

Client Name:

Client Number:

Intake Form Date: [Click here to enter text.](#)

Worker

Date of initial contact/referral:

New Client Reopen Update

Referral Source [Click here to enter text.](#)

Contact Information:

Name:

First

Last

Middle

Date of Birth:

Social Security Number:

Mailing address:

City:

Zip:

County:

Phone: Home:

Other:

(work, cell, partner)

(If discretion is necessary, please put a "D" at the end of the number)

Communication method to be used for follow-up, confidentiality considerations;

Phone: 1) Identify if calling from agency? Yes No

2) Identify ourselves by first name only? Yes No

3) Leave a message on answering machine/voice mail? Yes No

4) Leave a message with person answering the phone? Yes No

5) Other persons in household and confidentiality considerations:

Mail: 1) Client Services MAIL ONLY (anonymous envelope)? Yes No

2. NO MAIL CONTACT AT ALL?

Emergency Contact

Name:

Address:

Relationship:

Client Name:

Client Number:

Phone: Home: Other: (work, cell, partner)

Is discretion necessary: Yes No

URS Requirements

Gender: Male Female Transgender Unknown

Race: (Check all that apply)

- American Indian or Alaskan Native Native Hawaiian or other Pacific Islander
 Asian Unknown/not reported
 Black or African American White
 Other:

Ethnicity: (If applicable, check in addition to race)

- African Born
 Arab or Chaldean
 Hispanic/Latino/a

Self Reported HIV Status:

- HIV+ (non-AIDS) HIV Negative
 HIV+ (AIDS status not known) Infant/Indeterminate
 CDC Defined AIDS HIV status unknown

HIV+ Date: Est. AIDS Date: Est.

Primary risk factors: (Check all that apply)

- Men who have sex with men (MSM)
 Injection drug user (IDU)
 Hemophilia/coagulation blood disorder
 Heterosexual contact
 Receipt of blood, blood components, or tissue
 Perinatal transmission
 Other
 Undetermined/unknown/risk not identified or reported

Source of medical insurance:

- Private insurance Company name:
 Medicaid
 Medicare
 Other public insurance Name:

Client Name:

Client Number:

- No health insurance
- Other insurance Name: _____
- Unknown/not reported

Primary Source of HIV Medical Care:

- Emergency Room publicly funded clinic or health department
- Hospital outpatient center No primary source of HIV medical care
- Other _____ Private practice Unknown/not reported

Housing status:

- Permanently Housed
- Non-permanently Housed (includes homeless)
- Institution
- Unknown/unreported
- Other: _____

Household size: (number in household) Gross Annual Household Income \$

Financial Information:

Gross Monthly Household Income:

Work Status: Full-time Part-time Unemployed Disabled Sick leave

Other: _____

Medical/Health:

Primary Doctor: Name: _____ Phone: _____

Needs Primary Doctor **Date last seen?** _____

Medical Provider: Name: _____ Phone: _____

Needs Infectious Disease Doctor **Date last seen?** _____

OB/GYN Doctor: (If female) Name: _____ Phone: _____

Needs OB/GYN Doctor

Other Medical Providers:

Self-Reported CD4 count of unknown _____ as of _____

Self-Reported Viral Load of _____ as of _____

Client Name:

Client Number:

Co-Infection/Other significant diagnoses? (Please specify):

Medication status (Anti-retroviral Therapy):

- On medication New to medication Never taken ARV medication
 Other:

Immediate Health Care Needs:

- Emergency Treatment Urgent/in crisis
 Infectious Disease Physician Primary Care Physician
 Medical Insurance Access to Medications
 Other:

Other Presenting Problem(s):

- Food Mental Health
 HIV Education Social Support
 Homeless Substance use/abuse
 Housing Transportation
 Legal Other:

Summary of Services Provided:

Are you interested in Case Management services at this time? Y N

Referral and meets the requirements for EIS (Early Intervention Services)? Y N

Referral and meet the requirements for Care Coordination? Y N

To ensure you are receiving quality HIV/AIDS medical care, may we contact you again in six months?

Y N

Referral for Case Management (complete assessment in 7 days)

Information and Referral only (complete URS only)

Rationale for Services:

Client Advocate Signature

Date

Client Name:

Client Number:

Planned next appointment with client (date/time/location/who):