Comprehensive Needs Assessment

Client:	Last Name	First Name	MI	Client ID
Assessment Date		MCM Name		

Medical Care						No Change?	
New to Care		Returning to Care		Established in Care			
None		Publicly funded clinic		Private Practice		Veterans Affairs	
		Hospital Outpatient		ER		Other	

Medical Care Providers					No Change?
Primary Physician	Address	Phone	Specialty	Last Seen	Next Appt.

History of Hospitalizations (Include Psychiatric and Substance Abuse)		No Change?
Illness	Date	Where

Other Illnesses and Opportunistic Infections						No Change?
Have you been diagnosed with an Opportunistic Infection?	Yes		No		Describe	
Have you been diagnosed with an STD?	Yes		No		Describe	
Have you been tested for TB? Please provide date/results.	Yes		No		Describe	
Have you been tested for Hepatitis A, B, C, and if yes, when?	Yes		No		Describe	
If female, are you pregnant? If yes, when is your due date?	Yes		No		Describe	
If female, when was your last pap smear (gynecological exam)?	Yes		No		Describe	
Other medical issues, such as high blood pressure, diabetes, etc.	Yes		No		Unknown	
If so, describe						

Current Health Status		No Change?
What is your latest Viral Load?	Date	
What is your latest CD4 count?	Date	

Current Medications including over the counter (OTC)			No Change?
Medication	Dosage	Frequency	Prescribed for

Any known drug allergies?	Yes		No		Describe

Pharmaceutical Providers		No Change?	
Name/Address		Phone	Fax

Medication Adherence				**No Change?**	
Do you take medications (including antiretroviral) as directed?	Yes		No		Describe
Do you require assistance taking your medications?	Yes		No		Describe
Do you have any problems with provider appointments?	Yes		No		Describe
Describe any problems or assistance you need with medications					

Oral Health	**No Change?**	
When was your last dental exam?	Your Provider?	
Dental concerns or issues?		

Mental Health Screening	**No Change?**	
Do you have a history of mental health diagnosis?	If yes, describe	
Have you ever been prescribed medication for a mental health condition?	If so, what condition	

Diagnosis	Treatment	Date	Provider	Phone

Are you taking medication for a mental health condition now?	If so, what medication(s)				
Have you ever been hospitalized for a mental health condition?	If so, explain				
Have you had any of the following in the past year?	Depression		Anxiety		Insomnia
	Forgetfulness		Delusions		Dementia
	Withdrawal/ isolation		Suicidal thoughts		Other
Who is your current mental health provider, if you have one?					
Would you like to be connected with a counsellor?	Yes		No		

Suicide Assessment				
Have you ever attempted to hurt yourself or others?	Yes		No	
Do you currently have thoughts of hurting yourself or others?	Yes		No	
If yes, do you have a specific plan?	Yes		No	
Do you have the means to carry out the plan?	Yes		No	

If there is a "yes" answer to any of last 3 questions, case manager must follow the agency emergency crisis protocol for appropriate response.

Substance Abuse/Addiction History and Screening	**No Change?**	
Are you currently using any substances?	Yes	No
If you have used substances within the past 6 months, please explain.		

Do you need assistance with any substance abuse issues now?	Yes ☐	No ☐

Nutrition	**No Change?** ☐	
Do you have a good appetite?	Yes ☐	No ☐
Have you lost or gained weight in the last 6 months? (>/<10lbs) lost	Yes ☐	No ☐
Are you currently seeing or do you need to see a nutritionist?	Yes ☐	No ☐

Housing				**No Change?** ☐
What are your current living arrangements?	☐ Rent home/apartment	☐ Transitional living facility/half-way house	☐ Homeless, on street/in car	
	☐ Living with family	☐ Nursing Home/medical facility, etc.	☐ Homeless, in shelter	
	☐ Own home	☐ Other	☐ Homeless, living with others	

Are you receiving housing assistance (HOPWA, public housing, Section 8)?	Yes ☐	No ☐
Do you need help finding affordable housing or shelter?	Yes ☐	No ☐
Do you have any concerns about current housing? If so, explain.		

