RYAN WHITE MEDICAL CASE MANAGEMENT
PSYCHOSOCIAL ASSESSMENT

Medical case managers are responsible for meeting with clients annually and semi-annually to assess and evaluate client acuity in seventeen areas of functioning.

- Annually: Complete all questions and acuity tables to determine acuity in each of the seventeen areas of functioning. Document notes and complete the four appendices as needed.
- Semi-Annually: Complete all questions and acuity tables to determine acuity in each of the seventeen areas of functioning. Document notes and complete the four appendices as needed.

To evaluate acuity and score each functional area's acuity box:

- Utilize information gathered (*i.e.*, responses to questions on the psychosocial assessment and/or information obtained through direct interaction with the client within the past thirty (30) days) to evaluate client acuity.
- Check boxes in each functional area's acuity table according to what best corresponds with the client's current state (*e.g.*, the client may have three intensive needs and one self-management need and all four boxes should be checked accordingly). At minimum, at least one box should be checked in each of the functional area's acuity tables.
- Determine acuity level for each area of functioning by taking the highest level of need checked in the acuity table and documenting it next to annual or semi-annual review accordingly.
    - If two or more levels of need are checked for any area of functioning, the client should be assigned the number corresponding to the highest level of need for that area of functioning (*e.g.*, if two boxes are checked for basic need (4) and one box is checked for moderate (6), the level of need for the functional area would be moderate (6)).
    - The highest score the client may ever receive per functional area is eight (8) (*e.g.*, if three boxes are checked for intensive need (8), the score would be eight (8), not 24).

To determine the total annual/semi-annual acuity score:

- Total (add) the numbers from each area of functioning's annual or semi-annual score and document this number in the "total annual acuity score" or "total semi-annual acuity score" accordingly.
- Utilize the total acuity score result to determine the frequency of contact with the client. Clients with an acuity score of:
    - 45 - 99 are considered an "intensive effort case" and requires contact with the client monthly at minimum and more frequently as needed.
    - 21 - 44 are considered a "moderate effort case" and requires contact with the client every three months at minimum and more frequently as needed.
    - 2 - 20 are considered a "basic effort case" and requires contact with the client every six months at minimum and more frequently as needed.

ASSESSMENT SIGN-OFF & TOTAL ACUITY SCORE	Total Annual Score=	
	Total Semi-Annual Review Score =	

**Reminder*- Review intake information with client to confirm that it is up-to-date.*

Client Legal Name: _____ Client Date of Birth: _____/_____/_____

Case Manager Name: _____ Case Management Agency: _____

Date of Annual Assessment: _____/_____/_____ Date of Semi-Annual Review: _____/_____/_____

Annual Assessment:

_____ _____/_____/_____

Case Manager Signature Date

Semi-Annual Review:

_____ _____/_____/_____

Case Manager Signature Date

1. BASIC NEEDS	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the client's ability to independently obtain food and clothing and take care of activities of daily living.

Food and Clothing:

1. Do you have access to food? ☐ Yes ☐ No
2. Do you have access to appropriate clothing (*e.g.*, per season, per gender, clean)? ☐ Yes ☐ No
3. Do you utilize: ☐ Food Stamps ☐ Food Pantries ☐ Free Stores
4. Do you need help accessing assistance programs (*e.g.*, food stamps, WIC, pantries) to meet your basic needs (*e.g.*, food, clothing)? ☐ Yes ☐ No

   If YES: 4a. How frequently? _____

   4b. What resources do you use for food assistance? _____

Activities of Daily Living Skills (ADLs):

5. Do you experience difficulty with any of the following?

   5a. Feeding yourself ☐ Yes, Frequency: _____ ☐ No

   5b. Walking ☐ Yes, Frequency: _____ ☐ No

   5c. Getting in and out of a bed/chair ☐ Yes, Frequency: _____ ☐ No

   5d. Taking a bath/shower ☐ Yes, Frequency: _____ ☐ No

6. Do you have a caregiver (*i.e.*, someone who assists you with your activities of daily living)? ☐ Yes ☐ No

   If YES: 6a. How do they help you on a daily basis?

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 4	Annual	Review	Score = 6	Annual	Review	Score = 8
☐	☐	Food, clothing, and other items available through client's own means	☐	☐	Basic needs met on a regular basis with occasional need for help accessing assistance programs	☐	☐	Routinely needs help accessing assistance programs for basic needs	☐	☐	Has no access to food, or needs nutritional supplements
☐	☐	Has ongoing access to assistance programs that maintain basic needs consistently	☐	☐	Unable to routinely meet basic needs without emergency assistance	☐	☐	History of difficulties in accessing assistance programs	☐	☐	Without most basic needs
☐	☐	Able to perform ADLs independently	☐	☐	Needs assistance to perform some ADLs weekly	☐	☐	Often without food, clothing or other basic needs	☐	☐	Unable to perform most ADLs
						☐	☐	Needs daily in-home assistance with ADLs			

2. HOUSING	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the stability of the client's current housing situation, including safety, ability to meet payment responsibilities, risk for losing housing, and barriers towards obtaining/maintaining housing.

7. What is your past *(check all that apply)* and current living situation?

	Past	Current		Past	Current		Past	Current
Homeless/Street	☐	☐	Transitional Housing	☐	☐	Permanent Supportive Housing	☐	☐
Homeless/Emergency Shelter	☐	☐	Living with Relative/Friend	☐	☐	Renting Unsubsidized Apartment	☐	☐
Jail/Prison	☐	☐	Hospital/Medical Facility	☐	☐	Renting Subsidized Apartment	☐	☐
Hotel/Motel	☐	☐	Substance Abuse Treatment Facility	☐	☐	Owning House/Apartment	☐	☐
Other: _____				☐	☐			

8. Who do you currently live with? _____

9. Do you receive a housing subsidy and/or other form of financial assistance to pay your rent? ☐ Yes ☐ No

If YES: 9a. What rental assistance do you receive? _____

10. Do you access utility assistance (*e.g.*, HEAP, PIPP)? ☐ Yes ☐ No

If YES: 10a. What utility assistance do you receive? _____

If NO: 10b. Would you like assistance with enrolling into a utility assistance program? ☐ Yes ☐ No

