AARC Client Intake Summary Form

Date of Initial Contact:________________ Staff Name:_________________________

Name of Assigned Case Manager/Client Advocate:____________________________

MMN URN___________________________ARIES ID__________________________

Office Use Only

Client Information

Last Name:_________________________ Date of Birth: _____________ Age:_____

First Name:________________Initial:____ SS number:_________________________

Address:___________________________

City: ______________________________

State: _________ Zip:__________

Mailing Address: Same as residence:☐

____

____

May we contact you by mail? ☐ Yes ☐ No

Should mail be confidential? ☐Yes ☐ No

Email: ______________________________

Allow contact email? ☐Yes ☐ No

Confidential? ☐ Yes ☐ No

Gender: ☐Male ☐ Transgender MTF ☐Female ☐Transgender FTM ☐Not listed:________

Ethnicity:

☐(Non-Hispanic) White
☐ Hispanic
☐ (Non-Hispanic) Black
☐ American Indian/Eskimo/Aleut
☐ Asian Pacific Islander

Veteran:

☐ Yes
☐ No

Telephone

Cell Ph: (____)____________
Allow calls? ☐Yes ☐ No
Allow Texts? ☐ Yes ☐ No
Confidential? ☐ Yes ☐ No
Messages Ok? ☐ Yes ☐No

Hm/Wk Ph: (____)____________
Allow calls? ☐Yes ☐ No
Allow Texts? ☐ Yes ☐ No
Confidential? ☐ Yes ☐ No
Messages Ok? ☐ Yes ☐No

Emergency Contact

Name:______________________
Relationship:________________
Aware of Dx? ☐ Yes ☐ No
Telephone: (____)____________
Confidential? ☐ Yes ☐ No
Messages Ok? ☐ Yes ☐ No

Services needed

Would you like to talk to someone about anything listed below?

☐ Food/Clothing ☐ Finances/benefits ☐ Housing
☐ Transportation ☐ Condoms/Testing ☐ Substance use
☐ Counseling ☐ Domestic Violence ☐ Health Education
☐ Health Insurance

Is there anything else you would like to talk about today?

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AARC Staff Use Only

Do you receive Case Management services at any local resource? ☐ Yes ☐ No

If yes, where? ☐ SAAF ☐ Beat AIDS ☐ CHCS ☐ Haven for Hope ☐ Other: _________

Total number in client's household:_____

Client's monthly income:____________________ Income Source:____________________

Total Household income:____________________

Medical Information

HIV Dx Date:_________________

Other Medical conditions: ____

Within the past month have you been hospitalized? ☐ Yes ☐ No

Within the past 3 months have you been to the emergency room? ☐ Yes ☐ No

Date:of last doctor visit:________________Date of next doctor visit:________________

Doctor Name:________________________Facility Name:_______________________

Lab result: CD4__________ VL:_________

In the last month, I have missed medications dosages? ☐ Yes ☐ No

What Pharmacy do you use? _________________________________

AVITA Referral: ☐ Yes ☐ No

Do you have Insurance?: ☐ Yes ☐ No

Carrier/Type? ____

Ranking/Needs Assessment

Medical Case Management	Non-Medical Case Management	Client is Self-Sufficient
☐ Recently released from incarceration (6 months or more)	☐ Income less than 100% FPL (only for clients with income)	☐ Client is able to self-refer
☐ Homeless or no permanent address (on the streets)	☐ Unable to navigate System of Care due to language/illiterate	☐ Dental referral needed -offer self-referral form need (Private/VA/FACTS/ Centro Med)
☐ Untreated mental illness	☐ Homeless/Staying with family (i.e. Couch surfing)	NOTES:
☐ AIDS Diagnosis [CURRENT] CD4 < 200 Viral Load >10,000	☐ Transportation needs and is unable to schedule independently	
☐ Newly Diagnosed (E.I.S.)	☐ Housing assistance	
☐ Not in care/re-engaging in care	☐ Utility assistance	
☐ Non-adherent to HIV medication	☐ Employment/No Income	
☐ Unable to navigate System of Care due to language	☐ Needs community resources	Client Name:_________________
☐ Client does not have primary provider for HIV care (2 appts in last 12 months)	☐ Legal issues related to HIV	Client ID:____________________

Referred to: ☐Medical Case Mgmt CM Name:___________________________Appt. date/time:____________

☐Non-Medical Case Mgmt NMCM Name:________________________Appt. date/time:____________

☐EIS EIS Staff name:______________________

☐ AVITA----☐ Self-sufficient----☐ Provided Resource Guide----☐ Provided Self-Referral Form

Date of Initial Contact:_______________