_____

_____

_____

Current HIV Status: Asymptomatic _____ Symptomatic _____AIDS _____ At Risk _____

CD4 Count: _____ Date: _____ Viral Load: _____ Date: _____

Method of Verification: _____

Describe client's current situation: _____

_____

_____

_____

_____

_____

Emergency Contact: _____Phone # _____Relationship:_____

Aware of Status? _____Y _____N Is there a Release of Information?_____Y _____N Date of Release: _____

Address: _____

_____

List all Service Providers that were involved in the last 180 days:

Agency	Type of Service	Contact	Phone #	Case Conference Date	Release of Information Expiration Date

Identify Client's Collaterals/Children:

*If any new children (under the age of 21) have moved into the household in the last 180 days, complete Child Assessment.

Name	Relationship	In Household Y/N	New to Household Y/N	Aware of Status Y/N	Children's Assessment Completed Y/N	Date Children's Assessment Completed

NEEDS REASSESSMENT

For each area, review client's current status, and comment on any changes in client's functioning, needs and resources. Where appropriate, include information about the family support system. Comment on all areas checked and identify progress on goal areas for the previous quarter. Provide a brief summary for each section.

*Remaining Need = not previously addressed; client not ready; in process; or, other with detailed information.

HEALTH CARE	Remaining Need* Explain	New Need	Not Needed	Comments/Follow-up
Primary Health Care Provider				
Identify:				
Date of last primary care appointment: _____				
Is client keeping appointments with primary care provider? ____Y ____ N ___Inconsistent				
Explain:				
Means of Verification:				
Current Hospital Preference:				
Complementary/Alternative Therapies				
Clinical Trials				
TB Testing/Treatment				
OB/GYN				
Identify Provider:				
Date of Last Exam:				
Date of last PAP: Test Results:				
Is Client Pregnant? _____Yes _____No Due Date:				
If yes, is client receiving prenatal care? _____Yes _____No				
If yes, has AZT Therapy been discussed? _____Yes _____No				
Family Planning				
STD Testing/Treatment				

HEALTH CARE	Remaining Need* Explain	New Need	Not Needed	Comments/Follow-up
Hepatitis Testing/Treatment				
Home Care				
Hospice				
Nutrition				
Dental				
Vision				
Other: (Fill in spaces below)				
Medications				
Identify current medication – See next page specifically for medication				
Does client have access to medication? _____ Y ____ N ___Inconsistent				
If No or Inconsistent, Explain:				
Does client need education in this area? _____ Y ____ N				
Explain:				

MEDICATIONS:

Is client adhering to HIV medication regimen? ____Y ____ N ___Inconsistent ____Unclear
Explain:_____

_____

_____

Is assistance needed? ____Y ____ N Identify: _____

Antiretroviral medications

Protease Inhibitors (PI)	**Date Started**	**Dosage/Frequency**
Agenerase (amprenavir, APV)		
Aptivus (tipranavir, TPV)		
Crixivan (idinavir, IDV)		
Fortovase (saquinavir, SQV-soft gel cap)		
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)		
Nucleo*side*/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	**Date Started**	**Dosage/Frequency**
Fuzeon (enfuvirtide, ENF)		

The AIDS Institute updates the Medication List form on a quarterly basis for use with assessments and reassessments.

This page should be replaced with an the most recent copy of the updated medication list.

OTHER MEDICATIONS (All other medications including TB, Psychotropic, etc.)

Is client adhering to HIV medication regimen? ____Y ____ N ___Inconsistent ____Unclear
Explain:_____

_____

_____

Is assistance needed? ____Y ____ N Identify: _____

Name	Date Started	Dosage/Frequency

Collateral (especially children) Status/Needs:
Current Overall Status/Barriers:

FINANCIAL/ ENTITLEMENTS	Remaining Need* Explain	New Need	Not Needed	Comments/Follow-up (Include $ Amounts)
Food Stamps				
Medicaid				
ADAP				
SSI/SSD/VA Benefits				
Unemployment Benefits				
Home Relief/Safety Net				
TANF				
DAS (LDSS)				
Rent Enhancement				
Financial Management				
Other: (Fill in Section Below)				
If on MA spend down, Identify amount:				
Indicate methods of spend down:				
Current Overall Status/Needs:				

INDEPENDENT LIVING	Remaining Need* Explain	New Need	Not Needed	Comments/Follow-up
Date of most recent home: visit:				
Current housing status: _____ Permanent _____ Transitional _____ Homeless				
Describe:				
Appropriate/Affordable				
Eviction Notice				
Owes Back Rent				
Housing Repairs Needed				
Advocacy with Landlord				
Out of Pocket Rent Expense				
Utilities				
Phone				
Transportation				
Other:				
Current Overall Status/Barriers:				