11. Do you have, or are you at risk of receiving, an eviction notice? ☐ Yes ☐ No

12. Do you have, or are you at risk of receiving, a utility disconnection notice? ☐ Yes ☐ No

13. Is your current housing habitable? ☐ Yes ☐ No

If NO: 13a. What are your housing concerns? _____

14. Do you have any current issues with bed bugs or other pests/rodents? ☐ Yes ☐ No

If YES: 14a. Have you reported the issue to your landlord? ☐ Yes ☐ No

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 4	Annual	Review	Score = 6	Annual	Review	Score = 8
☐	☐	Clean, habitable, stable, affordable housing	☐	☐	Needs short-term assistance with rent/utilities to maintain stable housing	☐	☐	Eviction imminent	☐	☐	Homeless
			☐	☐	Housing is in jeopardy	☐	☐	Home completely uninhabitable due to health and/or safety hazards	☐	☐	Recently evicted
			☐	☐	Housing is marginally habitable	☐	☐	Living in shelter	☐	☐	Arrangements to stay with friends and family have fallen through
			☐	☐	Formerly independent person temporarily residing with friends or relatives, reasonably stable	☐	☐	Lives in transitional or temporary housing	☐	☐	Not able to live independently and needs referrals (refer to responses from basic needs, medical needs, mental health, and substance abuse sections)

3. MEDICAL NEEDS	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the client's quality of care to assure that the client is receiving comprehensive care, which will impact the client's HIV/AIDS, including primary, preventive, and specialty care.

If this is the client's first psychosocial assessment, complete the Client Historical Assessment (Appendix A) before proceeding

General Medical Care:

15. List the client's medical providers and date(s) of last visit (s) below:

Provider	Name of Provider(s)	Last Seen (Month/Year)
Primary Care		
HIV Specialist		
Other Specialists: (specify type) _____ _____ _____		

**If client identifies as transgender:*

15a. Do you need a referral and/or additional information on transgender health care? ☐ Yes ☐ No

16. Have you had any new diagnoses or medical changes in the past 6 months? ☐ Yes ☐ No

If YES: 16a. Please explain. _____

17. Have you ever been screened for Hepatitis C? ☐ Yes ☐ No ☐ Don't Know

If YES: 17a. Have you ever been diagnosed with Hepatitis C? ☐ Yes ☐ No

If YES: 17a1. Date of Diagnosis: _____/_____/_____

17a2. Have you ever been treated for Hepatitis C? ☐ Yes ☐ No

If YES: 17a2a. Date of Treatment: _____/_____/_____

If NO: 17b. Would you like to be screened for Hepatitis C? ☐ Yes ☐ No

18. Have you ever been screened for Syphilis? ☐ Yes ☐ No ☐ Don't Know

If YES: 18a. Have you ever been diagnosed with Syphilis? ☐ Yes ☐ No

If YES: 18a1. Date of Diagnosis: _____/_____/_____

18a2. Have you ever been treated for Syphilis? ☐ Yes ☐ No

If YES: 18a2a. Date of Treatment: _____/_____/_____

If NO: 18b. Would you liked to be screened for Syphilis? ☐ Yes ☐ No

Provide education on risk factors, transmission, signs, and symptoms

19. When did you have your last HIV-related labs drawn?

CD4 Count: _____ Viral Load: _____ ☐ Lab Values Pending

Date: _____/_____/_____ Date: _____/_____/_____ ☐ No Labs Drawn

20. Were you hospitalized in the past 6 months? ☐ Yes ☐ No

If YES: 20a. What was the reason(s) you were hospitalized? _____

21. Are you experiencing any current symptoms (*e.g.*, nausea, weight loss, night sweats)? ☐ Yes ☐ No

If YES: 21a. What symptoms are you experiencing? _____

MEDICAL NEEDS, continued

21b. Are you talking to your doctor about these symptoms? ☐ Yes ☐ No

If the client indicates they are not talking to a doctor, explore their plans to do so.

If NO: 21b1. How can I help you to facilitate this conversation? _____

Pregnancy Care:

22. Is there a chance that you or your partner might be pregnant? ☐ Yes ☐ No

If YES: 22a. Are you or your partner in prenatal care? ☐ Yes ☐ No

If YES: 22a1. Does your prenatal care provider know that you or your partner has HIV? ☐ Yes ☐ No

Cognitive Functioning:

23. Have you been diagnosed with a cognitive impairment? ☐ Yes ☐ No

If YES: 23a. Are you receiving care? ☐ Yes ☐ No

If YES: 23a1. Please explain. _____

24. Have you ever had problems with any of the following: *(check all that apply)*

☐ Memory ☐ Organization ☐ Confusion ☐ Other: _____

If YES: 24a. Please explain. _____

25. Have you ever had a head injury? ☐ Yes ☐ No

If YES: 25a. Please explain. _____

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 4	Annual	Review	Score = 6	Annual	Review	Score = 8
☐	☐	Stable health with access to ongoing HIV medical care	☐	☐	Needs primary care referral	☐	☐	Needs referral for treatment or medication for non-HIV related condition	☐	☐	Client is pregnant
☐	☐	Virally suppressed (Viral Load <40)	☐	☐	Short-term acute condition; receiving medical care	☐	☐	OI diagnosis or hospitalization within 6 months	☐	☐	Client post-partum (within 6 weeks of delivery)
			☐	☐	Chronic, non-HIV related condition is being treated with medication/treatment	☐	☐	Detectable viral load (>1000)	☐	☐	Newly diagnosed within last 6 months (refer to responses on the intake form)
			☐	☐	HIV symptomatic (*i.e.*, nausea, weight loss, night sweats) with one or more conditions that impair overall health	☐	☐	History of cognitive impairment – moderately functioning (TBI, Dementia)	☐	☐	CD4 < 200 (AIDS diagnosis) and detectable viral load >1000 and inconsistent or refusing meds
			☐	☐	Detectable viral load (40-1000)	☐	☐	Requires Part B pre-authorization for services	☐	☐	History of cognitive impairment – diminished functioning (TBI, Dementia)
									☐	☐	Needs immediate linkage to medical care due to acute problems related to low body weight, poor appetite, nausea, vomiting, or other urgent health issues that impact nutritional status

4. CARE & MEDICATION ADHERENCE	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the client's compliance with HIV/AIDS medications and its implications for transmission and drug resistance, including barriers towards taking medications, risk for transmitting the disease, and impact on quality of life from side effects from medications.

26. What medications have been prescribed to you and why?

List below, or attach a copy, of all medications prescribed to the client. Please specify in purpose section the reason the client is taking the medication. If the client indicates they are not taking medication(s) as prescribed, discuss methods to improve medication adherence.

Medication	Purpose	Frequency	Taken as Prescribed
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

27. Do you have any medication concerns? ☐ Yes ☐ No

If YES: 27a. What are your medication concerns?

