STEPS TO CARE

Reassessment Form

Client Name: _____ Client Record #: _____

Reassessment Date: ____ / ____ / ____ (mm/dd/yyyy)

Program Staff: Re-assess clients at least every six months. When completing this interview/chart review, you should have the intake or previous assessment available for reference. Clients may need to be reminded of responses on the previous assessment in order to report accurately on what has changed. For items collected via client interview, mention the date of the last assessment, and explain that, except where otherwise specified, you will be asking about any changes since that date.

Data elements surrounded by a double border are required.

1. Clinical Information—Labs

Chart Review or Client Interview

CD4 tests since last update	*If none are available, check box at right:*	☐ No new CD4 count on record
CD4 count	**CD4 %** *(optional)*	**Date (mm/dd/yyyy)**
		_____/_____/_____
		_____/_____/_____
		_____/_____/_____

Viral Load tests since last update	*If none are available, check box at right:*				☐ No new VL on record
Viral Load count	**Viral Load Undectable**				**Date (mm/dd/yyyy)**
	☐	Yes	☐ No	☐ Unknown	_____/_____/_____
	☐	Yes	☐ No	☐ Unknown	_____/_____/_____
	☐	Yes	☐ No	☐ Unknown	_____/_____/_____

2. Antiretroviral Treatment (ART) Review

Has client had any change in ART status or ART regimen (e.g., started or stopped any antiretroviral medication) since the last assessment? ☐ Yes ☐ No

If yes, **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	☐ Not ready – by PCP determination	☐ Intolerance/side effects/toxicity
☐ Payment/insurance/cost issue	☐ Client refused	☐ Other reason ☐ Unknown

3. HIV/AIDS Status Information

Most Recent HIV Status: *(Check only one)*

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

If AIDS, AIDS Diagnosis Date: _____/_____/_____ (mm/dd/yyyy)

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

Has client received or newly reported any other medical conditions requiring treatment since last assessment?

- ☐ Yes
- ☐ No
- ☐ Unknown

If Yes, **What condition(s)?** *(check all that apply)*

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

Has client received or newly reported a mental health diagnosis since last assessment?

- ☐ Yes
- ☐ No
- ☐ Unknown

If Yes, **What diagnosis or diagnoses?** *(check all that apply)*

- ☐ Depression
- ☐ Anxiety Disorder (Panic, GAD, etc.)
- ☐ PTSD
- ☐ Bipolar Disorder
- ☐ Psychosis (Schizophrenia, etc.)
- ☐ HIV-associated Dementia
- ☐ Other (Specify: _____)

5. **Client information** *Client Interview*

Has your employment status changed since the last assessment? ☐ Yes ☐ No

If No, go to Section III.

If Yes, please complete the following:

Current employment status: *(check only one)*

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

6. Insurance Information

Chart Review or Client Interview

Has your insurance status changed since the last assessment?	☐ Yes	☐ No
If Yes, **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 (mm/dd/yyyy)	End/Expiration Date (mm/dd/yyyy)
☐ 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

STEPS TO CARE

Client Name: _____

7. **Financial Information** *Client Interview*

What is your annual household income? $_____ per year

We will be asking you questions in the next two sections about substance use and sexual behaviors. 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

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

Substance	Used in the past 3 months?	How often do you use?	How have you taken this? *(Check all that apply)*
Haven't used any		** If haven't used any substance **IN THE PAST 3 MONTHS**, skip to Section VI.*	
Tobacco	☐ 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	____ drinks weekly or ☐ < weekly ☐ Declined	
Marijuana	☐ Yes ☐ No ☐ Declined	____ times weekly or ☐ < weekly ☐ Declined	☐ Orally (eaten/swallowed) ☐ Smoked ☐ Declined (no answer)
PCP/ Hallucinogens	☐ Yes ☐ No ☐ Declined	____ times weekly or ☐ < weekly ☐ Declined	☐ Orally (eaten/swallowed) ☐ Smoked ☐ Inhaled/snorted ☐ Injected ☐ Declined (no answer)
Crystal Meth	☐ Yes ☐ No ☐ Declined	____ times weekly or ☐ < weekly ☐ Declined	☐ Orally (eaten/swallowed) ☐ Smoked ☐ Inhaled/snorted ☐ Injected ☐ Declined (no answer)

Cocaine/Crack	☐ Yes ☐ No ☐ Declined	___ times weekly or ☐ < weekly ☐ Declined	☐ Orally (eaten/swallowed) ☐ Smoked ☐ Inhaled/snorted ☐ Injected ☐ Declined (no answer)
Heroin	☐ 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	___ times weekly or ☐ < weekly ☐ Declined	☐ Orally (eaten/swallowed) ☐ Smoked ☐ Inhaled/snorted ☐ Injected ☐ Declined (no answer)
Hormones/ steroids	☐ Yes ☐ No ☐ Declined	___ times weekly or ☐ < weekly ☐ Declined	☐ Orally (eaten/swallowed) ☐ Patch ☐ Injected ☐ Declined (no answer)
Anything else: _____	☐ 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 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 VII.*

☐ 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

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

Has your insurance status changed since the last assessment? ☐ Yes ☐ No

If No, go to Household Composition questions

If Yes, please complete the following questions:

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 (month and year) 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
Have you been homeless any time since your last assessment?	☐ 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: _____)

HOUSEHOLD COMPOSITION

Has there been any change in who lives with you (any change in your household)? *If No, go to Section VII. If Yes, continue:* ☐ Yes ☐ No

Total number in Household (including the client): _____

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

In the past 3 months, have you ever served any time in jail, prison, or juvenile detention (JD)?	☐ Yes	☐ No	☐ Declined
If No, **Have you served any time in the past 12 months?**	☐ Yes	☐ No	☐ Declined
Are you currently on parole/probation?	☐ Yes	☐ No	☐ Declined

If client served any time in New York State, enter the NYSID [unique identifier assigned by the New York State Division of Criminal Justice Services (DCJS)]. This is an eight-digit number followed by one-character alpha (letter). Note: if the client has an old NYSID (with only 7 digits plus the letter at the end), insert a zero (0) at the start to reach 8 digits.

NYSID: _____ *Entered via eSHARE Common Demographics screen*

Notes:

Staff Member Completing Form:	_____	_____	**Date:** ___/___/___
	Name	Signature	mm/dd/yyyy