CASE MANAGEMENT
STANDARDS OF CARE

FOR

HIV CARE SERVICES IN ORANGE COUNTY

Effective 4/11/18
SECTION 1: INTRODUCTION

The goal of case management is to enhance independence and increase quality of life for individuals living with HIV through adherence to medical care. Case management shall prioritize individuals who need support in accessing and maintaining regular medical care. Case management addresses the needs of clients with HIV disease and assists them in overcoming the obstacles they face in obtaining critical services. Case management shall be flexible to accommodate the medical and psychosocial needs of clients with different backgrounds and in various stages of health and illness. The services delivered shall reflect a philosophy of service delivery that affirms a client’s right to privacy, confidentiality, self-determination, nondiscrimination, compassionate and non-judgmental care, dignity, and respect.

Case management is a client-centered process. This means respecting the client’s perception of his/her needs and developing service plans in collaboration with him/her. This also means empowering the client to take control of his/her care. It is recommended to incorporate a strengths-based approach, by helping clients identify barriers to accessing care and subsequently identifying personal strengths to overcome these barriers. This is especially important when working with newly diagnosed clients or clients who are returning to care and linking them into medical care. A client-centered process is beneficial to relationship and trust building between the client and his/her case manager.

Case managers shall also see themselves as educators and seize opportunities to educate clients about HIV prevention and care. When appropriate, case managers shall educate their clients on life skills such as: practical living skills, functional communication, community integration, treatment adherence, nutritional counseling, and skill building exercises.
Goals of the Standards. These standards of care are provided to ensure that Orange County’s case management services:

- Are accessible to all persons infected with HIV who meet eligibility requirements
- Promote continuity of care, client monitoring, and follow-up
- Enhance coordination among service providers to eliminate duplication of services
- Foster interagency collaboration
- Provide opportunities and structure to promote client and provider education
- Maintain the highest standards of care for clients
- Protect the rights of persons living with HIV
- Provide support services to enable clients to stay in medical care
- Increase client self-sufficiency and quality of life

SECTION 2: DEFINITIONS OF CASE MANAGEMENT

There are various categories of case management: Medical Case Management and Non-Medical Case Management.

Under Medical Case Management there are two (2) levels:
   1) Linkage to Care
   2) Medical Retention Services

Under Non-Medical Case Management there are four (4) levels:
   1) Client Support Services
   2) Client Advocacy
   3) Benefits Counseling
   4) Eligibility Screening

Definitions for each service are stated below:

**Linkage to Care (LTC):** Includes a range of client-centered services using the Anti-Retroviral Treatment and Access to Services (ARTAS) strengths-based model that link clients with access to medically appropriate levels of health and supportive services and continuity of care, provided by trained professionals, including both medically credentialed and other health care staff who are part of the clinical care team, through all types of encounters including face-to-face, phone contact, and any other form of communication. These services ensure timely and coordinated access to medically appropriate levels of health and support services. LTC shall also ensure continuity of care through ongoing assessment of the client’s needs and personal support systems. The ARTAS Linkage to Care program shall be limited to six (6) months. Individuals that require additional assistance beyond six (6) months shall be transitioned to ongoing medical case management services to ensure linkage and retention in care. Key activities for LTC include 1) initial assessment of service needs; 2) development of an individualized strength-based service plan; 3) coordination of services required to implement the plan; 4) monitoring of client to assess the efficacy of the plan; 5) periodic re-evaluation and adaptation of the plan, as necessary; and 6) clear documentation of assessment, plan, and referrals.
LTC services are intended for individuals who are:
- Newly HIV-diagnosed
- New to Orange County and have not linked to a HIV medical provider
- Returning or re-engaging to HIV care
- Recently released from incarceration
- Transitioning to another payer source and have not linked to a HIV medical provider

**Medical Retention Services:** Includes a range of client-centered services that link clients with access to medically appropriate levels of health and supportive services. These services ensure timely and coordinated access to medically appropriate levels of health and support services. Medical Retention Services shall also ensure continuity of care through ongoing assessment of the client’s needs and personal support systems. Medical Case Management services shall focus on ensuring medical adherence and retention in care. Successful engagement in care may be defined by sustained viral load suppression or acuity scores consistent with Client Support Services or Client Advocacy; however, case managers should utilize best judgement in choosing to change the client’s level of case management. The rationale must be documented. Individuals who are successfully engaged in care should have a plan for transitioning out of Medical Retention Services. Key activities for Medical Retention Services include 1) initial assessment of service needs; 2) development of a comprehensive, individualized service plan; 3) coordination of services required to implement the plan; 4) monitoring of client to assess the efficacy of the plan; 5) periodic re-evaluation at least every three (3) months and adaptation of the plan, as necessary; and 6) clear documentation of assessment, plan, and referrals.

Medical Retention Services are intended for individuals who are:
- Not HIV medication adherent
- Medically compromised or have a viral load greater than 100,000 copies/mL
- Dealing with medical and/or behavioral health co-morbidities that impede medical care adherence

**Client Support Services:** The provision of needs assessment and timely follow up to ensure clients are appropriately accessing needed supportive services. Key activities include 1) initial assessment of service needs; 2) development of a comprehensive, individualized service plan; 3) coordination of services required to implement the plan; 4) monitoring of client to assess the efficacy of the plan; 5) periodic re-evaluation at least every six (6) months and adaptation of the plan, as necessary; and 6) clear documentation of assessment, plan, and referrals. Service Coordination may be used as a “step-down” model for transitioning clients to increasing levels of self-sufficiency.

**Client Advocacy:** The provision of basic needs assessment and assistance (through appropriate referrals) in obtaining medical, social, community, legal, financial, and other needed services. Key activities include 1) assessment of service needs; 2) provision of information and/or referrals; 3) assistance in obtaining intake information for individuals pending enrollment in a service and who are initiating a thirty (30) day grace period, if needed; and 4) clear
documentation of assessment and referrals. On-going follow-up with clients is not a requirement of Client Advocacy.

Benefits Counseling: Services that refer or assist eligible clients to obtain access to non-Ryan White public and private programs for which they may be eligible, including Medicaid, Medicare Part D, Social Security Disability Insurance, State Disability Insurance, Supplemental Security Income, General Relief, State Pharmacy Assistance Programs, Health Insurance Premium Programs, and other supportive services. Key activities include 1) assessment of service needs; 2) helping clients to understand the eligibility criteria for benefits, the benefits provided by the program, the payment process and the rights of beneficiaries; providing consultation and advice regarding benefits programs; 3) assistance in completing the benefits application forms; 4) negotiating on the behalf of clients with benefits administration staff; and/or 5) referring to and coordinating with legal services in cases of administrative proceedings.

Eligibility Screening: Services that assist individuals in identifying programs for which they are eligible. Screening is required for Ryan White services. Key activities include 1) obtaining proof of HIV status, 2) assessment of Orange County residency, 3) determining household income, 4) assessing other prior resources (e.g., public or private insurance), and conducting an assessment of eligibility every six (6) months.

Coordination of Medical Care

Beyond simply educating the client about medical care, all case managers shall make the following efforts to support and coordinate the continuity of medical care:

- **Assess Medical Care Access.** Case managers shall regularly assess client’s access to medical care and any barriers to care. Case managers shall make an effort to identify barriers to medical care in each case (housing instability, alcohol and drug use, mental health issues, financial factors, attitudes toward medicines, etc.).

- **Monitor Medication Adherence.** Case managers shall monitor client medication adherence. Client self-reports, pill counts, electronic pill bottle caps, diaries, adherence watches and other reminder systems, lab reports, etc., are used to assist with adherence. Lab reports under Medical Case Management is an integral part of understanding a client’s adherence to medications and medical care. The case manager needs to be able to determine which method may be more helpful for a particular client. As needed, the case manager shall find out who has the primary responsibility for giving medication and shall provide HIV and adherence education to family members or caregivers. Case managers shall refer clients to additional treatment adherence services as needed.

- Case managers shall communicate any adherence barriers to client medical care providers.
• Case managers shall make an effort to identify barriers to adherence in each case (housing instability, alcohol and drug use, mental health issues, financial factors, attitudes toward medicines, etc.).