28. How are you currently getting your prescriptions filled? _____

29. In the past 7 days, how many HIV medication doses have you missed? _____

If 1 or more: 29a. What were the circumstances that caused you to miss these doses?

_____

30. Where do you store your medications? _____

31. Are you experiencing any side effects with your medications? ☐ Yes ☐ No

If YES: 31a. Do you discuss these side effects with your health care provider? ☐ Yes ☐ No

If the client indicates they are not talking to a doctor, explore their plans to do so.

If NO: 31a1. How can I help you to facilitate this conversation? _____

32. In the past 6 months, have you missed any medical appointments? ☐ Yes ☐ No

If YES: 32a. How many medical appointments have you missed? _____

If 1 or more: 32a1. What were the circumstances that caused you to miss these appointments?

_____

CARE & MEDICATION ADHERENCE, continued

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 4	Annual	Review	Score = 6	Annual	Review	Score = 8
☐	☐	Adherent to medications as prescribed for 6 months without assistance	☐	☐	Newly diagnosed	☐	☐	Requires ongoing assistance for adherence to medications and treatment plan	☐	☐	Resistance/minimal adherence to medications and treatment plan even with assistance
☐	☐	Able to maintain primary care	☐	☐	Adherent to medications in the last 6 months with minimal assistance	☐	☐	Moderate adverse side effects that occasionally impact adherence	☐	☐	Refuses/declines to take medications against medical advice
☐	☐	Keeps medical appointments as scheduled	☐	☐	Has attended all HIV medical appointments in the last 6 months but may have missed an appointment within the last 12 months or has rescheduled multiple appointments	☐	☐	Misses several doses of scheduled HIV medications weekly	☐	☐	Medical care is sporadic due to many missed appointments (refer to responses from Medical Needs section)
☐	☐	Not currently being prescribed medications-not medically indicated				☐	☐	Takes long/extended "drug holidays" against medical advice	☐	☐	Only uses emergency department in lieu of primary care (refer to responses from Medical Needs section)
☐	☐	Expresses no issues with side effects or schedule				☐	☐	Has missed one or two HIV medical appointments in the last 6 months	☐	☐	Inability to take meds as scheduled; requires professional assistance to take meds and keep appointments
☐	☐	Can name or describe current medications and common side effects							☐	☐	Experiences significant adverse side effects that impacts adherence
☐	☐	Can identify the importance of medication adherence									

5. MENTAL HEALTH	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the client's mental health status and the impact of this status on client functioning in all areas of the client's life.

33. How do you manage difficult feelings or situations?

34. Do you have any current unmet mental health concerns or symptoms? ☐ Yes ☐ No

If YES: 34a. Please explain. _____

Use clinical judgement to determine if anxiety (GAD-7 Appendix B) and/or depression (PHQ-9 Appendix C) screens are needed and proceed accordingly.

35. Have you ever received a mental health diagnosis? ☐ Yes ☐ No

If YES: 35a. What was the diagnosis? _____

36. Have you ever been hospitalized for mental health concerns? ☐ Yes ☐ No

If YES: 36a. When were you hospitalized? _____

37. Are you currently linked to any mental health care provider(s)? ☐ Yes ☐ No

If YES: Record provider(s) in the table below.

If NO: 37a. Would you like a referral for mental health services? ☐ Yes ☐ No

Name of Provider(s)	Phone Number	Last Seen (Month/Year)

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 4	Annual	Review	Score = 6	Annual	Review	Score = 8
☐	☐	No history of mental illness, psychological disorders or psychotropic medications	☐	☐	Needs emotional support to avert crisis	☐	☐	Experiencing an acute episode and/or crisis*	☐	☐	Unable to adhere to prescribed psychiatric medications* (refer to responses from care and medication adherence section)
☐	☐	No need for counseling referral	☐	☐	History of mental health disorders/treatment in client	☐	☐	Clinical diagnosis with current mental health provider but inconsistent treatment compliance*	☐	☐	Danger to self or others**
			☐	☐	Clinical diagnosis with current mental health provider and consistent treatment compliance	☐	☐	History of inpatient mental health hospitalizations within last 12 months*	☐	☐	Needs immediate psychiatric assessment/evaluation/treatment**
			☐	☐	Client desires mental health services	☐	☐	Requires Part B pre-authorization for services	*Conduct an anxiety (GAD-7) and depression screen (PHQ-9) **Refer to immediate crisis intervention		
						*Conduct an anxiety (GAD-7) and depression screen (PHQ-9)					

6. SUBSTANCE ABUSE	Annual Score=	
	Semi-Annual Review Score=	

Evaluate how the client's substance use impacts their HIV care and functioning in all areas of the client's life.

38. Do you smoke cigarettes or use other nicotine products? ☐ Yes ☐ No

If YES: 38a. There are resources available to help you quit; would you be interested in a referral? ☐ Yes ☐ No

If YES: Educate and refer to the tobacco quit line, 1-800-QUIT-NOW.

39. Do you have any history with substance abuse? ☐ Yes ☐ No

If YES: 39a. Please describe.

40. Do you drink alcohol? ☐ Yes ☐ No

If YES: 40a. How often do you drink alcohol? _____

Based upon frequency of alcohol consumption, use your clinical judgement to determine if you should ask the following CAGE questions:

40b. Have you ever felt you should cut down on your drinking? ☐ Yes ☐ No

40c. Have people annoyed you by criticizing your drinking? ☐ Yes ☐ No

40d. Have you ever felt bad or guilty about your drinking? ☐ Yes ☐ No

40e. Have you ever had a drink first thing in the morning (as an "eye opener") to steady your nerves or get rid of a hangover? ☐ Yes ☐ No

If YES to 2 or more of the CAGE questions:

40f. There are resources available to help you quit; would you be interested in a referral? ☐ Yes ☐ No

41. Have you used drugs other than for medical reasons (*e.g.*, unprescribed medications, marijuana, methadone, crack, cocaine, ecstasy, heroin, etc.)? ☐ Yes ☐ No

If YES: 41a. What drugs (other than for medical reasons) are you using? _____

If YES: Ask the questions on the DAST-20 (Appendix D).

41b. Do you use needles to inject drugs? ☐ Yes ☐ No

If YES: Educate and refer to the needle access program (e.g., Safe Point through Equitas Health).

