RYAN WHITE CLIENT INTAKE FORM

Date of Intake: ____/____/_____
Client Acknowledgement of Understanding Confidentiality and HIPAA: ☐ Yes ☐ No ☐ NA

Client Contact Information

Legal First Name: _____ Legal Last Name: _____

Street Address: _____ ☐ Currently Homeless

City: _____ County: _____ Zip Code: _____

Contact Phone Number(s): _____ E-mail Address: _____

Preferred Method(s) of contact: ☐ Call ☐ Text (if applicable) ☐ E-mail ☐ Letter ☐ Home Visit

May confidential messages be left on voicemail? ☐ Yes ☐ No

If YES: What information can we leave? ☐ Name ☐ Number ☐ Agency information

Has the court appointed someone to make decisions on your behalf? ☐ Yes ☐ No

If YES: Guardian/Conservator Name: _____

Phone Number(s): _____

Emergency Contact

Name: _____ Relationship: _____

Phone Number(s): _____

Client Demographic Information

Client ID: _____ Date of Birth: ____/____/_____

Sex at Birth: ☐ Male ☐ Female

Gender Identity: ☐ Male ☐ Female ☐ Transgender (Male to Female) ☐Transgender (Female to Male)

Preferred Pronouns: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Other: _____

Preferred Name: _____ Relationship/marital Status: _____

Have you ever gone by another name: ☐ Yes ☐ No *If YES:* Other name: _____

Race: *(Check all that apply)*

☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Pacific Islander

If ASIAN: Specify: ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other

If NATIVE HAWAIIAN/PACIFIC ISLANDER: Specify: ☐ Native Hawaiian ☐ Samoan ☐ Guamanian/Chamorro ☐ Other

Ethnicity: ☐ Not Hispanic/Latino(a) ☐ Hispanic/Latino(a)

If HISPANIC/LATINO(A): Specify: ☐ Mexican, Mexican American, Chicano(a) ☐ Puerto Rican ☐ Cuban ☐ Other

Preferred Language: _____

HIV / Medical Care History

HIV Status: ☐ HIV-positive, not AIDS ☐ HIV-positive, AIDS status unknown ☐ CDC-defined AIDS

HIV-positive Date: ____/____/_____

History of Care: ☐ In care ☐ Never in care ☐ Out of care *If OUT OF CARE:* Date of last doctor's visit: ____/____/_____

HIV care Provider: _____ Appointment Dates: _____

Anti-retroviral Therapy (ART) History: ☐ Never on ART ☐ Not currently on ART ☐ Currently on ART

Basic Need Information—GREEN

Support System

Do you have friends/family you can rely on? ☐ Yes ☐ No

Do you receive services from any other agencies? *(For example: JFS, Department of Developmental Disabilities, WIC)*

☐ Yes ☐ No *If YES:* Which one(s)?

_____

Knowledge of HIV Disease

Were you diagnosed with HIV in the last 12 months?

☐ Yes ☐ No

Sexual Health/Risk Reduction

Risk Factors:

☐ Male who has sex with male(s) ☐ Heterosexual contact

☐ Injection drug use ☐ Perinatal transmission

☐ Hemophilia/coagulation disorder ☐ Not reported or N/A

Legal

Have you been released from jail/prison in the past 6 months? ☐ Yes ☐ No

Moderate Need Information—YELLOW

Oral Health

Do you have any immediate needs for oral health treatment? ☐ Yes ☐ No

Health Insurance/Medical Care Coverage

Do you have health insurance? ☐ Yes ☐ No

If YES: What is your primary type of insurance?

☐ Private—Employer ☐ Private—Individual (ACA)

☐ Medicare ☐ Medicaid/CHIP/other public plan

☐ Indian Health Service ☐ Other (not listed above)

☐ Veterans Health Administration (VA), military health care (TRICARE), other military health care

Have you ever served in the military? ☐ Yes ☐ No

Financial Planning

What is your monthly gross household income? $_____

What is your household size? _____

(Spouse and legal dependents only)

Transportation

Do you need assistance with transportation to medical appointments? ☐ Yes ☐ No

Language and Literacy

Do you need an interpreter? ☐ Yes ☐ No

Do you need assistance with reading/writing?

☐ Yes ☐ No

Developmental Disability/Cognitive

Have you ever been diagnosed with a developmental disability? ☐ Yes ☐ No

Intensive Need Information—RED

Basic Needs

Do you have any immediate needs for food? ☐ Yes ☐ No

Housing

Do you have any immediate housing needs? ☐ Yes ☐ No

Medical Needs

Is there a chance that you or your partner might be pregnant? ☐ Yes ☐ No ☐ N/A

Have you been hospitalized in the last 6 months? ☐ Yes ☐ No

If YES: Why? _____

Care and Medication Adherence

If you are currently on ART, do you have less than 14 days of medication left? ☐ Yes ☐ No

Substance Abuse

Current/recent use of drugs/alcohol? ☐ Yes ☐ No

Mental Health

Do you have any mental health concerns? ☐ Yes ☐ No

If YES: Please describe: _____

Intake Sign-Off

_____
Printed Name of Person Completing this Form

_____
Agency Name

_____
Signature of Person Completing this Form

_____/_____/_____
Date Completed

CASE ASSIGNMENT USE ONLY

Date Intake Form Received: _____/_____/_____ Client Acuity: ☐ GREEN ☐ YELLOW ☐ RED

Name of Assigned Medical Case Manager: _____ Date of Assignment: ____/_____/_____

Name of Case Assignment Staff: _____ Signature: _____