STEPS TO CARE

Intake Assessment Form

Client Name: _____ Client Record #: _____

Intake Date: _____

Complete this form from the client interview and chart review at intake. Sections surrounded by a double border are required. No changes should be made to the Intake Assessment Form. Significant client changes should be recorded on the Reassessment Form.

1. **Clinical Information** *Chart Review or Client Interview*

Date of First Known Visit to This Agency for Any Service: _____

HIV Status: *(check only one)*

- ☐ HIV+, Not AIDS
- ☐ HIV+, AIDS status unknown
- ☐ CDC-Defined AIDS

HIV Diagnosis Date: _____

If AIDS, **AIDS Diagnosis Date:** _____

HIV Risk Factor: *(check all that apply)*

- ☐ MSM
- ☐ IDU
- ☐ Heterosexual
- ☐ Blood transfusion/components
- ☐ Hemophilia/coagulation disorder
- ☐ Perinatal
- ☐ Risk factor not reported or not identified

Do you currently have a primary care physician (PCP)/HIV primary care provider?

- ☐ Yes
- ☐ No

Last PCP Visit *Prior* to Enrollment: _____

or

- ☐ Unknown
- ☐ N/A

Initial/Referral Visit with PCP within This Program: _____

Most Recent CD4 Counts and Viral Load Measures from On or Before the Program Enrollment Date: *(Start with the most recent)*

CD4 Records **If none are available, check box at right:** ☐ No CD4 count on record

CD4 count	CD4 % *(optional)*	Date

STEPS TO CARE

Client Name: _____

Client Record #: _____

Viral Load Records	If none are available, check box at right: ☐ No viral load count on record	
Viral Load Count	**Viral Load Undetectable**	**Date**
	☐ Yes ☐ No ☐ Unknown	
	☐ Yes ☐ No ☐ Unknown	
	☐ Yes ☐ No ☐ Unknown	

Does client have any other medical conditions requiring treatment? ☐ Yes ☐ No ☐ Unknown

If Yes, **what condition(s)?** *(Check all that apply)*

- ☐ Cancer
- ☐ Diabetes
- ☐ Heart disease/hypertension
- ☐ Liver disease
- ☐ Other (Specify: _____)
- ☐ Kidney disease
- ☐ Hepatitis C
- ☐ Tuberculosis (TB)
- ☐ Asthma

Has client ever received a mental health diagnosis? ☐ Yes ☐ No ☐ Unknown

If Yes, **what diagnosis or diagnoses?** *(Check all that apply)*

- ☐ Depression
- ☐ Anxiety disorder (panic, GAD, etc.)
- ☐ PTSD
- ☐ Other (Specify: _____)
- ☐ Bipolar disorder
- ☐ Psychosis (schizophrenia, etc.)
- ☐ HIV-associated dementia

2. **Antiretroviral Treatment (ART) Review** *Chart Review or Client Interview*

Is client currently prescribed ART? ☐ Yes ☐ No

If client is not on ART, **why is the client not currently prescribed ART?** *(check only one)*

- ☐ Not medically indicated
- ☐ Payments/insurance/cost issue
- ☐ Not ready—by PCP determination
- ☐ Client refused
- ☐ Intolerance/side effects/toxicity
- ☐ Other reason
- ☐ Unknown

STEPS TO CARE

Client Name: _____

Client Record #: _____

3. Client Information

Client Interview

Total Number in Household: *(including the client)* _____

Current Employment Status: *(check only one)*

- ☐ Full-time
- ☐ Part-time
- ☐ Unemployed
- ☐ Unpaid volunteer/peer worker
- ☐ Out of workforce
- ☐ Other (Specify: _____)
- ☐ Declined

Highest Level of Education Achieved: *(check only one)*

- ☐ No schooling
- ☐ 8th grade or less
- ☐ Bachelors/technical degree
- ☐ High school/GED or equivalent
- ☐ Some college
- ☐ Declined
- ☐ Postgraduate
- ☐ Some high school

Primary Language Spoken (i.e., at home): *(check only one)*

- ☐ English
- ☐ Spanish
- ☐ Other (Specify: _____)
- ☐ Declined

If Primary Language Is Not English: **Secondary Language Spoken:** *(check only one)*

- ☐ English
- ☐ Spanish
- ☐ Other (Specify: _____)
- ☐ Declined

Country of Birth: *(check only one)*

- ☐ USA
- ☐ US territory/dependency
- ☐ Other country (Specify: _____)
- ◯ Puerto Rico
- ◯ Other (Specify: _____)
- ☐ Declined