SUBSTANCE USE	Remaining Need* Explain	New Need	Not Needed	Comments/Follow-up
Is client currently using substances? _____Yes _____No				
Explain (What/How Much/How Often):				
Out Patient Treatment				
Residential Treatment				
MMTP (Dosage _____)				
AA/NA Meetings				
DETOX				
Needle Exchange				
Other: (Fill in section below)				
If yes to any of the above, indicate frequency:				
Does client keep scheduled appointments: _____ Yes _____ No _____ Inconsistent				
Current Overall Status/Barriers:				

MENTAL HEALTH	Remaining Need* Explain	New Need	Not Needed	Comments/Follow-up
Psychiatric Care				
Identify Provider:				
Identify psychotropic medication (These should be included on Medication page):				
Is client adhering to psychotropic medication regimen? ____Y ____ N ___Inconsistent				
Individual/Family Counseling				
Support Group				
Bereavement Counseling				
Religious Support				
If yes to any of the above, indicate frequency:				
Does client/family keep scheduled appointments: _____ Yes _____ No _____ Inconsistent				
Is client involved in any recreational/social activity: _____ Yes _____ No _____ Inconsistent				
Explain:				
Other:				
Current Overall Status/Barriers:				

FAMILY STABILITY	Remaining Need* Explain	New Need	Not Needed	Comments/Follow-up
Children's Service Needs:				
Medical				
Educational				
Developmental				
Emotional				
Social				
Client/Collateral Service Needs:				
Guardianship/ Permanency Planning				
Child Abuse/Neglect				
Parenting Skills				
Child Care				
Respite				
Disclosure				
Domestic Violence				
Partner/Spousal Notification				
Is client linked with support systems? _____ Yes _____ No _____ Inconsistent				
Identify:				
Other:				
Current Overall Status/Barriers:				

LEGAL	Remaining Need* Explain	New Need	Not Needed	Comments/Follow-up
Legal Rights/Discrimination				
Will				
Living Will				
Health Care Proxy				
DNR				
Power of Attorney				
Criminal Justice				
Parole/Probation				
Immigration/Naturalization				
Is client/family keeping legal appointments? _____ Yes _____ No _____ Inconsistent				
Other:				
Current Overall Status/Barriers:				

EMPLOYMENT/ EDUCATION	Remaining Need* Explain	New Need	Not Needed	Comments/Follow-up
GED/Education				
Job Readiness Assessment				
Job Training				
Job Placement				
Volunteer/Stipend				
Has client returned to work or joined the workforce for the first time? _____ Yes _____ No				
If yes, PT/FT (> 20h/week):				
Other:				
Current Overall Status/Barriers:				

PREVENTION EDUCATION REVIEW Date:

**** Discussion in all areas is required unless referral is made***.

Topic	Referral Needed **Y/N**	New Need	Comments/Follow-up
HIV			
TB			
Hepatitis – (A, B,C)/Vaccines			
STD			
Safer Sex			
Condoms			
Spermicide			
Dental Dam			
Drug Use			
Needle Sharing			
Use of Bleach			
Other Harm Reduction Techniques			
Universal Precautions			

Does client report consistent adherence to safer sex/harm reduction guidelines? _____ Yes _____ No _____ Inconsistent

Other:

Current Overall Status/Barriers:

Ability to Perform Activities of Daily Living:				If Assistance is Required, Who Currently Assists?
Feeding	0	1	2	_____
Ambulating	0	1	2	_____
Transferring	0	1	2	_____
Grooming	0	1	2	_____
Dressing	0	1	2	_____
Bathing	0	1	2	_____
Toileting	0	1	2	_____
Homemaking	0	1	2	_____
Financial Management	0	1	2	_____
Preparing Meals	0	1	2	_____
Taking Medicine	0	1	2	_____
Grocery Shopping	0	1	2	_____
Traveling	0	1	2	_____
Using Telephone	0	1	2	_____
Decision Making	0	1	2	_____

0 = By Self
1 = Some Assistance
2 = Total Assistance

Recommended Care Environment:

_____ Home
_____ Alone
_____ Family
_____ Other
_____ Home with Support
_____ Homemaking
_____ Personal Care
_____ Skilled Nursing
_____ Hospital
_____ Nursing Home
_____ Supportive Housing
_____ Hospice
_____ ADHC
_____ Other
_____
_____

Other identified client/support system service needs or issues which need to be addressed:

_____

_____

_____

_____

_____

Summary Comments/General Status of Client/Family:

Indicate client's level of participation in goal achievement over the past quarter: _____

Case Manager Signature _____ Date _____

Supervisor Signature _____ Approval Date _____