42. Have you ever been in a recovery program? ☐ Yes ☐ No

If YES: 42a. When were you in a recovery program? _____

43. Are you currently in a recovery program? ☐ Yes ☐ No

If YES: 43a. Recovery program name: _____

43b. Length of time in recovery program: _____

If NO: 43c. There are resources available for treatment assistance; would you be interested in a referral? ☐ Yes ☐ No

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

SUBSTANCE ABUSE, continued

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 4	Annual	Review	Score = 6	Annual	Review	Score = 8
☐	☐	No current or past issues with alcohol or drug use	☐	☐	Current or recent drug or alcohol use does not interfere with adherence to care, treatment, and/or activities of daily living but indicates need for additional support or regular check-in* (refer to responses from DAST-20)	☐	☐	Current or recent drug or alcohol use that sometimes interferes with adherence to HIV care and/or daily living (refer to responses from care and medication adherence section)	☐	☐	Chronic daily use or dependence that consistently interferes with adherence to HIV care and treatment and/or activities of daily living
☐	☐	In stable recovery with sufficient supports, and no indication of need for additional support	☐	☐	In recovery for 12 months or less	☐	☐	Currently or intermittently in substance abuse treatment	☐	☐	Refusal to connect to substance abuse treatment
			**Refer to AOD supportive services (e.g., AA, CA, NA)*			☐	☐	Indication of need for clinical substance use assessment	☐	☐	Doesn't acknowledge negative impact on health and safety from substance abuse
						☐	☐	Participating in a needle access program	☐	☐	Substance use while pregnant (refer to responses from care and medical needs section)
									☐	☐	Sharing needles; not participating in a needle access program

7. ORAL HEALTH	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the client's need for regular dental care and/or their ability/willingness to address dental issues as they arise.

44. Do you have a dentist? ☐ Yes ☐ No

If YES: 44a. What is the name of your dentist? _____

45. When was the last time you saw a dentist? Date of last visit: _____/_____/_____

46. Do you have any current dental health concerns (*e.g.*, pain, difficulty eating)? ☐ Yes ☐ No

If YES: 46a. What is the concern? _____

46b. Are you currently seeing a dentist to address this concern? ☐ Yes ☐ No

If applicable: 47. Would you be interested in a referral to a dentist? ☐ Yes ☐ No

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 3	Annual	Review	Score = 4	Annual	Review	Score = 5
☐	☐	Is currently in active dental care	☐	☐	Does not have a regular dentist	☐	☐	Reports episodic pain and/or sensitivity in teeth, gums or mouth	☐	☐	Current tooth, gum or mouth pain and severe discomfort
☐	☐	Has seen dentist in past six months	☐	☐	No dental insurance or needs co-pay assistance (refer to responses from health insurance and financial planning sections)	☐	☐	Missing days from work because of problems with teeth, gums or mouth	☐	☐	Very few or no teeth and no denture plan in place
☐	☐	No complaint of mouth, tongue, tooth or gum pain	☐	☐	Has not seen a dentist in more than six months	☐	☐	Observe appearance of dark, discolored teeth, missing teeth, bleeding, red gums or other problems with mouth	☐	☐	Client reports significant difficulty eating due to oral health problems
☐	☐	Client has means for paying for oral health care				☐	☐	Client reports episodic or moderate difficulty eating	☐	☐	Client has difficulty talking because of oral health problems
						☐	☐	Part B Dental pre-authorization required	☐	☐	Client needs emergency dental services

8. HEALTH INSURANCE	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the client's ability to independently enroll in and obtain health insurance coverage.

48 Do you have health insurance? ☐ Yes ☐ No

If YES: 48a. What is your primary type of insurance?

- ☐ Private – Employer
- ☐ Private – Individual (ACA)
- ☐ Medicare
- ☐ Medicaid/CHIP/other public plan
- ☐ Indian Health Service
- ☐ Veteran's Health Administration (VA, military health care (TRICARE), other military health care
- ☐ Other (not listed above): _____

If NO: 48b. Do you need assistance with obtaining health insurance coverage? ☐ Yes ☐ No

48c. Do you need assistance with obtaining prescription coverage? ☐ Yes ☐ No

49. Are you able to pay your physician co-pays? ☐ Yes ☐ No

50. Are you able to pay your prescription co-pays? ☐ Yes ☐ No

51. Are you able to pay your insurance premium? ☐ Yes ☐ No

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score =3	Annual	Review	Score = 4	Annual	Review	Score = 5
☐	☐	Has insurance/medical care coverage (refer to responses on Intake form)	☐	☐	Client needs information/ referral with accessing insurance or other coverage for medical/prescription costs	☐	☐	Needs direct assistance in accessing insurance or other coverage for medical costs	☐	☐	Needs immediate assistance in accessing insurance or other coverage for medical costs due to medical crisis (refer to responses from medical needs section)
☐	☐	Has ability to pay for care on own	☐	☐	Needs direct assistance with OHDAP application	☐	☐	Needs direct assistance with navigating complex insurance needs (refer to responses from care and medication adherence and financial planning/counseling sections)	☐	☐	Not currently eligible for insurance or public benefits
☐	☐	Can independently complete the OHDAP application				☐	☐	Needs assistance with co-pays	☐	☐	Needs assistance completing/follow-up with Rx exceptions

9. FINANCIAL PLANNING / COUNSELING	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the client's ability and barriers towards meeting their financial obligations and accessing benefit programs.

Education and Employment Information:

52. What is the highest level of education you completed?

☐ Some High School ☐ High School Diploma ☐ GED ☐ Some College
☐ Associate's Degree ☐ Bachelor's Degree ☐ Vocational Training ☐ Graduate Degree

53. Are you currently:

Enrolled in school	☐ Yes	☐ No	Enrolled in job training	☐ Yes	☐ No
Employed	☐ Yes	☐ No	Seeking employment	☐ Yes	☐ No
Retired	☐ Yes	☐ No			

If EMPLOYED: 53a. Average number of hours worked/week: _____

If applicable:

53b. Would you like a referral to employment resources? ☐ Yes ☐ No

53c. Would you like a referral to education resources? ☐ Yes ☐ No

53d. Has a doctor determined that you are medically unable to work? ☐ Yes ☐ No

Financial Information:

54. Do you have children or others who depend upon you financially? ☐ Yes ☐ No

If YES: Complete the chart below for all children and dependents, including those not living with the client.