If not USA, ask: **In what month and year did you first come to the USA?** _____ (mm/yyyy)

- ☐ Declined

4. Insurance Information

Chart Review or Client Interview

Insurance Status:

- ☐ Uninsured
- ☐ Insured

(If Insured, complete insurance details below. Otherwise, skip to Section 5: Financial Information)

Check all that apply, and complete the related details/dates on each checked insurance type:

Insurance Type	Insurance details	Effective Date	End/Expiration Date
☐ Private	*(check only one)* ☐ Employer plan ☐ Individual plan	_____	_____ ☐ Unknown ☐ N/A
☐ ADAP/ADAP+	*(check all that apply)* ☐ ADAP (Rx Coverage) ☐ ADAP Plus	_____	_____ ☐ Unknown ☐ N/A
☐ Medicaid or CHIP	*(check only one plan type)* ☐ SNP (special needs plan) ☐ MCO (managed care organization) ☐ FFS (fee-for-service) ☐ Not sure which type	_____	_____ ☐ Unknown ☐ N/A
☐ Medicare		_____	_____ ☐ Unknown ☐ N/A
☐ Military, VA, Tricare		_____	_____ ☐ Unknown ☐ N/A
☐ IHS (Indian Health Service)		_____	_____ ☐ Unknown ☐ N/A
☐ Other Public Insurance		_____	_____ ☐ Unknown ☐ N/A

5. **Financial Information** *Client Interview*

What is your annual household income? $_____ per year

STEPS TO CARE

Client Name: _____

Client Record #: _____

We will be asking you questions in the next section about substance use. Some of these questions may seem personal in nature, but we ask them of everyone in this program.

» Please answer honestly. You may refuse to answer a question; refusing will not affect your care.

» Please feel free to ask if you need any of the questions explained to you.

» If you do not want to answer a question now, please tell me and we will return to it another time.

6. **Use of Prescriptions, Injectables, and Other Substances** *Client Interview*

Have you used any of the following substances? *Read the list starting with tobacco.*				
Substance	**…have you ever used this?**	*If ever used it, ask:* **In the past 3 months?**	*For use in past 3 months, ask:* **How often do you use?**	*For use in past 3 months, ask:* **How have you taken this?** *(check all that apply)*
Haven't used any		** If haven't used any substance **EVER**, skip to Section 7.*		
Tobacco	☐ Yes ☐ No ☐ Declined	☐ Yes ☐ No ☐ Declined	____ cigarettes smoked weekly (for other forms of tobacco, # times used weekly) or ☐ < weekly ☐ Declined (reminder: 1 pack = 20 cigarettes)	☐ Orally (chewing tobacco) ☐ Smoked ☐ Inhaled/snorted (snuff) ☐ Declined (no answer)
Alcohol	☐ Yes ☐ No ☐ Declined	☐ Yes ☐ No ☐ Declined	____ drinks weekly or ☐ < weekly ☐ Declined	
Marijuana	☐ Yes ☐ No ☐ Declined	☐ Yes ☐ No ☐ Declined	____ times weekly or ☐ < weekly ☐ Declined	☐ Orally (eaten/swallowed) ☐ Smoked ☐ Declined (no answer)
PCP/ Hallucinogens	☐ Yes ☐ No ☐ Declined	☐ Yes ☐ No ☐ Declined	____ times weekly or ☐ < weekly ☐ Declined	☐ Orally (eaten/swallowed) ☐ Smoked ☐ Inhaled/snorted ☐ Injected ☐ Declined (no answer)
Crystal Meth	☐ Yes ☐ No ☐ Declined	☐ Yes ☐ No ☐ Declined	____ times weekly or ☐ < weekly ☐ Declined	☐ Orally (eaten/swallowed) ☐ Smoked ☐ Inhaled/snorted ☐ Injected ☐ Declined (no answer)