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<th>Standard</th>
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<tr>
<td>Case managers shall regularly assess client’s access to medical care and any barriers to care</td>
<td>Documentation on ARTAS Tools, Psychosocial/Acuity Tool, Psychosocial Follow-up Tool, or progress note will ensure</td>
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<td>Case managers shall monitor client medication adherence</td>
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SECTION 3: STAFFING REQUIREMENTS AND QUALIFICATIONS

Quality case management starts with well-prepared and qualified staff. To ensure this, Ryan White providers must meet all of the following requirements and qualifications:

• **HIV Knowledge.** Staff shall have training and experience with HIV related issues and concerns. At a minimum, case managers will have completed one educational session on any of the topics listed below on an annual basis. Certificate of completion shall be included in employee files as proof of attendance. Education can include round table discussion, training, one-on-one educational session, in-service, or literature review. Topics may include:
  o HIV disease process and current medical treatments
  o Adherence to medication regimens
  o Mental health or psychosocial issues related to HIV
  o Cultural issues related to communities affected by HIV
  o HIV legal and ethical issues
  o Human sexuality, gender, and sexual orientation issues
  o Prevention issues and strategies specific to HIV-positive individuals (“prevention with positives”)
  o Partner Services
  o Strengths-Based approach to case management trainings
  o Anti-Retroviral Treatment and Access Services (ARTAS) strengths-based model

• **Community Resources (Required for Benefits Counseling and recommended for case managers).** Case managers shall be knowledgeable about local, state, and federal resources and eligibility requirements of available resources for clients. At a minimum, benefits counselors will have completed one educational session on any of the topics listed below on an annual basis. Education can include round table discussion, training, one-on-one educational session, in-service, or literature review. Topics may include eligibility criteria and process for obtaining the following:
  o Medical care including Medi-Cal, Medicare, Medical Safety Network (MSN), and California Major Risk Medical Insurance Plan (MRMIP)
- Disability insurance including State Disability Insurance, Social Security Disability Insurance
- Financial assistance including Supplemental Security Income (SSI) and Cash Assistance Program for Immigrants (CAPI)
- Health insurance assistance including CalOptima Health Insurance Premium Payment Program, Office of AIDS-Health Insurance Premium Payment program
- Medications including Medicare Part D and AIDS Drug Assistance Program
- California Health Insurance Exchange (Covered California)

**Licensure and Training Requirements.** Staff shall have the necessary State of California licenses, and/or trainings for the functions they perform.

- **Linkage to Care:**
  - Staff performing Linkage to Care services shall be ARTAS trained and are not required to have healthcare licensure.

- **Medical Retention Services:**
  - Staff performing Medical Retention Services shall have appropriate healthcare licensure (i.e., Registered Nurse, Licensed Vocational Nurse, Licensed Clinical Social Worker, Marriage and Family Therapist, Licensed Professional Clinical Counselor).
  - Staff that does not meet the licensure requirement may be exempted and allowed to provide Medical Retention Services with approval using the established Exemption Policy.
  - Marriage and Family Therapist (AMFT) and Master of Social Work (ASW) interns may provide Medical Case Management services as long as they are earning hours toward licensure are appropriately registered and clinically supervised.
    - Staff shall have a current California Board of Behavioral Sciences (BBS) registration in order to provide services.

- **Non-Medical Case Management**
  - Staff performing non-medical case management shall have a minimum of Bachelor’s degree in a social service field or comparable case management experience, licensure is not required.

**Caseloads.** Staff shall have caseloads set at levels that allow them to conduct their activities adequately and competently. The following outline recommended caseloads by case management level:

- Linkage to Care (LTC): 10-15 clients
- Medical Retention Services (MRS): 25-40 clients
- Client Support Services (CSS): 30-45 clients
- Client Advocacy (CA): currently, no recommendations are provided; however, the average number of CA clients among funded providers is 65.

Caseloads may vary based on agency capacity, staffing, and total client levels.
Supervision. Programs shall provide appropriate supervision to case management staff, which includes, but is not limited to, the following:

- Staff and clients shall have access to supervisory levels of case management.
- Supervision that is observant and attentive to possible bias in treatment of clients because of their sexual orientation, ethnicity, gender, substance use, etc.
- Individual supervision and clinical guidance that is available to case managers as needed.
- Multiple methods shall be used to evaluate case manager performance including: direct observation; chart reviews; and client feedback (e.g., through surveys, focus groups, complaint and grievance processes, etc.).

Case Conferencing. Formal or informal case conferencing shall occur at minimum monthly or when important client-specific issues arise that require a team or interdisciplinary approach or solution.

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| Case management staff receive initial trainings within 60 days of hire and annual education regarding HIV related issues/concerns | Training/education documentation on file including:  
  - Date, time, and location of the education  
  - Education type  
  - Name of the agency and case managers receiving education  
  - Education outline, meeting agenda and/or minutes |
| Case management staff receive initial trainings within 60 days of hire and annual education regarding community resources | Training/education documentation on file including:  
  - Date, time, and location of the education  
  - Education type  
  - Name of the agency and case managers receiving education  
  - Certificate of completion |
| Provider will ensure that staff have necessary licenses or degrees for the functions they perform | Documentation of licensure or degree on file |
| Staff shall have caseloads set at levels that allow them to conduct their activities adequately and competently (with assistance to include supervision and clinical guidance, formal or informal case conferencing, as well as case manager transition if needed) | Program managers shall conduct periodic assessments to see if caseload assignments allow for quality services and completion of job duties. Documentation of periodic assessments on file. |
| Formal or informal monthly case conference focused on clients-specific issues | Documentation of case conference on file |
SECTION 4: CULTURAL AND LINGUISTIC AWARENESS

Providers must participate in a process of training and education that increases cultural and linguistic competence and improves their ability to provide culturally and linguistically appropriate services to all persons living with HIV disease. Although an individual’s ethnicity is generally central to their identity, it is not the only factor. Other relevant factors include gender; gender identity; language; disability; sexual orientation; beliefs, and institutions. In providing culturally and linguistically competent services, it is important to acknowledge one’s personal limits and treat one’s client as the expert on their culture and relation to it.

Case managers shall be mindful of clients’ literacy level and be able to accurately interpret and appropriately respond to a client’s situation. If a case manager determines that they are not able to provide culturally or linguistically appropriate services, they must be willing to refer the client to another case manager or provider that can meet the client’s needs.

Culturally and linguistically appropriate services:

- Respect, relate, and respond to a client’s culture in a non-judgmental, respectful manner
- Match the needs and reflect the culture and language of the clients being served, including providing written materials in a language accessible to clients
- Recognize the significant power differential between provider and client, and work toward developing a more collaborative interaction
- Consider each client as an individual, not making assumptions based on perceived membership in any group or class
- Translation and/or interpretation services as appropriate
- Open non-judgmental environment concerning sexual orientation and practices

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<tr>
<td>Providers will recruit a diverse staff that reflects the culture (including gender, sexual identity, and disability) of the community served</td>
<td>Providers have a written strategy on file</td>
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</table>
| All staff (including administrative staff) will receive initial trainings within 60 days of hire and annual trainings to build cultural and linguistic awareness | Training/education documentation on file including:  
  - Date, time, location, and provider of education  
  - Education type  
  - Name of staff receiving education  
  - Certificate of training completion or education outline, meeting agenda, and/or minutes |
### Section 5: Client Registration

Registration is a time to gather demographic data and provide basic information about case management and other HIV services. It is also a pivotal moment for establishment of trust and confidence in the care system. Case managers shall provide an appropriate level of information that is helpful and responsive to client need, but not overwhelming.

If a client is receiving multiple Ryan White services with the same provider, registration is only required to be conducted one time. If registration information was completed as part of another service; documentation in the client file is sufficient.

If a client has been referred by another Ryan White provider to receive services and the client has opted to share their ARIES data, the provider receiving the referral does not have to collect registration information. The provider shall review ARIES to ensure all registration data has been collected and is documented in ARIES. If the client is non-share in ARIES, the referring provider may provide registration information or the provider receiving the referral shall gather registration information from the client. Provision of information regarding Client Rights and Responsibilities and Client Grievance Process may be conducted one-time at the referring provider agency. To document the provision of this information, the referring provider may send the provider receiving the referral a signed document indicating that they have provided this information to the client.

