STEPS TO CARE

Part 1: Logistics for Patient Navigation and Contact Information Form

Client Name: _____ Client Record #: _____

Complete this form as part of the intake process along with the Intake Assessment Form.
Update both Parts 1 and 2 of this form as needed.

Before you begin your work with the staff for this home-based support program, we have a few questions that will help us meet your needs for privacy and comfort as a client.

1. **Client will be enrolled in:**

☐ Quarterly Patient Navigation/HIV Self-Management (no ART) ☐ Quarterly Patient Navigation/HIV Self-Management

☐ Monthly Patient Navigation/HIV Self-Management ☐ Weekly Patient Navigation/HIV Self-Management

2. **What days and times are best for you to meet with someone from this program?**

Check as many days as the client says he or she can meet, and fill in available times for each checked day.

Day(s) of Week:	Time(s) of Day:
☐ Monday	
☐ Tuesday	
☐ Wednesday	
☐ Thursday	
☐ Friday	
☐ Saturday	
☐ Sunday	
☐ Other answer (Specify: _____)	

If the patient is not enrolled in Weekly:

2a. **Which week of the month is best for your Patient Navigator visit?**

☐ Any ☐ First ☐ Second ☐ Third ☐ Fourth ☐ Last

3. **Are there any days or times when you will not be available for a meeting with someone from this program?**

_____

4. **Where would you most like to meet for adherence support?** *Read choices:*

☐ At home

☐ At another person's home (Specify the home and relationship: _____)*

☐ Client's PCP clinic within the Care Coordination Program

☐ Other location (Specify: _____)*

**Please specify location in Part 2: Contact Information*

5. **Where do you store your medications?** _____

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Client Name: _____

Client Record #: _____

6. **Is anyone routinely involved in your care who could support your participation in this program?**
☐ YES ☐ NO

6a. **If YES, who is that person?****

First Name: _____ Relationship to Patient: _____

***If named, please refer back to the person when completing Part 2: Contact Information*

Complete this section only if client indicated preference to meet in their own or someone else's home in Question 4:

7. **In the home where you would like to meet, is there anyone who does NOT know your HIV status?**
☐ YES ☐ NO

7a. **If YES, what is their relationship to you?** _____

7b. **Should we visit you at home WITHOUT that person or those people?**
☐ YES ☐ NO

7bi. **If YES, what times and days are appropriate?**

_____

8. **Where in the home do you want to do the visits?**
☐ Living Room ☐ Kitchen ☐ Other (Specify: _____)

9. **For reasons of confidentiality, how would you like the Patient Navigator to identify him- or herself when calling or visiting you?** *(For example, should they go by their first name, say they are a friend, or say they "work with so-and-so?")*

_____

10. **What else would you like us to know about how to work with you at home and protect your confidentiality?**

_____

INTRO: I have a few additional questions, which will help us to tailor our work with you in a way that should fit your needs and comfort level. By giving your most honest answers, you will help us to better serve you.

11. **How comfortable are you reading English?**
☐ Not at all ☐ Somewhat ☐ Very

12. **How comfortable are you writing in English?**
☐ Not at all ☐ Somewhat ☐ Very

13. **Are you comfortable reading or writing in another language?**
☐ Yes, in reading (Specify: _____)
☐ Yes, in writing (Specify: _____)
☐ Yes, in both reading and writing (_____)
☐ No

Program Staff Completing Form:

_____ _____ Date _____
Name Signature

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Client Name: _____

Client Record #: _____

Patient Navigator Assignment Questions:

Complete this section only if a Patient Navigator has not yet been assigned.

14. **Do you have a preference for the gender of your Patient Navigator?**

☐ No Preference ☐ Male ☐ Female ☐ Other (Specify: _____)

15. **What language do you prefer for regular communication with your Navigator?**

☐ English ☐ Other (Specify: _____)

16. **Patient Navigator Assigned (Name):** _____ as of _____

Program Staff Completing Form:

_____ _____ Date _____

Name Signature

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Part 2: Contact Information

Client Name: _____ Client Record #: _____

Complete this form at baseline and any time there is a change in address or alternate contact. ***This section is to be used solely for the purpose of locating a client if they fall out of contact. Do not reveal patient health, program, or HIV status information to any contact listed below.***

Current Home Address:

Street: _____ **Apartment/Unit:** _____

City: _____ **State:** _____ **Home ZIP Code:** _____

Mailing Address: ☐ **Same as Current Home Address**

Street: _____ **Apartment/Unit:** _____

City: _____ **State:** _____ **Mail ZIP Code:** _____

Home Visit Location: ☐ **Same as Current Home Address** ☐ **Same as Mailing Address**

Street: _____ **Apartment/Unit:** _____

City: _____ **State:** _____ **ZIP Code:** _____

Primary Telephone Number: _____

Alternate Telephone Number: _____

Primary E-mail: _____

Alternative Contacts

One of the goals of this program is to help you remain in good health. For this purpose, we may need to attempt to contact you in places other than your home. I'm going to ask you a few questions about how I may contact you in case we lose touch while you are enrolled in this program. If and when we reach out to you through these contacts, we will not reveal any information about your health.

1) **Other than home, where (or with whom) do you "hang out" most often?**

Contact 1 Name or Location: _____

Relationship, if applicable: _____

Street or Intersection: _____ Apartment/Unit: _____

City: _____ State: _____ ZIP Code: _____

Primary Telephone Number: _____

Alternate Telephone Number: _____

Primary E-mail: _____

Program Staff Completing Form:

_____ _____ Date _____

Name Signature

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Client Name: _____

Client Record #: _____

2) *If applicable,* **could we contact the person you identified as someone who is routinely involved in your care? If yes, what is their information?**

Contact 2 Name: _____

Relationship: _____

Street: _____ Apartment/Unit: _____

City: _____ State: _____ ZIP Code: _____

Primary Telephone Number: _____

Alternate Telephone Number: _____

Primary E-mail: _____

3) **Who would often know where you are when you are not at home?** (*This could include any parole/probation officer*)

Contact 3 Name: _____

Relationship: _____

Street: _____ Apartment/Unit: _____

City: _____ State: _____ ZIP Code: _____

Primary Telephone Number: _____

Alternate Telephone Number: _____

Primary E-mail: _____

4) **Who do you expect to continue to know you and where you live/hang out, one year from now?**

Contact 4 Name: _____

Relationship: _____

Street: _____ Apartment/Unit: _____

City: _____ State: _____ ZIP Code: _____

Primary Telephone Number: _____

Alternate Telephone Number: _____

Primary E-mail: _____

Program Staff Completing Form:

_____ _____ Date _____

Name Signature

5) **Is there anyone else who is close to you and could help us get in touch with you?**

Contact 5 Name: _____

Relationship: _____

Street: _____ Apartment/Unit: _____

City: _____ State: _____ ZIP Code: _____

Primary Telephone Number: _____

Alternate Telephone Number: _____

Primary E-mail: _____

Program Staff Completing Form:

_____ _____ Date _____

Name Signature