Name	Age	Relationship to Client	Living with Client?	
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No

55. What is your source(s) of income? _____

If applicable: 55a. Do you need assistance with applying for benefits? ☐ Yes ☐ No

56. Has your source(s) of income changed in the last 6 months? ☐ Yes ☐ No

If YES: 56a. Please explain. _____

57. Are you able to pay for all of your monthly expenses? ☐ Yes ☐ No

58. Would you like help with developing a personal budget? ☐ Yes ☐ No

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

FINANCIAL PLANNING / COUNSELING, continued

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 3	Annual	Review	Score = 4	Annual	Review	Score = 5
☐	☐	Steady source of income which is not in jeopardy	☐	☐	Has steady source of income which is in jeopardy	☐	☐	No income or income is inadequate to consistently meet basic needs	☐	☐	Immediate need for emergency financial assistance
☐	☐	Able to meet monthly obligations	☐	☐	Occasional need for financial assistance	☐	☐	Unfamiliar with application process for benefits	☐	☐	Needs referral to representative payee (refer to responses from developmental disabilities section)
☐	☐	No financial planning or counseling required	☐	☐	Awaiting outcome of benefits applications	☐	☐	Unable to apply without benefit assistance	☐	☐	Benefits denied or under appeal and has no financial support
			☐	☐	Needs information about benefits, financial matters	☐	☐	Needs financial planning & counseling			

10. TRANSPORTATION	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the client's ability to get to medical appointments and other support service visits.

59. How do you get to your HIV-related appointments and services such as medical, mental health, food, etc.?

☐ Bus ☐ Personal Vehicle ☐ Ride from Family/Friend ☐ Cab ☐ Other: _____

60. Do you have difficulty arranging transportation? ☐ Yes ☐ No

If YES: 60a. What are the barriers in arranging transportation?

61. Can we assist you in accessing your eligible transportation resources (*e.g.,* Medicaid transportation, Ryan White bus passes/gas cards)? ☐ Yes ☐ No

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 3	Annual	Review	Score = 4	Annual	Review	Score = 5
☐	☐	Has own or other means of transportation consistently available	☐	☐	Has limited access to transportation	☐	☐	No means via self/others	☐	☐	Lack of transportation is a serious contributing factor to current crisis (refer to responses from medical needs section)
☐	☐	Can afford private or public transportation	☐	☐	Needs occasional assistance with finances for transportation	☐	☐	In area not served or under served by public transportation	☐	☐	Lack of transportation is a serious contributing factor to lack of regular medical care (refer to medical needs and care and medication adherence sections)
						☐	☐	Unaware of or needs help accessing transportation services	☐	☐	Consistently unreliable in coordinating transportation to and from appointments (refer to medical needs and care and medication adherence sections)
						☐	☐	Unable to use public transportation	☐	☐	Requires ongoing assistance for transportation
						☐	☐	Has physical or emotional challenges that limit ability to coordinate transportation (refer to responses from basic needs, mental health, and developmental disability sections)			

11. LANGUAGE & LITERACY

Annual Score=	
Semi-Annual Review Score=	

Evaluate the client's need for interpretation and translation services.

Review preferred language, need for an interpreter, and need for assistance with reading/writing on intake form to determine acuity level

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 3	Annual	Review	Score = 4	Annual	Review	Score = 5
☐	☐	Understands service system and is able to navigate it	☐	☐	Demonstrates basic understanding of information with some assistance	☐	☐	Needs appropriate interpretation services for medical/case management services	☐	☐	Always needs interpretation for all services
☐	☐	Language and literacy are not barriers to accessing services							☐	☐	Functionally illiterate

12. DEVELOPMENTAL DISABILITY

Annual Score=	
Semi-Annual Review Score=	

Evaluate the client's ability to manage their own affairs if living with a developmental disability.

62. Have you ever been diagnosed with a Developmental Disability? ☐ Yes ☐ No

If YES: 62a. Please explain. _____

63. Are you currently linked to a Developmental Disability service? ☐ Yes ☐ No

If YES: 63a. What Developmental Disability service do you receive? _____

If YES: 63b. What is the name of the agency that provides you with Disability Services? _____

64. Did you ever have problems in school? ☐ Yes ☐ No

If YES: 64a. Please explain. _____

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 3	Annual	Review	Score = 4	Annual	Review	Score = 5
☐	☐	No signs of impairment	☐	☐	Signs of impairment with no diagnosis	☐	☐	Diagnosis of Developmental (DD) Disability with DD Services in place	☐	☐	DD Diagnosis without DD Services
☐	☐	Has ability to function independently									

13. SAFETY	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the client's experience with, and level of risk for, emotional, physical, and/or sexual abuse, neglect, and/or human trafficking.

Remind the client that at this point in the assessment process, you would like to meet with them alone. Also, remind the client about confidentiality and its limits (e.g., mandated reporting).

If there is an indication of potential or current domestic violence, based upon your clinical judgement and/or responses to the following questions, review with the client options for referrals, such as domestic violence services, human trafficking outreach, rape crisis centers, mental health services, etc.

65. Do you currently have any personal safety concerns? ☐ Yes ☐ No

If YES: 65a. Please explain.

66. Have you been affected by domestic violence? ☐ Yes ☐ No

If YES: 66a. Please explain.

67. Is anyone hurting and/or threatening you, making you feel afraid, or forcing you to do something against your will?
☐ Yes ☐ No

If YES: 67a. Who and how? _____

68. Are you being forced by another person to engage in sexual acts to receive needs (*e.g.*, food, clothing, shelter, drugs, money, protection, etc.)? ☐ Yes ☐ No

If YES: 68a. Please explain. _____

69. Are your IDs or passports unwillingly being held by another person? ☐ Yes ☐ No

If YES: 69a. Please explain. _____

70. Have you ever been involved with Child Protective Services? ☐ Yes ☐ No

71. Have you ever been involved with Adult Protective Services? ☐ Yes ☐ No

72. Are there any firearms in your home? ☐ Yes ☐ No

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 3	Annual	Review	Score = 4	Annual	Review	Score = 5
☐	☐	No history or current instances of abuse or domestic violence	☐	☐	History, past relationships with violence	☐	☐	Agency(ies) involved due to signs of potential abuse (emotional, sexual, physical)	☐	☐	Medical, legal or outside intervention has occurred
☐	☐	Client feels safe				☐	☐	Reports current violent episodes	☐	☐	Life-threatening violence and/or abuse chronically and presently occurring*
						☐	☐	Unsafe history and pattern in current relationship	☐	☐	Volatile home environment
						☐	☐	Involvement with Child Protective Services	**Refer to domestic violence resources*		

14. SUPPORT SYSTEM	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the client's level of connectedness to others and need for assistance with disclosing their HIV status.

73. Who are the people you go to when you feel like you need support (*e.g.*, friends or family)?

74. How satisfied are you with your support system?

☐ Very Dissatisfied ☐ Dissatisfied ☐ Neutral ☐ Satisfied ☐Very Satisfied

If applicable: 74a. What could help to increase your satisfaction?