The case manager shall conduct the client registration with respect and compassion. The following describe components of registration:

- **Timeframe.** Registration shall take place as soon as possible, at minimum within five days of referral or initial client contact. If there is an indication that the client may be facing imminent loss of medication or is facing other forms of medical crisis, the registration process shall be expedited and appropriate interventions may take place.

- **Eligibility and Qualification Determination.** The service provider shall obtain the necessary information to establish the client’s eligibility via the Eligibility Verification
Form (EVF); See Requirements to be Eligible and Qualify for Services:

- **Demographic Information.** The service provider shall obtain the appropriate and necessary demographic information to complete registration; this includes basic information about the client’s HIV medical history, living situation, employment and financial status, service linkages, and emergency contact information.

- **Registration Information.** The provider shall obtain information to complete registration as required for the Ryan White Services Report (RSR). This includes, but is not limited to, information regarding demographics, and risk factors.

- **Provision of Information.** The case manager shall clearly explain what case management entails, levels of case management, and provide information to the client. The case manager shall provide adequate information about the availability of various services or resources within the agency and in the community. The case manager shall also provide the client with information about resources, care, and treatment available in Orange County this may include the county-wide HIV Client Handbook.

- **Required Documentation.** The provider shall develop the following forms in accordance with state and local guidelines. The following forms shall be signed and dated by each client.
  - **ARIES Consent:** Clients shall be informed of the AIDS Regional Information and Evaluation System (ARIES). The ARIES consent must be signed at intake prior to entry into the ARIES database and every three (3) years thereafter. The signed consent form shall indicate (1) whether the client agrees to the use of ARIES in recording and tracking their demographic, eligibility and service information and (2) whether the client agrees to share select information contained in ARIES with other agencies in the Ryan White system of care.
  - **Confidentiality and Release of Information (ROI)/Authorization to Disclose (ATD):** When discussing client confidentiality, it is important not to assume that the client’s family or partner knows the HIV-positive status of the client. Part of the discussion about client confidentiality shall include inquiry about how the client wants to be contacted (at home, at work, by mail, by phone, etc.). If there is a need to disclose information about a client to a third party, including family members, clients shall be asked to sign a Release of Information form, authorizing such disclosure. Clients receiving medical case management shall strongly be encouraged to sign a Release of Information authorizing their case manager to speak to their medical provider so that the case manager can better assist the client in coordinating care for the client. An ROI/ATD form describes the situations under which a client’s information can be released and includes the name of the agency and/or person with whom information will be shared, the specific information to be shared, duration of the release consent, and the client’s signature. This form may be signed at intake prior
to the actual need for disclosure. The ROI/ATD may be cancelled or modified by the client at any time. For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), the ROI/ATD must be a HIPAA-compliant disclosure.

- **Consent for Services**: Signed by the client, agreeing to receive case management services.

The following forms shall be signed and dated by each client receiving case management services and posted in a location that is accessible to clients receiving client advocacy services. For documents available in the HIV Client Handbook, completed forms may indicate that the client has received the HIV Client Handbook.

- **Notice of Privacy Practices (NPP)**: Clients shall be informed of the provider’s policy regarding privacy rights based on the provider’s confidentiality policy. For agencies and information covered by HIPAA, providers shall comply with HIPAA guidelines and regulations for confidentiality.

- **Client Rights and Responsibilities**: Clients shall be informed of their rights and responsibilities (included in the HIV Client Handbook).

- **Client Grievance Process**: Clients shall be informed of the grievance process. The HCA’s Grievance Process is included in the HIV Client Handbook.

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<tr>
<td>Registration process began within five (5) business days of initial contact with client or documentation of delay</td>
<td>Registration documents are completed and in client service record</td>
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<td>Registration information is obtained</td>
<td>Client’s service record includes data required for Ryan White Services Report</td>
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<tr>
<td>ARIES Consent signed and completed prior to entry into ARIES</td>
<td>Signed and dated based on ARIES consent form guidelines by client and in client service record</td>
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<tr>
<td>ROI/ATD is discussed and completed as needed</td>
<td>Signed and dated by client and in client service record as needed</td>
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<tr>
<td>Consent for Services completed</td>
<td>Signed and dated by client and in client service record</td>
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<tr>
<td>Client is informed of Notice of Privacy Practices</td>
<td>For clients receiving case management: Signed and dated by client and in client file</td>
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<td>For clients receiving client advocacy: One of the following (based on provider policy):</td>
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<td>1) Posted in a location that is accessible to clients; or</td>
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<td>2) Signed and dated by client and in client service record; or</td>
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<td>3) Other (based on provider policy)</td>
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<td>Standard</td>
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<td>Client is informed of Rights and Responsibilities</td>
<td>For clients receiving case management: Signed and dated by client and in client file</td>
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<td>2) Signed and dated by client and in client service record; or</td>
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<td>3) Client’s service record includes signed referral form indicating provision of information</td>
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<td>Client is informed of Grievance Procedures</td>
<td>For clients receiving case management: Signed and dated by client and in client file</td>
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<td></td>
<td>3) Client’s service record includes signed referral form indicating provision of information</td>
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**SECTION 6: COMPREHENSIVE PSYCHOSOCIAL ASSESSMENT**

Proper assessment of client need is fundamental to case management. A comprehensive psychosocial assessment is required for all persons receiving case management. Assessments shall be provided by staff with the appropriate level of education and experience. Assessments are conducted to determine:

- The client’s need for case management services and other treatment and support services,
- Current capacity to meet those needs,
- Ability of the client's social support network to help meet client need,
- Extent to which other agencies are involved in client's care,
- Areas in which the client requires assistance in securing services.

Case management shall target individuals assessed as needing support in accessing and maintaining regular medical care. Individuals who are assessed as self-sufficient and not needing periodic follow-up may not need case management services and may receive services under Client Advocacy.
• **Initial and Annual Assessment.** The case manager shall conduct an in-depth assessment of the client’s current and potential needs. The assessment process shall start within five days of client intake and completed within thirty (30) days. A strengths assessment consisting of past accomplishments is recommended to identify clients’ skills and abilities in order to successfully follow through with their medical care visits, support a positive, trusting relationship with case manager or accessing other services, and other goals. In addition, a comprehensive Psychosocial assessment must be completed annually thereafter. Case managers shall use the Psychosocial Assessment/Acuity Tool (see Appendix B for the Acuity Scale) to document general findings of the assessment and periodic reassessments of client need. **Reassessment.** Reassessments (which may be more focused and less comprehensive) shall be conducted whenever health and situational changes make it helpful and necessary to do so. Notwithstanding situational changes, reassessments shall be conducted utilizing the Psychosocial Follow-up Tool (see Appendix C).

The following *minimum* standards for reassessments have been set based upon case management type:
- **Linkage to Care:** Not applicable for Linkage to Care
- **Medical Retention Services:** face-to-face reassessment every three months
- **Client Support:** face-to-face reassessment every six months

Reassessments shall include a review of all pertinent issues. This may be accomplished by reviewing recent comprehensive assessments with the client and focusing only on areas of need. They can also, if appropriate, invite clients to use a form or checklist to self-assess their needs. **Client Advocacy, Benefits Counseling, and Eligibility Screening** do not require comprehensive assessments or reassessments.

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<tr>
<td>Initial psychosocial assessment/acuity tool shall be completed within thirty (30) days of intake and annually thereafter</td>
<td>Completed assessment, signed and dated by case manager and in client file</td>
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<tr>
<td>Reassessment conducted at intervals determined by the level of case management</td>
<td>Psychosocial Follow-up Tool demonstrating reassessment in client file</td>
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**SECTION 7: SERVICE MANAGEMENT**

Once client registration and intake has been conducted, the provider may provide the appropriate range of services to the client. Service management is the system by which all levels of case management are delivered. Service management shall be consistent with the following principles:

- **Service Delivery.** Services shall be delivered in a manner that promotes continuity of care. Newly diagnosed clients shall be assessed for barriers that prevent linkage to medical care. To address these barriers, as recommended by the strengths-based case
management model, skills and abilities shall be identified to assist clients to successfully access medical care and maintain a positive relationship with the care coordinator.