Cocaine/Crack	☐ Yes ☐ No ☐ Declined	☐ Yes ☐ No ☐ Declined	____ times weekly or ☐ < weekly ☐ Declined	☐ Orally (eaten/swallowed) ☐ Smoked ☐ Inhaled/snorted ☐ Injected ☐ Declined (no answer)
Heroin	☐ Yes ☐ No ☐ Declined	☐ Yes ☐ No ☐ Declined	____ times weekly or ☐ < weekly ☐ Declined	☐ Orally (eaten/swallowed) ☐ Smoked ☐ Inhaled/snorted ☐ Injected ☐ Declined (no answer)
Rx Pills to Get High	☐ Yes ☐ No ☐ Declined	☐ Yes ☐ No ☐ Declined	____ times weekly or ☐ < weekly ☐ Declined	☐ Orally (eaten/swallowed) ☐ Smoked ☐ Inhaled/snorted ☐ Injected ☐ Declined (no answer)
Hormones/ Steroids	☐ Yes ☐ No ☐ Declined	☐ Yes ☐ No ☐ Declined	____ times weekly or ☐ < weekly ☐ Declined	☐ Orally (eaten/swallowed) ☐ Patch ☐ Injected ☐ Declined (no answer)
Anything Else: _____	☐ Yes ☐ No ☐ Declined	☐ Yes ☐ No ☐ Declined	____ times weekly or ☐ < weekly ☐ Declined	☐ Orally (eaten/swallowed) ☐ Smoked ☐ Inhaled/snorted ☐ Injected ☐ Declined (no answer)

If client has, at this interview, reported injecting any substance listed in the table above, select "Yes" to the question below and select "in the past 3 months" beneath that. Ask the client directly about sharing injection equipment.

Have you ever injected any drug or substance? *If No, go to Section 7.*

☐ Yes ☐ No ☐ Declined

If Yes, **when was the last time you injected any substance?**

☐ In the past 3 months
☐ Between 3 and 12 months ago
☐ More than 12 months ago
☐ Declined

If the client reported any injection behavior in the past 3 months, ask:

Do you currently receive clean syringes from a syringe exchange program or pharmacy?

☐ Yes ☐ No ☐ Declined

Have you ever shared needles or injection equipment with others?

☐ Yes ☐ No ☐ Declined

If Yes, **when was the last time you shared needles or injection equipment?**

☐ In the past 3 months
☐ Between 3 and 12 months ago
☐ More than 12 months ago
☐ Declined

7. **Living Arrangement/Housing Information** *Client Interview*

Are you currently enrolled in a housing assistance program?

☐ Yes ☐ No ☐ Declined
If Yes, **agency:** _____ ☐ Unknown

What is your current living situation? *(check only one box at left)*

☐ Homeless/Place not meant for human habitation (such as a vehicle, abandoned building, or outside)
☐ Emergency shelter (non-SRO hotel)
☐ Single room occupancy (SRO) hotel
☐ Other hotel or motel (paid for without emergency shelter voucher or rental subsidy)
☐ Supportive housing program *If checked, complete the indented detail questions below:*
  ☐ Transitional congregate
  ☐ Transitional scattered-site
  ☐ Permanent congregate
  ☐ Permanent scattered-site
  HIV housing program? ☐ Yes ☐ No
☐ Room, apartment, or house that you rent (not affiliated with a supportive housing program)
☐ Staying or living in someone else's (family's or friend's) room, apartment, or house
☐ Hospital, institution, long-term care facility, or substance abuse treatment/detox center
☐ Jail, prison, or juvenile detention facility
☐ Foster care home or foster care group home
☐ Apartment or house that you own

Since what date have you been living in your current situation?	_____ (mm/yyyy) Or select one of the following: ☐ Unknown ☐ Declined
How long do you expect to be in your current living situation? If you do not know, what is your best guess? *(check only one)*	☐ At least 1 year ☐ 1 month—<6 months ☐ 6 months—<12 months ☐ < 1 month
Were you ever homeless?	☐ Yes ☐ No ☐ Declined
If Yes, **when were you last homeless?**	_____(mm/yyyy)

Do not ask if client is homeless:

What are your current housing issues? *(check all that apply)*

- ☐ Cost
- ☐ Doubled-up in the unit
- ☐ Health or safety concerns
- ☐ Eviction or pending eviction
- ☐ Expanding household (e.g. newborn)
- ☐ N/A
- ☐ Space/configuration (e.g. too small)
- ☐ Conflict with others in household
- ☐ Release from institutional setting
- ☐ Other (Specify: _____)

8. **Legal and Incarceration History** *Client Interview*

Have you ever served any time in jail, prison, or juvenile detention (JD)?	☐ Yes	☐ No	☐ Declined
If Yes, **have you served any time in the past 12 months?**	☐ Yes	☐ No	☐ Declined
Are you currently on parole/probation?	☐ Yes	☐ No	☐ Declined

Client Name: _____

Client Record #: _____

Notes:

Staff Member Completing Form: _____ _____ **Date:** _____

Name Signature