75. Who have you chosen to share your health status with? (*Include name and relationship to client*)

76. Is disclosing your health status something that you are considering? ☐ Yes ☐ No

If YES: 76a. Would you like support and/or resources on disclosing your diagnosis to family or friends? ☐ Yes ☐ No

77. Would you be interested in receiving information about social opportunities? ☐ Yes ☐ No

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 2	Annual	Review	Score = 3	Annual	Review	Score = 4
☐	☐	Indicates satisfactory social support	☐	☐	Indicates adequate support systems, but identified need for additional supports	☐	☐	Indicates inadequate support system	☐	☐	Indicates no identified support system
☐	☐	Has disclosed HIV status to all sexual and drug injection partners and household members (refer to substance abuse and legal issues sections)	☐	☐	Has disclosed HIV status to most members of the household and sexual or drug injection partners, but requests disclosure support (refer to substance abuse and legal issues sections)	☐	☐	Reports feeling isolated or unsupported in relationships	☐	☐	Has not disclosed HIV status to any members of the household including sexual and drug injection partners (potential barrier to medication adherence, risk for transmission) (refer to substance abuse and legal issues sections)
☐	☐	Does not identify disclosure of HIV status as a barrier to medication adherence				☐	☐	Has not disclosed HIV status to all members of the household, including some sexual or drug injection partners (potential barrier to medication adherence, risk for transmission) (refer to substance abuse and legal issues sections)	☐	☐	Death/loss of primary support person

15. SEXUAL HEALTH / RISK REDUCTION	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the client's sexual health risks as it relates to their overall health and well-being.

Inform the client that there are some basic things about sexual health that the medical case manager discusses with all clients when completing an assessment. While this topic may be uncomfortable, it is important to acknowledge sexuality and sexual relationships as important elements of an individual's overall health and well-being. Be sure to provide education surrounding risk reduction and methods to obtain safe sex protection (e.g., barrier protection, PrEP, etc.).

78. How many sex partners have you had in the past 6 months? _____

79. Do you have a significant other? ☐ Yes ☐ No

If YES: 79a. Is your partner HIV-positive? ☐ Yes ☐ No

If NO, not HIV-positive: 79a1. Are they on PrEP? ☐ Yes ☐ No

If NO, not on PrEP: 79a1a. Would they be interested in a referral? ☐ Yes ☐ No

80. In the past 6 months, which sexual activities have you engaged in? ☐ None

☐ Vaginal Sex	☐ with a Male	☐ with a Female	☐ with a Transgender person
☐ Anal Sex	☐ with a Male	☐ with a Female	☐ with a Transgender person
☐ Oral Sex	☐ with a Male	☐ with a Female	☐ with a Transgender person

81. In the past 6 months, how often have you used protection for:

Vaginal Sex	☐ Always (100%)	☐ Often (more than 50%)	☐ Seldom (less than 50%)	☐ Never (0%)	☐ N/A
Anal Sex	☐ Always (100%)	☐ Often (more than 50%)	☐ Seldom (less than 50%)	☐ Never (0%)	☐ N/A
Oral Sex	☐ Always (100%)	☐ Often (more than 50%)	☐ Seldom (less than 50%)	☐ Never (0%)	☐ N/A

82. In the past 6 months, were any of your partners?

☐ A person who is HIV positive
☐ An IV drug user
☐ A person who exchanges sex for drugs or money
☐ A person who you didn't know or only knew by first name

83. Do you have sex while drunk or high? ☐ Yes ☐ No

84. Do you have access to condoms? ☐ Yes ☐ No (*If NO: offer resources.)*

85. Do you have access to lube? ☐ Yes ☐ No (*If NO: offer resources.)*

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

SEXUAL HEALTH / RISK REDUCTION, continued

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 2	Annual	Review	Score = 3	Annual	Review	Score = 4
☐	☐	Abstaining from risky behavior by safer practices	☐	☐	Often uses protection during sex (more than 50%)	☐	☐	Seldom uses protection during sex (less than 50%)	☐	☐	Never uses protection during sex (0%)
☐	☐	Client has good understanding of risk reduction/transmission (refer to knowledge of HIV disease section)	☐	☐	Sero-discordant couple, partner is using PrEP or protection	☐	☐	Has access to protection and sometimes able to negotiate use	☐	☐	Engages in sex with multiple partners without protection
☐	☐	Understands the importance of preventing the spread of HIV (refer to knowledge of HIV disease section)	☐	☐	Sero-concordant couple, both virally suppressed	☐	☐	Sero-discordant couple, partner interested in PrEP or protection	☐	☐	No or limited access to protection, and unable to negotiate use with sexual partners
☐	☐	Understands the importance of avoiding reinfection (refer to knowledge of HIV disease section)							☐	☐	Sero-discordant couple, not using PrEP or protection
☐	☐	Engages in sex with one or multiple partners, always uses protection							☐	☐	Engages in commercial sex work (exchange for money, food, drugs, or survival)
☐	☐	Sero-discordant couple, virally suppressed client, partner is using PrEP or protection									

16. KNOWLEDGE OF HIV DISEASE	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the client's understanding of their diagnosis and the impact on their overall health.

86. Please explain your understanding and impact of the following on your overall health:

86a. CD4 Count:

86b. Viral Load:

86c. HIV Transmission:

87. What other questions can I help you answer regarding HIV/AIDS?

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 2	Annual	Review	Score = 3	Annual	Review	Score = 4
☐	☐	Verbalizes clear understanding about disease	☐	☐	Some understanding verbalized, but needs additional information in some areas	☐	☐	Limited understanding	☐	☐	Lack of understanding of HIV disease progression, etc.*
						☐	☐	Needs additional education to make informed decisions about health	☐	☐	Unable to make informed decisions about health*
						☐	☐	Newly diagnosed within past 12 months	☐	☐	Newly diagnosed within past 3 months
									*Refer to medical provider		

17. LEGAL ISSUES	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the client's legal needs, including involvement with the legal system and advance directives, as it relates to their overall care.

88. Do you have any current legal concerns? ☐ Yes ☐ No

If YES: 88a. Please explain.

89. Have you ever been incarcerated? ☐ Yes ☐ No

If YES: 89a. Where and when were you incarcerated? _____

90. Are you aware of the felonious assault law? ☐ Yes ☐ No *(Regardless of answer, explain the felonious assault law.)*

91. Do you have a durable power of attorney for healthcare? ☐ Yes ☐ No

If YES: 91a. Name: _____ Phone Number: _____

91b. Have there been any changes to your durable power of attorney? ☐ Yes ☐ No

If YES: 91b1. What is the new contact information for your durable power of attorney?