- Providers shall refer clients to other providers if they cannot provide a level of service that is medically, culturally, linguistically, or otherwise appropriate for the needs of the clients.
- Ideally clients should see the same case manager over time, as this is a desirable arrangement that helps develop trust. However, the program may consider changing client-case manager assignments if a client expresses their wish to do so.

- **Confidentiality.** Provider agencies shall have a policy regarding informing clients of privacy rights, including use of Notice of Privacy Practices. For agencies and information covered by HIPAA, providers shall comply with HIPAA guidelines and regulations for confidentiality.

- **Service Planning.** Where service provision options are substantially equivalent, the least costly alternative shall be used in meeting the needs of clients.
- Services shall be planned, managed, and monitored to avoid the need for urgent or emergency services, the interruption of services, and need for emergency or unplanned appropriations of funding to continue services during contract periods.

- **Documentation and Data Collection.** Program and administrative staff shall provide adequate data collection in a timely manner and documentation of all services provided for accounting, reporting compliance, and evaluation purposes. Program data shall be entered into ARIES within five (5) business days as specified in the contract or scope of work. Providers shall document and keep accurate records of units of services for use in reporting units of service for reimbursement and community planning. Providers shall gather and document data (e.g. demographic and risk factor information) for the Ryan White Services Report.

- **Compliance with Standards and Laws.** Service directors and managers shall ensure compliance with all relevant laws, regulations, policies, procedures, and other requirements designed to enforce service standards and quality. Services shall be consistent with standards set forth in this document.

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<tr>
<td>Provider shall have procedure to address walk-ins, telephone triage, and emergencies and after-hour care</td>
<td>Written procedure in place</td>
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<tr>
<td>Provider shall have procedure for making referrals to offsite services</td>
<td>Written procedure in place</td>
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<tr>
<td>Staff shall be aware of HIPAA and Notice of Privacy Practices regulations via training upon employment and annually thereafter</td>
<td>Documentation of HIPAA and Notice of Privacy Practices education or training on file</td>
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Provider shall ensure client information is in a secured location

Provider shall screen clients to ensure the least costly case management service is used as appropriate to client needs; screening shall occur at minimum when client is accessing a new service and periodically as the client’s needs change

Provider shall regularly review client charts to ensure proper documentation including progress notes

Providers shall document and keep accurate records of units of services

Required client data and services shall be entered in ARIES

Service directors and managers shall ensure compliance with all relevant laws, regulations, policies, procedures, and other requirements designed to enforce service standards and quality

Provider shall have a procedure to ensure continuity of care to address changes in case managers, level of case management, and/or service providers

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<td>Provider shall ensure client information is in a secured location</td>
<td>Site visit will ensure</td>
</tr>
<tr>
<td>Provider shall screen clients to ensure the least costly case management service is used as appropriate to client needs; screening shall occur at minimum when client is accessing a new service and periodically as the client’s needs change</td>
<td>• Written procedure in place</td>
</tr>
<tr>
<td></td>
<td>• Documentation of client screening and determination on file</td>
</tr>
<tr>
<td></td>
<td>• Site visit will ensure</td>
</tr>
<tr>
<td>Provider shall regularly review client charts to ensure proper documentation including progress notes</td>
<td>Written procedure in place</td>
</tr>
<tr>
<td>Providers shall document and keep accurate records of units of services</td>
<td>Site visit and/or audit will ensure</td>
</tr>
<tr>
<td>Required client data and services shall be entered in ARIES</td>
<td>Required data fields will be validated by the Ryan White Services Report</td>
</tr>
<tr>
<td>Service directors and managers shall ensure compliance with all relevant laws, regulations, policies, procedures, and other requirements designed to enforce service standards and quality</td>
<td>Site visit and/or audit will ensure</td>
</tr>
<tr>
<td>Provider shall have a procedure to ensure continuity of care to address changes in case managers, level of case management, and/or service providers</td>
<td>Written procedure in place</td>
</tr>
</tbody>
</table>

SECTION 8: INDIVIDUAL SERVICE PLAN (ISP)

Once client needs have been assessed, case managers together with clients shall prioritize care, support needs, and identify activities to address them. This process is documented on the Individual Service Plan (see Appendix D). Individuals enrolled in Linkage to Care are not required to have a completed ISP if utilizing the ARTAS Session Plan tool to document service plan goals. The plan provides a map for both the client and case manager on how to address needs in a manner that promotes self-sufficiency of the client. The ISP shall be completed within thirty (30) days of intake and revised as necessary, but not less than every six (6) months. Discernment is required on the part of case managers to provide enough support to assist clients in meeting needs, while fostering client ability and responsibility for self-care. Often this requires an approach that is heavier in initial support, which includes a transition over time to increased client responsibility. Good communication regarding roles and expectations is essential from the beginning of the client-case manager relationship because it is necessary to respectfully and successfully navigate the process of establishing and modifying the ISP. The ISP must be developed in collaboration with the client, taking into account his/her priorities and perception of needs. The ISP should drive the referrals, communication, and services with client. Implementation, monitoring, and follow up involve ongoing contact and interventions with (or on behalf of) the client to achieve the goals detailed on the ISP, evaluate whether
services are consistent with the ISP and determine any changes in the client's status that require updates to the ISP. These activities ensure that referrals are completed and services are obtained in a timely, coordinated fashion. In implementing the ISP, case managers are responsible for the following:

- **Client Education.** Based on the client’s assessed needs and goals stated in their ISP, case managers shall provide clients with information and education about basic health care, prevention, available resources, and the application process for available resources.

- **Referrals/Linkages/Coordination of Care.** Case managers shall make appropriate and complete referrals to medical and support services offered within the agency or in the community. Case managers shall build strong relationships with health care providers and have a referral network they are comfortable with referring their clients to. After the referral, the case manager shall make contacts with the client and/or the agency to which he or she was referred to make sure linkages were established. This must be done even when the client has been the one to initiate the referral. To ensure that appropriate and complete referrals are made, the following are required:
  - Information about resources shall be readily and continually available to all clients.
  - As appropriate, case managers shall facilitate referrals by obtaining releases of information to permit provision of information about the client’s needs and other important information to the service provider.
  - Case managers are encouraged to help clients access services on their own (advocacy). Advocacy is a form of empowerment and may help the client to take control of his or her own care. However, case managers must first assess the client’s ability to do so, and shall actively facilitate referrals when the likelihood is high that a client will be unable to follow through on his or her own. Examples of these situations include: minimal English language ability; impairment in cognitive functioning, developmental delays, lack of client understanding of, or experience with, the system to be able to negotiate access to care; an unstable living situation; fragile health; drug, alcohol or substance use that interferes with the client’s ability to follow through; emotional burden from a new diagnosis; mental health issues; cultural or other reasons that cause the client to be apprehensive about approaching a service providers. In such cases, case managers must take an active role in making and following up on the referral.
  - It is important that the client is satisfied with the referral since they will be more likely to attend the appointment. If the client shows a sense of resignation or lack of motivation, he or she is not likely to seek needed care and services. In such cases, the case manager shall take an active role in making the referral, and an assessment shall be done to determine the basis for the client’s behavior. In particular the need for a medical evaluation and/or mental health assessment may be in order.
  - Whenever appropriate, case managers shall assure ongoing coordination of services between providers of care for the client. Case managers shall follow up with clients and providers of services to make sure clients are staying in care, making progress.
toward their individual service plans, and to see if there are changes in the their living situation or if there are any problems that need to be addressed. This may be done on a one-on-one basis or through case conferencing.