Household			**No Change?** ☐
How long have you been living at your current residence?			Comment
How many adults live with you?			Comment
How many children live with you?			Comment
Is your name on the lease/mortgage?	Yes ☐	No ☐	Comment
Are there any household pets? Describe.			
Are all other household members aware of your status?	Yes ☐	No ☐	Comment
Do you have a living will and/or other advanced directives?	Yes ☐	No ☐	Comment
If you become unable to care for yourself, is there someone to help you?	Yes ☐	No ☐	Comment

Literacy					**No Change?** ☐
Primary Language:	English ☐	Need an interpreter? ☐	Difficulty speaking primary language? ☐	Difficulty writing primary language? ☐	
	Spanish ☐				
	Other ☐				
Have you been told you have a Developmental/Disability/ Cognitive Impairment? ☐		If yes, specify:			
		If Services are in place, specify:			

Education	**No Change?** ☐
Your highest level of education achieved	
Do you have other training? Describe.	

Insurance and Other Coverage				**No Change?** ☐
Have any type of insurance:	No ☐	Yes ☐	Don't Know ☐	
If yes, check all types that you currently have	Medicaid ☐	Medicare A/B ☐	Medicare D ☐	

	Private Ins ☐	Veterans Affairs/TriCare, Champa ☐
Other coverage		
Issues with understanding, navigating and using insurance benefits		
Needs help with health insurance enrollment		

Eligibility Period (See NOE for details)			**No Change?** ☐
From to	Redetermination due by		
Client is eligible and enrolled in	Ryan White ☐	ADAP ☐	HOPWA ☐

Daily Living Activities				**No Change?** ☐	
Do you need help with:	Yes	No	Comments (How much, how often, who helps)	Referral Needed	
				Yes	No
Personal care: Dressing	☐	☐		☐	☐
Personal care: Bathing	☐	☐		☐	☐
Personal care: Eating	☐	☐		☐	☐
Personal care: Toileting	☐	☐		☐	☐
Mobility	☐	☐		☐	☐
Transportation	☐	☐		☐	☐
Using the telephone	☐	☐		☐	☐
Shopping	☐	☐		☐	☐
Preparing Meals	☐	☐		☐	☐
Laundry	☐	☐		☐	☐
Light housekeeping	☐	☐		☐	☐
Heavy chores	☐	☐		☐	☐
Managing personal finances	☐	☐		☐	☐
Keeping track of appointments	☐	☐		☐	☐

Social Support				**No Change?** ☐	
Relationship (Spouse, partner, parent, child, sibling, friend, relative, pet, other)	Aware of HIV Status		Type of Support (ex. emotional/moral, financial, transportation, shelter, medical/adherence)	Signed release?	
	Yes	No		Yes	No
	☐	☐	Select	☐	☐
	☐	☐	Select	☐	☐
	☐	☐	Select	☐	☐
Are you getting services from any other agencies?					

Legal Issues						**No Change?** ☐
Do you have	Trust ☐	Will ☐	Physicians Directive ☐	Durable Power of Attorney ☐		

	Health Care Power of Attorney ☐	Living Will ☐	Guardian/Conservator for self/dependents ☐
Power of Attorney	Name		Phone
Legal Status	Arrest ☐	Conviction(s) ☐	Restraining Order ☐
	Name Change ☐	Immigration ☐	
	Change in legal status of relationship like marriage, separation or divorce ☐	Describe	

Sexual History/Risk Assessment			**No Change?** ☐
Are you sexually active?	Yes ☐	No ☐	
Is/are your partner(s) aware of your status?	Yes ☐	No ☐	
Is/are any of your sex partner(s) HIV positive? (Discuss test/treatment PrEP as needed)	Yes ☐	No ☐	
Are you using safe sex practices? Explain	Yes ☐	No ☐	
Are you having sex under the influence of drugs?	Yes ☐	No ☐	
Do you disclose HIV status to sexual partners?	Yes ☐	No ☐	
Do you have past or current experiences with sexually transmitted infections in addition to HIV?	Yes ☐	No ☐	
If so, have you been treated?	Yes ☐	No ☐	
If no, date of your last test			
Do you use needles for drugs, tattoos, piercings?	Yes ☐	No ☐	
Do you share needles?	Yes ☐	No ☐	
Have all your needle sharing partners been informed about your HIV status?	Yes ☐	No ☐	
How do you protect yourself and drug using partners?			

Information Services				**No Change?** ☐
Service Need	Date Identified	Referral Needed Yes	Referral Needed No	Referral Details
General HIV/AIDS Education Materials		☐	☐	
Specific OI/Treatment Modalities Information		☐	☐	
Safer Sex Practices		☐	☐	
Living with HIV/AIDS Education Materials		☐	☐	
Social Security and other Public Assistance		☐	☐	
Family Planning/Women's Health		☐	☐	
Other		☐	☐	

Assessment	☐	Case Manager Signature		Date
Reassessment	☐			

Case Manager must sign Assessment prior to uploading to CAREWare