Name: _____ Phone Number: _____

92. Do you need assistance with any of the following? *(Check all that apply.)*

☐ Will ☐ Power of Attorney
☐ Guardianship ☐ Payee
☐ Health Care Proxy ☐ Other
☐ Living Will

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 2	Annual	Review	Score = 3	Annual	Review	Score = 4
☐	☐	No recent or current legal problems	☐	☐	Recent or current legal involvement	☐	☐	Present involvement in civil or criminal matters	☐	☐	Immediate crisis involving legal matters
☐	☐	Understands felonious assault law	☐	☐	Some understanding of the felonious assault law but needs additional education	☐	☐	Pending incarceration	☐	☐	Recently released from jail or federal prison
						☐	☐	Recently released from State prison	☐	☐	Currently residing in community based facility (*e.g.*, halfway house, residential treatment facility, etc.)

ADDITIONAL NOTES

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Appendix A: Client Historical Assessment

RYAN WHITE MEDICAL CASE MANAGEMENT
CLIENT HISTORICAL ASSESSMENT

Client Legal Name: _____ Client Date of Birth: _____/_____/_____

Case Manager Name: _____ Case Management Agency: _____

Client ID: _____ Date Assessment: _____/_____/_____

Have you ever been diagnosed with any of the following Opportunistic Infections (OIs)? ☐ No
Please see Appendix A for Glossary of Opportunistic Infections.

Diagnosis:	Date:
☐ Candida Esophagitis	
☐ Cryptococcal Meningitis	
☐ Cryptosporidiosis	
☐ Cytomegalovirus-eyes (CMV)	
☐ Disseminated Mycobacterium Avium Complex (MAC)	
☐ Encephalopathy (HIV Dementia)	
☐ Histoplasmosis	
☐ Invasive Cervical Cancer	
☐ Invasive Herpes Simplex infection	
☐ Isosporiasis (with diarrhea for more than a month)	
☐ Kaposi's Sarcoma (KS)	
☐ Lymphoma-type	
☐ Pneumocystis pneumonia (PCP)	
☐ Progressive Multifocal Leukoencephalopathy (PML)	
☐ Recurrent Bacterial Pneumonia	
☐ Retinitis (CMV)	
☐ Salmonella	
☐ T-cell count <200	
☐ Toxoplasmosis	
☐ Tuberculosis (TB)	
☐ Wasting Syndrome	
☐ Other:	

Have you ever been diagnosed with any of the following? ☐ No

Diagnosis:	Date:
☐ Cancer	
☐ Chlamydia	
☐ Cholesterol/Triglycerides	
☐ Chronic Yeast Infections	
☐ Diabetes	
☐ Epilepsy (seizure disorder)	
☐ Gonorrhea	
☐ Heart Disease	
☐ Hepatitis A	
☐ Hepatitis B	
☐ Hepatitis C	
☐ Herpes Simplex	
☐ Human Papillomavirus (HPV)	
☐ Hypertension	
☐ Liver Disease (Cirrhosis)	
☐ Other STDs: _____	
☐ Syphilis	
☐ TBI (Traumatic Brain Injury)	
☐ Other condition(s): _____	

APPENDIX A: GLOSSARY OF OPPORTUNISTIC INFECTIONS

Candida Esophagitis or Esophageal thrush is a yeast infection of the throat.

Cryptococcal meningitis is a fungal infection of the tissues covering the brain and spinal cord (meninges). Cryptococci's is not contagious and it is caused by a fungus.

Cryptosporidiosis (crypto) is an illness caused by a parasite. The parasite lives in soil, food and water. It may also be on surfaces that have been contaminated with waste. You can become infected if you swallow the parasite.

Cytomegalovirus (CMV) is a common virus that can infect almost anyone. Most people don't know they have CMV because it rarely causes symptoms. It is a part of the herpes virus family. Once a person has had a CMV infection, the virus usually lies dormant (or inactive) in the body, but it can be reactivated. The virus is more likely to be reactivated — and cause serious illness — in people who have weakened immune systems due to illness.

CMV retinitis is an infection that attacks the light-sensing cells in the retina. It is a serious disease that should be diagnosed and treated immediately, because it can lead to loss of vision, and in the worst cases, blindness.

Mycobacterium avium complex (MAC) is a group of bacteria that are related to tuberculosis. These germs are very common in food, water, and soil. MAC is an opportunistic infection that takes advantage of a weakened immune system. It can infect one part of your body, such as your lungs, bones, or intestines. This is called localized infection. It can spread and cause disease throughout your body. This is called disseminated infection.

Encephalopathy or HIV dementia is a condition that leads to the loss of intellectual abilities such as memory, judgment, and abstract thinking. It can also cause changes in personality. AIDS Dementia Complex (or ADC) is a type of dementia that occurs in advanced stages of AIDS.

Histoplasmosis is a fungal infection and grows as a mold in the soil. You may get sick when you breathe in spores produced by the fungus.

Invasive Cervical Cancer is cancer that has spread from the surface of the cervix to tissue deeper in the cervix or to other parts of the body.

Invasive Herpes Simplex infection is known has genital herpes and is a common STD. Genital herpes is caused by two types of viruses. The viruses are called herpes simplex type 1 and herpes simplex type 2. Most people with the virus don't have symptoms. It is important to know that even without signs of the disease; it can still spread to sexual partners.

Isosporiasis is a disease caused by the protozoan *Isospora belli*. The organism infects the lining of the small intestine and can cause severe diarrhea and malabsorption (an inability to absorb nutrients).

Kaposi's sarcoma (KS) is a type of cancer that mainly affects the skin, mouth, and lymph nodes (infection-fighting glands) but can also affect other organs such as the lungs and gastrointestinal tract.

Lymphomas are cancers that affect the white blood cells of the lymph system, part of the body's immune system. The lymph system is made up of the following: Lymph, Lymph vessels, Lymph nodes, Spleen, Thymus, Tonsils and Bone marrow.

Pneumocystis pneumonia (PCP) is a serious infection that causes inflammation and fluid buildup in the lungs. It is caused by a fungus likely spread through the air and is very common.

Progressive multifocal leukoencephalopathy (PML) is a brain disorder that affects the white matter part of the brain, specifically targeting the cells that make myelin (an oily substance that helps protect nerve cells in the brain and spinal cord).

Recurring pneumonia is a serious health condition that involves chronic inflammation or infection in one or both lungs.

Salmonella is a type of food poisoning caused by the Salmonella enteric bacterium. You can get salmonellosis by eating food contaminated with salmonella.