- **Follow-Up and Monitoring.** Case management is to be an ongoing “management” process, not simply initial or occasional assessments and referrals. Individuals who are self-sufficient and do not need periodic follow-up may not need case management services. Case management shall target individuals needing support in accessing and maintaining regular care. Follow-up contact by case managers shall be appropriate to the needs of the client rather than at predetermined intervals (e.g., once every one, three, or six months). To that end:
  o Case managers shall respond in a timely and appropriate manner to client requests for assistance and to client needs identified by other providers. In general, case managers are expected to respond to clients and provider within one working day.
  o Even when a case manager has not become aware of any care-related problems or situational issues, he or she shall contact the client periodically in case the client has hesitated contacting the case manager about his or her needs or issues regarding services. Such contacts can serve as opportunities for reassessment of the client’s needs and living situation. Frequency of these contacts shall be determined by the case manager’s assessment of the client’s situation.
  o For newly diagnosed clients, case managers may want to meet more frequently during the initial intake process to link clients into care within ninety (90) days.
  o The following table is provided as a guide for the minimum frequency of assessments and contacts (see Appendix E for Client Flow Chart):

<table>
<thead>
<tr>
<th>Level of Case Management</th>
<th>Minimum Face-to-Face Reassessment Frequency</th>
<th>Minimum Contact Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linkage to Care</td>
<td>Not Applicable</td>
<td>1 month</td>
</tr>
<tr>
<td>Medical Retention Services</td>
<td>3 months</td>
<td>1 month</td>
</tr>
<tr>
<td>Client Support Services</td>
<td>6 months</td>
<td>3 months</td>
</tr>
</tbody>
</table>

  o These follow-up contacts need not all be face-to-face; telephone contacts would be adequate. However, periodic face-to-face contact is highly desirable, as it provides the chance for development of relationship and trust between the client and the case manager. Case managers shall acknowledge clients’ successes and appreciate their commitment as progress is made throughout the individual service plan. With positive feedback, clients will be confident and empowered in committing to their service plans.
  o To foster self-sufficiency, clients shall be encouraged to initiate contact with the case manager when changes occur in their health condition, living situation or support systems.
<table>
<thead>
<tr>
<th>Standard</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISPs or ARTAS Session Plan (for LTC clients) must be finalized within thirty (30) days of the completion of client intake</td>
<td>Completed ISP/ARTAS Session Plan, signed and dated by case manager, and in client file</td>
</tr>
<tr>
<td>Review and revise ISP as necessary, but not less than once every six (6) months</td>
<td>Documentation of updated ISP in client file</td>
</tr>
</tbody>
</table>

SECTION 9: CASE MANAGEMENT SERVICE CLOSURE

Case management is considered a critical component in assuring access to medical care and other critical services. Discharge from case management services may affect the client’s ability to receive and stay compliant with medical care. Client Records will be closed when there is no longer a need for the service. As such, discharge from case management must be carefully considered and reasonable steps must be taken to assure clients who need assistance in accessing care are maintained in case management programs.

A client may be discharged from case management services due to the following conditions:

- The client has become ineligible for services (e.g., due to relocation outside Orange County or other eligibility requirements).
- The client no longer demonstrates need for case management due to his/her own ability to effectively advocate for his/her needs.
- The client chooses to terminate services.
- The client’s needs would be better served by another agency.
- The client is being discharged from the correctional facility at which he/she is receiving jail case management services.
- The client demonstrates pervasive unacceptable behavior that violates client rights and responsibilities.
- The client cannot be located after documented multiple and extensive attempts for a period no less than three (3) months.
- The client has died.

The following describe components of discharge planning:

- **Efforts to Find Client.** The provider shall periodically query data systems to identify clients who appear to be lost to follow-up. It is recommended, but not mandatory, that at least three (3) attempts to contact the client are made over a period of three (3) months. Efforts shall be made to locate and contact a client who has not shown up for appointments or responded to provider’s phone calls. These efforts shall include contacting last known medical provider and other providers for which releases have previously been obtained. Clients who cannot be located after extensive attempts may be referred to available outreach services so that they may be linked back into the care.
system. Emergency contacts may be used to reach a client and may be done based on agency policy.

- **Closure Due to Unacceptable Behavior.** If closure is due to pervasive unacceptable behavior that violates client rights and responsibilities including excessive missed appointments, the provider shall notify the client that his/her services are being terminated and the reason for termination. Within the limits of client's authorization to receive mail, notification of closure shall be mailed to the client. A copy of the notification shall be placed in the client’s chart. If the client has no known address or the provider is not authorized to send mail to the client, the provider shall document other types of notification of closure (e.g. phone calls, visit) or attempts to notify the client of closure. If the client does not agree with the reason for closure, he/she shall be informed of the provider’s grievance procedure.

- **Case Management Service Closure Summary.** A discharge summary shall be documented in the client’s record. The case management service closure summary shall include the following:
  - Circumstances and reasons for closure
  - Summary of service provided
  - Goals completed during case management
  - Diagnosis at closure
  - Referrals and linkages provided at closure

- **Data Collection Closeout.** The provider shall close out the client in the data collection system (ARIES) as soon as possible, but no later than thirty (30) days of service closure unless the client is receiving other services at the agency. A progress note should clearly indicate why the client was not closed out of ARIES.

- **Transfer.** A client may be closed if his/her needs would be better served by another agency. If the client is transferring to another case management provider, case management service closure shall be preceded by a transition plan. To ensure a smooth transition, relevant documents shall be forwarded to the new service provider with authorization from client. Case Management providers from the two agencies shall work together to provide a smooth transition for the client and ensure that all critical services are maintained. Clients may be anxious to attend the first appointment with the new provider. Introducing the new case manager or staff with whom they will be working with may assist in the transfer process.

- **Jail Case Management.** If a jail case management client is being released from a correctional (or other institutional) setting, case closure shall be preceded by discharge planning. To ensure a smooth transition, provide a discharge plan to the new service provider as soon as possible; however, no greater than thirty (30) days. Intense case management efforts may be needed prior to and immediately following a person’s release/discharge. Since a person may leave custody of a correctional facility with only
a few days’ worth of medication, case managers shall plan ahead and help the client qualify for AIDS Drug Assistance Program (ADAP) or other programs to ensure continued access to medication. Also, a person leaving a correctional facility may have immediate problems in finding employment, housing, substance abuse treatment, etc. Social support systems may also be absent. Instability in living situation may interfere with the person’s ability to access care and supportive services. Therefore, case managers shall plan ahead and try to help the person access public assistance or link him/her with community resources that could bring some stability to that person’s situation. If possible, attend the initial appointments with clients.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow up will be provided to clients who have dropped out of case management without notice</td>
<td>Signed and dated note to document attempt to contact in client service record</td>
</tr>
<tr>
<td>Notify client regarding closure if due to pervasive unacceptable behavior violating client rights and responsibilities</td>
<td>Copy of notification in client service record</td>
</tr>
<tr>
<td>A case management service closure summary shall be completed for each client who has terminated case management</td>
<td>Client service record will include signed and dated case management service closure summary to include:</td>
</tr>
<tr>
<td>Closeout of data collection shall be completed for each client who has been closed from all Ryan White services at that provider agency</td>
<td>Data collection system (ARIES) will indicate client’s closure no later than thirty (30) days of service closure</td>
</tr>
<tr>
<td>A client may be closed due to transfer if his/her needs would be better served by another agency</td>
<td>Client service record will include signed and dated case management progress note or other documentation that the client was closed due to a transfer and shall include:</td>
</tr>
</tbody>
</table>

- Circumstances and reasons for closure
- Summary of service provided
- Goals completed during case management
- Referrals and linkages provided at closure
- authorization from client
- transition plan
- documentation that relevant documents have been forwarded to the new service provider
Case closure for jail case management shall be preceded by discharge planning.

To ensure a smooth transition, provide a discharge plan to the new service provider as soon as possible, however no greater than thirty (30) days.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client service record will include signed and dated case management progress note or other documentation that the client was closed due to release from a correctional (or other institutional) setting</td>
<td></td>
</tr>
</tbody>
</table>

SECTION 10: QUALITY MANAGEMENT

Providers shall have at least one member on the Health Care Agency’s Quality Management (QM) Committee. The QM Committee will oversee quality management activities for all providers under Ryan White Part A. Providers may continue to have their own QM committee if they desire and/or are required to do so under other funding streams. The intent of a centralized QM committee with representation from all providers is to ensure information between agencies is consistent, quality initiatives are undertaken by the entire Ryan White system, and service delivery issues can be addressed system wide.

As providers participate in the centralized QM committee, the intent is for all providers to actively participate in and provide feedback on the following items:

- Providers shall participate in community-wide Quality Improvement initiatives as developed by the QM committee.
- Providers will implement strategies that may lead to improvements in health outcomes as outlined in annual Performance Outcome Goals.
- Providers will implement quality assurance strategies that improve the delivery of services.

Each case management provider is responsible for Quality Assurance (QA) activities. QA activities shall include, at minimum, the following:

- Supervisors shall conduct record reviews of all staff utilizing the Ryan White Site Visit Tool at minimum quarterly. The number of records shall be three (3) to five (5), but can be more than five (5) based on findings.
- Providers shall conduct peer reviews utilizing the Ryan White Site Visit Tool at minimum quarterly. Each peer shall review two (2) to three (3) records. Providers that have five (5) or more case managers in a case management tier shall review two (2) records per peer. Providers who have less than five (5) case managers per tier shall review three (3) files per peer.
- All providers shall conduct case conferencing. Case conferencing may include clinical supervision activities, supervisory meetings, team lead meetings, or coordination meetings. Providers shall document their process for case conferencing.
<table>
<thead>
<tr>
<th>Standard</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers shall participate in annual quality initiatives</td>
<td>Documentation of efforts to participate in quality initiatives</td>
</tr>
<tr>
<td>Providers shall participate as a member of the Quality Management Committee</td>
<td>Quality Management Committee membership</td>
</tr>
<tr>
<td>Supervisor and peer chart reviews shall be conducted at minimum quarterly</td>
<td>Completed site visit tools for client records reviewed</td>
</tr>
<tr>
<td>Providers shall conduct case conferencing</td>
<td>Documented policy and procedure for case conferencing and notes, highlights, and/or sign-in sheets of case conferences</td>
</tr>
</tbody>
</table>
Appendix A. Glossary of Terms

**Americans with Disabilities Act of 1990 (ADA):** The ADA is a civil rights law that prohibits discrimination against individuals with disabilities in all areas open to the general public. The purpose of the law is to make sure that people with disabilities have the same rights and opportunities as the general public.

**ARIES:** The AIDS Research Information and Evaluation System (ARIES) is a centralized HIV/AIDS client management system that allows for coordination of client services among medical care, treatment and support providers and provides comprehensive data for program reporting and monitoring. ARIES is used by Ryan White-funded service providers to automate, plan, manage, and report on client data.

**Authorization to Disclose (ATD):** Signed consent by client that wants to grant another individual or organization access to their protected health information (PHI).

**Benefits Counseling (BC):** The provision of specific assistance applying for benefits (i.e., Social Security, State Disability, Medicare, etc.).

**Client:** Individual receiving services.

**Client Advocacy (CA):** The provision of information and referrals to services for clients who are not receiving Linkage to Care, Medical Retention Services, or Client Support Services. Client Advocacy clients do not require regular follow-up for eligibility screening, psychosocial assessments, or client service plans. They also do not require registration in ARIES unless a referral is being made on the client’s behalf.

**Client Support Services (CSS):** The provision of services to a client who is HIV medically stable but requires assistance to access support services like housing, food services, legal services, etc.

**Eligibility for a service:** Is based on Health Resources Services Administration (HRSA) and/or Housing Opportunities for Persons with AIDS (HOPWA) requirements. It includes that a person must have proof of HIV status, proof of Orange County residency, and proof of payer of last resort. Eligibility workers are responsible for verifying this information.

**Eligibility Screening (ES):** The provision of eligibility screening for Ryan White programs which includes proof of diagnosis, proof of Orange County residency, income verification, and verification or referral to healthcare insurance options based on established criteria. This service also provides screening for and assistance with completing the AIDS Drug Assistance Program (ADAP) and the Office of AIDS CARE Health Insurance Premium Program (CARE-HIPP) documents. **Health Insurance Portability and Accountability Act of 1996 (HIPAA):** Is the US federal legislation that provides data privacy and security provisions for safeguarding medical information. Additional information can be found: [https://www.hhs.gov/hipaa/index.html](https://www.hhs.gov/hipaa/index.html)

**Health Resources and Services Administration (HRSA):** HRSA is an agency of the U.S. Department of Health and Human Services, responsible for improving health care to people who are geographically isolated, economically or medically vulnerable including people living with HIV.

**Intake:** The process of acquiring information to begin services such as need screening, medical history, and other information that is needed to provide the appropriate level of service and is specific to each provider.
Appendix A. Glossary of Terms (continued)

**Linkage to Care (LTC):** The provision of services to link clients to HIV medical care.

**Medical Case Management:** The overarching service category that includes services to ensure linkage and retention in medical care. Services under Medical Case Management include Linkage to Care (LTC) and Medical Retention Services (MRS).

**Medical Retention Services (MRS):** The provision of services to help clients address HIV medical issues and stay engaged in HIV medical care.

**Notice of Privacy Practice (NPP):** A notice to clients that provides a clear, user friendly explanation of client’s rights with respect to their personal health information and the privacy practices of health plans and health care providers as required by HIPAA.

**Non-Medical Case Management:** The overarching service category that includes supportive services to ensure retention in medical care. Services under Non-Medical Case Management include Client Support Services (CSS), Client Advocacy (CA), Benefits Counseling (BC), and Eligibility Screening (ES).

**Protected health information (PHI):** Under US law, any information about health status, provision of health care, or payment for health care that is created or collected by a covered entity such as a health plans, health care clearinghouses, and health care providers as defined by HIPAA rules that can be linked to a specific individual.

**Provider:** An institution or entity that receives funding to provide Ryan White services. This includes a group of practitioners, clinic, or other institution that provide Ryan White services and the agency at which services are provided.

**Qualifying for a service:** Based on HRSA and/or HOPWA eligibility and Planning Council determined requirements (for example, proof of disability for Food Bank, income less than 300% of Federal Poverty Level for Mental Health Services), providers are responsible for ensuring that services provided adhere to qualifying requirements.

**Registration:** The process of acquiring documentation such as ARIES consent form, Confidentiality and Release of Information, Consent for Services, Notice of Privacy Practices (NPP), Client Grievance Process, and Client Rights and Responsibilities required to provide services.

**Release of Information (ROI):** Signed consent by client that wants to grant another individual or organization access to their protected health information (PHI).

**Ryan White Act:** Federal legislation first authorized in 1990 that created Ryan White HIV/AIDS Program which provides a comprehensive system of care that includes primary medical care and essential support services for people living with HIV who are uninsured or underinsured.

**Service Management:** The provider specific system by which all levels of case management services are delivered. The structure includes how clients are transitioned, service delivery, confidentiality is maintained, service planning, data collection, and how providers should comply with standards and/or appropriate laws.
**Staff:** An individual who directly provides Ryan White services, oversees the provision of Ryan White services, or perform administrative functions for Ryan White services. This may include paid employees, subcontractors, volunteers, or interns.
### Appendix B. Ryan White Psychosocial Assessment/Acuity Combined Tool

**Assessment Conducted at** (Check one):  
- Office  
- Client’s Home  
- Hospital  
- Other: __________ 

**Date:** __________ / __________ / __________

**Assessment/Acuity Type** (Check one):  
- Initial Assessment/Acuity  
- Annual Assessment/Acuity  

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>MI</th>
<th>OR</th>
<th>No MI</th>
<th>AKA</th>
<th>Mother’s MN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Date of Birth:** __________ / __________ / __________  
**Age:** __________  
**Gender** (Check one):  
- M  
- F  
- TG (M-F)  
- TG (F-M)

**Marital Status:**  
- Married  
- Single  
- Divorced  
- Other: __________  

**Sexual Orientation:** __________

**Risk Factors OR N/A** (Only required for initial assessment):  
- MSM  
- Sex W/ Female  
- IDU  
- Infected by Mother  
- Received HIV-Infected Blood/Product  
- Partner of HIV+  
- Partner of IDU  
- Partner of MSM  
- Other: __________