Toxoplasmosis is an infection due to the parasite *Toxoplasma gondi*. This infection is caused by a microscopic parasite that can live inside the cells of humans and animals, especially cats and farm animals.

Tuberculosis, commonly known as TB, is a bacterial infection that can spread through the lymph nodes and bloodstream to any organ in your body. It is most often found in the lungs. Most people who are exposed to TB never develop symptoms because the bacteria can live in an inactive form in the body. But if the immune system weakens, such as in people with HIV or elderly adults, TB bacteria can become active. In their active state, TB bacteria cause death of tissue in the organs they infect.

AIDS wasting syndrome is when a person loses at least 10 percent of her body weight and has at least 30 days of either diarrhea or weakness and fever. A person with HIV-associated wasting is considered to have AIDS. Severe loss of weight and muscle, or lean body mass, leads to muscle weakness and organ failure.

Appendix B: Anxiety Screen (GAD-7)

GAD-7

Identifier | Date

Please read each statement and record a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past two weeks. There are no right or wrong answers. Do not spend too much time on any one statement. This assessment is not intended to be a diagnosis. If you are concerned about your results in any way, please speak with a qualified health professional.

0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day

1	Feeling nervous, anxious or on edge	
2	Not being able to stop or control worrying	
3	Worrying too much about different things	
4	Trouble relaxing	
5	Being so restless that it is hard to sit still	
6	Becoming easily annoyed or irritable	
7	Feeling afraid as if something awful might happen	

Total GAD-7 score =

Privacy - please note - this form neither saves nor transmits any information about you or your assessment scores. If you wish to keep your results you will need to print this document. These results are intended as a guide to your health and are presented for educational purposes only. They are not intended to be a clinical diagnosis. If you are concerned in any way about your health, please consult with a qualified health professional.

Scoring guide

Normal	Mild	Moderate	Severe
0 - 4	5 - 9	10 - 14	15 - 21

The maximum score of the GAD-7 is 21, lower scores are better. Scores are assigned in the following manner:

0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day

The total score is simply the sum of question items one through seven. Scores of 5, 10 and 15 are taken as the cut off points for mild, moderate, and severe anxiety respectively. When used as a screening tool, further evaluation is recommended should the score be ten or greater.

Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for generalised anxiety disorder. It is moderately good at screening three other common anxiety disorders - panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%), and post-traumatic stress disorder (sensitivity 66%, specificity 81%).

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Kroenke, K., Spitzer, R.L., Williams, J.B. *et al;* Anxiety disorders in primary care: Prevalence, impairment, comorbidity, and detection. Ann Intern Med. 2007 Mar 6; 146(5):317-25

Spitzer, R.L, Kroenke, K. & Williams, J.B. *et al.* A brief measure for assessing generalised anxiety disorder: the GAD-7. *Arch. Intern. Med.* 2006: 166:1092-7.

Appendix C: Depression Screen (PHQ-9)

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

Over the *last 2 weeks,* how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
		add columns:	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **TOTAL:**

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- **Not difficult at all** _____
- **Somewhat difficult** _____
- **Very difficult** _____
- **Extremely difficult** _____

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls8@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at *http://www.pfizer.com*. Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.

ZT274388

Fold back this page before administering this questionnaire

INSTRUCTIONS FOR USE

for doctor or healthcare professional use only

PHQ-9 QUICK DEPRESSION ASSESSMENT

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment on accompanying tear-off pad.
2. If there are at least 4 ✓s in the blue highlighted section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.
3. ***Consider Major Depressive Disorder***
   —if there are at least 5 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

   Consider Other Depressive Disorder
   —if there are 2 to 4 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician and a definitive diagnosis made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring Card to interpret the TOTAL score.
5. Results may be included in patients' files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION

for healthcare professional use only

Scoring—add up all checked boxes on PHQ-9

For every ✓: Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
0-4	None
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Appendix D: Substance Abuse Screen (DAST-20)

Drug Use Questionnaire (DAST-20)

Name: _____

Case Number: _____

Charges: _____

Test Date: _____

Score: _____

Preliminary Comments

Adapted from language provided by Dr. Harvey Skinner (January 5, 2009)

The following questions concern your potential involvement with drugs other than alcohol. When you answer the questions, remember that the term "drug abuse" does not include alcohol. Instead, it refers to your use of prescribed or over the counter drugs in excess of the recommended dosage. For example, if you were given a prescription for pain killers, but took more than you were supposed to, that would be included. The phrase "drug abuse" also includes *any* non-medical drug use, including illegal drugs. This includes substances like marijuana, valium, cocaine, amphetamines, LSD, and heroin. Remember that the term "drug abuse" does not include alcohol. If you have difficulty with a statement, then choose the response that is mostly right.

Do you understand?

Questions

These questions refer to the past 12 months.	**Circle the Response**	
1. Have you used drugs other than those required for medical reasons?	Yes	No
2. Have you abused prescription drugs?	Yes	No
3. Do you abuse more than one drug at a time?	Yes	No
4. Can you get through the week without using drugs?	Yes	No
5. Are you always able to stop using drugs when you want to?	Yes	No
6. Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes	No
7. Do you ever feel bad or guilty about your drug use?	Yes	No
8. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
9. Has drug abuse created problems between you and your spouse or your parents?	Yes	No
10. Have you lost friends because of your use of drugs?	Yes	No
11. Have you neglected your family because of your use of drugs?	Yes	No
12. Have you been in trouble at work (or school) because of drug abuse?	Yes	No
13. Have you lost your job because of drug abuse?	Yes	No
14. Have you gotten into fights when under the influence of drugs?	Yes	No
15. Have you engaged in illegal activities in order to obtain drugs?	Yes	No
16. Have you been arrested for possession of illegal drugs?	Yes	No
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
18. Have you had medical problems as a result of your drug use? (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)	Yes	No
19. Have you gone to anyone for help for a drug problem?	Yes	No
20. Have you been involved in a treatment program specifically related to drug use?	Yes	No

Scoring the DAST-20

Adopted or excerpted from materials provided by Dr. Harvey Skinner (January 5, 2009)

Scoring The DAST-20

Score 1 point for each question answered "yes," except for Questions 4 and 5, for which a "no" receives 1 point.

DAST-20 Interpretation Guide

Score	Severity	Intervention Recommended
0	N/A	N/A
1 – 5	Low	Brief Intervention
6-10	Intermediate (likely meets DSM criteria)	Outpatient (Intensive)
11-15	Substantial	Intensive
16-20	Severe	Intensive

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