**Information in “double line” section is documented elsewhere and not completed below.**

**Indicate Location:**

**Race:**  
- White  
- Black/African Amer.  
- Asian  
- Pacific Islander/Hawaiian  
- Native Amer.  
- Other: __________

**Ethnicity:**  
- Hispanic/Latino  
- Not Hispanic/Latino  
- Unknown  
- Decline to State  
- Sub-ethnicity: __________

**Primary Language:** __________  
**Requires Translation Services:**  
- Yes  
- No

**Address**

<table>
<thead>
<tr>
<th>City or location if homeless</th>
<th>Zip Code</th>
<th>Ok to Mail</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Preferred Number OR None**  
**Ok to Call**  
**Ok to Leave Message**  
**Ok to Text**  
**Email**  
**Ok to Email**  

**Monthly Income** (Reported or Based on ARIES-Eligibility): __________  
**FPL/AMI Percentage:** __________

**Income Type** (Check all that apply):  
- Employment  
- Unemployment  
- Disability  
- Retirement  
- Gen. Assist/TANF  
- Other: __________

**Disability:**  
- None  
- Type (List): __________  
- Permanent OR Temporary  
- Expiration: __________ / __________ / __________

**Emergency Contact**  
- ROI/ATD on File OR HIV Aware  
- HIV Unaware OR Refused: __________  

**Language of Emergency Contact:** __________

**Employment Info OR N/A**  
**Employment Type:** __________  
- Full Time OR Part Time  
- Benefits:  
- Yes  
- No

**Current Living Situation:**  
- Stable/Permanent Housing  
- Homeless/Unstable  
- Other: __________  

**Temporary/Transitional Housing - Indicate Date Housing Ends:** __________ / __________ / __________

**Education Completed:**  
- Elementary/Primary  
- Jr. High  
- High School/GED  
- Trade/Vocational  
- College  
- Other: __________
Client ID: ____________________

**Psychosocial Assessment/Acuity Tool**

**Linkage to Care** (Client is newly diagnosed/new to the area, Client is returning to Care, or Client is transitioning to another payer source for medical care). If applicable, check one box for each area of assessment below. □ N/A

<table>
<thead>
<tr>
<th>Assessment/Acuity</th>
<th>HIV Medical Provider:</th>
<th>Phone:</th>
<th>OR</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Home</strong></td>
<td>None at this time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ N/A</td>
<td>□ Referral Needed</td>
<td>□ Accept</td>
<td>□ Declined</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessment/Acuity</th>
<th>HIV Medical Provider:</th>
<th>Phone:</th>
<th>OR</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Home</strong></td>
<td>None at this time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ N/A</td>
<td>□ Referral Needed</td>
<td>□ Accept</td>
<td>□ Declined</td>
<td></td>
</tr>
</tbody>
</table>

Client is engaged in medical care for longer than 12 months.

Client is engaged in care for more than 6 months but less than 12 months.

Client has been engaged in care for less than 6 months.

Client is not engaged in medical care;

Client is in and out of jail resulting in lack of linkage to care;

Client is newly diagnosed.

<table>
<thead>
<tr>
<th>Access to Medical Care</th>
<th>Insurance Type:</th>
<th>None</th>
<th>Medi-Cal</th>
<th>Medi-Medi</th>
<th>Medicare</th>
<th>Private (list):</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ N/A</td>
<td>□ Referral Needed</td>
<td>□ Accept</td>
<td>□ Declined</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Client has adequate insurance;

OR

Client has insurance but insurance does not include all essential health benefits;

OR

Client has insurance but needs referral for assistance with deductibles, co-payments, share-of-cost requirements;

OR

Client has no health insurance and requires referral to Ryan White care.

Client has insurance but needs referral for assistance to complete application (Medi-Cal, Covered CA, OA-HIPP, ADAP);

OR

Client’s application is pending and requires follow-up.

Client has history of difficulty or non-compliance completing the application for insurance;

OR

Client refuses treatment;

OR

Client has had a change in medical coverage and is at risk for falling out of care in the next 60 calendar days.

<table>
<thead>
<tr>
<th>Access to Medical Care</th>
<th>Insurance Type:</th>
<th>None</th>
<th>Medi-Cal</th>
<th>Medi-Medi</th>
<th>Medicare</th>
<th>Private (list):</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ N/A</td>
<td>□ Referral Needed</td>
<td>□ Accept</td>
<td>□ Declined</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Client has adequate insurance;

OR

Client has HIV medical coverage through Ryan White.

Client has insurance but insurance does not include all essential health benefits;

OR

Client has insurance but needs referral for assistance with deductibles, co-payments, share-of-cost requirements;

OR

Client has no health insurance and requires referral to Ryan White care.

Client is eligible for insurance but needs referral for assistance to complete application (Medi-Cal, Covered CA, OA-HIPP, ADAP);

OR

Client’s application is pending and requires follow-up.

Client has history of difficulty or non-compliance completing the application for insurance;

OR

Client refuses treatment;

OR

Client has had a change in medical coverage and is at risk for falling out of care in the next 60 calendar days.

Notes: ________________________________

Notes: ________________________________

Page 27 of 46

Rev 4/11/18
### Linkage to Care (Continued)

<table>
<thead>
<tr>
<th>HIV Knowledge</th>
<th>Zero</th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>Total</th>
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<tbody>
<tr>
<td>N/A</td>
<td></td>
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<tr>
<td>Referral Needed</td>
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<tr>
<td>Accepted</td>
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<td></td>
</tr>
<tr>
<td>Declined</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

- **Box**: Client is able to verbalize accurate understanding of HIV disease, treatments, progression, and/or transmission.
- **Box**: Client has basic knowledge of HIV disease, treatments, progression, and/or transmission but may benefit from a referral to HIV 101.
- **Box**: Client has limited understanding of HIV disease, treatments, progression, and/or transmission and requires significant education to engage in HIV care.
- **Box**: There is no indicator for this level.

### Notes:

- Assessment/Acuity

<table>
<thead>
<tr>
<th>HIV Knowledge re: Access to Care</th>
<th>Zero</th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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<tr>
<td>Referral Needed</td>
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<td></td>
<td></td>
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<tr>
<td>Accepted</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Declined</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

- **Box**: Client is able to verbalize accurate understanding of their medical coverage and/or options for care.
- **Box**: Client has basic knowledge of their medical coverage and/or options for care but may benefit from a referral to a benefits counselor.
- **Box**: Client has limited understanding of their medical coverage and/or options for care and requires significant education to access care appropriately.
- **Box**: There is no indicator for this level.

### Total Linkage to Care Score:

- **For Women Only OR N/A:**
  - **Currently Pregnant:** No Yes: If Yes, In prenatal care OR Referred to prenatal care

### Notes:

(Continued on next page)
### Retention in Medical Care

Check one box for each area of assessment below. □ N/A if client is in the process of being Linked to Care.

<table>
<thead>
<tr>
<th>Assessment/Acuity</th>
<th>HIV Medical Provider:</th>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV Medical Care Adherence</td>
<td>Date of Last HIV Medical Appointment: / /</td>
<td></td>
</tr>
<tr>
<td>□ N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Referral Needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Accepted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Declined</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV Medication Adherence:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Referral Needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Accepted</td>
<td></td>
<td></td>
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<tr>
<td>□ Declined</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Reasons for Missed Appointments (check all that apply) OR □ N/A:

<table>
<thead>
<tr>
<th>Zero</th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Client has no missed HIV medical appointments in the last 6 months.</td>
<td>□ Client has missed no more than one (1) HIV medical appointment in the last 6 months.</td>
<td>□ Client has missed more than two (2) HIV medical appointments in last 12 months;</td>
<td>□ Client has missed more than three (3) HIV medical appointments in the last 12 months;</td>
<td>□ Client has missed more than three (3) HIV medical appointments in the last 12 months;</td>
</tr>
<tr>
<td>□ Client’s immigration status limits access to medical care.</td>
<td></td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
</tr>
<tr>
<td>□ Client is in and out of jail resulting in lack of medical care adherence.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Problems with ART (check all that apply) OR □ N/A:

<table>
<thead>
<tr>
<th>Zero</th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Client reports 90% or greater adherence to HIV meds and is virally suppressed;</td>
<td>□ Client reports 85-90% adherence to HIV meds and is virally suppressed;</td>
<td>□ Client reports missing doses of HIV meds and is not virally suppressed;</td>
<td>□ Client reports that he/she has stopped taking HIV meds;</td>
<td>□ Client reports that he/she has stopped taking HIV meds;</td>
</tr>
<tr>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
</tr>
<tr>
<td>□ Client’s doctor chooses not to start HIV meds;</td>
<td>□ Client reports sporadic issues with adherence and may benefit from referral to treatment adherence assistance;</td>
<td>□ Client has begun HIV meds within the last three (3) months;</td>
<td>□ Client reports he/she has not started taking prescribed HIV meds;</td>
<td>□ Client reports he/she has not started taking prescribed HIV meds;</td>
</tr>
<tr>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
</tr>
<tr>
<td>□ Client is unable to provide medication Rx details.</td>
<td>□ Client reports taking HIV meds for at least six months as prescribed but viral load is</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

---

**Notes:**

### HIV Medication Adherence:

□ N/A

□ Referral Needed

□ Accepted

□ Declined

Current HIV Meds:

____

Medication Rx:

____ Pills Rx Each Day

____ Days in Month

____ Total Pills

Taken/Month

____ % Adherence

Calculation: Total Pills Taken in a month/Total Pills Rx Each Day x Number of Days in
# Retention in Medical Care (Continued)

## Assessment/Acuity

<table>
<thead>
<tr>
<th>HIV Treatment and Medication Knowledge</th>
<th>Zero</th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>Total</th>
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<tbody>
<tr>
<td>□ N/A</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>□ Referral Needed</td>
<td></td>
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<tr>
<td>□ Accepted</td>
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<tr>
<td>□ Declined</td>
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</tbody>
</table>

- Client is able to verbalize accurate understanding of their HIV disease treatments and medication (side effects, purpose of meds).
- Client has basic knowledge of their HIV disease treatments (e.g., viral load, CD4, and labs) and medication but may need treatment adherence assistance.
- Client needs repeated oral instructions or assistance to understand health information or medications;
  - OR
  - Client is cognitively impaired.
- Client does not know or understand health information or medications.

### Notes:

#### Retention in Medical Care (Continued)

<table>
<thead>
<tr>
<th>HIV Disease Progression</th>
<th>Viral Load(^1) (Suppressed is under 200 copies/mL):</th>
<th>Date of Test:</th>
<th>CD4 (Prophylaxis required under 200 cell/mm(^3)):</th>
<th>Date of Test:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ N/A</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>□ Referral Needed</td>
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</tr>
<tr>
<td>□ Accepted</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>□ Declined</td>
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</tr>
</tbody>
</table>

\(^1\)HRSA Viral Load suppression definition is used for consistency.

### Notes:

- Client has no history of an Opportunistic Infection (OI);
  - OR
  - No HIV-related hospitalization in the last 12 months.
- Client has had an OI in the past 12 months with appropriate treatment (TX);
  - OR
  - Client has a CD4 count less than 200 cell/mm\(^3\) but has started prophylaxis.
- Client has had an OI in the past 12 months on TX;
  - OR
  - Client has been hospitalized due to HIV in past 6 months.
- Client viral load is greater than 100,000;
  - OR
  - Client currently has an OI and not currently on TX;
  - OR
  - Client has been hospitalized due to HIV in past 3 months.

### Notes:

(Continued on the next page)
### Retention in Medical Care (Continued)

#### Assessment/Acuity

<table>
<thead>
<tr>
<th>Disease Co-Morbidities</th>
<th>Problems with Meds OR N/A:</th>
<th>Problems with Meds OR N/A:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ N/A</td>
<td>□ Too many pills</td>
<td>□ Too many pills</td>
</tr>
<tr>
<td>□ Referral Needed</td>
<td>□ Side effects</td>
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<tr>
<td>□ Accepted</td>
<td>□ Alcohol/drug use</td>
<td>□ Alcohol/drug use</td>
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<tr>
<td>□ Declined</td>
<td>□ Forgot</td>
<td>□ Forgot</td>
</tr>
<tr>
<td></td>
<td>□ No Privacy</td>
<td>□ No Privacy</td>
</tr>
<tr>
<td></td>
<td>□ Cost</td>
<td>□ Cost</td>
</tr>
</tbody>
</table>

#### Problems with Meds OR N/A:

- □ Client has no reported co-morbidities;
- □ Client has reported difficulties managing co-morbidities.
- □ Client has reported an unmanaged co-morbidity.

<table>
<thead>
<tr>
<th>Zero</th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

#### Notes:

#### Medication List (Check all that apply):

**Antibiotics**

- □ Amoxicillin (generic for Amoxil)
- □ Amoxicillin/Potassium Clavulanate ER (generic for Augmentin XR)
- □ Azithromycin (generic for Zithromax)
- □ Other: ___________

**Anti-inflammatories**

- □ Meloxicam (generic for Mobic) Methylprednisolone (generic for Medrol)
- □ Prednisone (generic for Deltasone)
- □ Other: ___________

**Anti-hypertensives/Heart Medications**

- □ Amlodipine (generic for Norvasc)
- □ Atenolol (generic for Tenormin)
- □ Carvedilol (generic for Coreg)
- □ Clopidogrel (generic for Plavix)
- □ Hydrochlorothiazide (generic for Microzide)
- □ Lisinopril (generic for Prinivil)
- □ Lisinopril/HCTZ (generic for Zestoretic)
- □ Losartan (generic for Cozaar)
- □ Losartan Potassium (generic for Cozaar)

**Asthma/Chronic Obstructive Pulmonary Disease**

- □ Fluticasone (generic for Flonase)
- □ Montelukast (generic for Singulair)
- □ Ventolin
- □ Other: ___________

**Cholesterol**

- □ Atorvastatin Calcium (generic for Lipitor)
- □ Crestor
- □ Fenofibrate (generic for Tricor)
- □ Pravastatin (generic for Pravachol)
- □ Simvastatin (generic for Zocor)
- □ Other: ___________

**Diabetes**

- □ Metformin (generic for Glucophage)
- □ Other: ___________

**Depression**

- □ Bupropion (generic for Wellbutrin)
- □ Citalopram (generic for Celexa)
- □ Other: ___________

**Opiate or Pain Medications**

- □ Gabapentin (generic for Neurontin)

**Other**

- □ Allopurinol (generic for Zyloprim)
- □ Cialis
- □ Cyclobenzaprine (generic for Flexeril)
- □ Furosemide (generic for Lasix)
- □ Levothyroxine (generic of Synthroid)
- □ Omeprazole (generic of Prilosec)
- □ Pantoprazole (generic for Protonix)
- □ Potassium Chloride (generic for Klor-Con)
- □ Tamsulosin (generic for Flomax)
- □ Warfarin (generic for Coumadin)
- □ Other: ___________

**Psychotropic**

- □ Alprazolam (generic for Xanax)
- □ Amphetamine/Dextroamphetamine (generic for Adderall)
- □ Duloxetine (Cymbalta)
- □ Escitalopram (generic for Lexapro)
- □ Fluoxetine (generic for Prozac)
- □ Sertraline (generic for Zoloft)
- □ Trazodone (generic for Oleptro)
### Psychosocial Assessment/Acuity Tool

**Client ID:**

<table>
<thead>
<tr>
<th>Metoprolol (generic for Lopressor)</th>
<th>Hydrocodone/Acetaminophen (generic for Lortab)</th>
<th>Venlafaxine (generic for Effexor)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metoprolol ER (generic for Toprol XL)</td>
<td>Tramadol (generic for Ultram)</td>
<td>Zolpidem (generic for Ambien)</td>
</tr>
<tr>
<td>Other: __________________________</td>
<td>Other: __________________________</td>
<td>Other: __________________________</td>
</tr>
</tbody>
</table>

### Retention in Medical Care (Continued)

**Date of Last Dental Appointment:** / / [OR] Doesn’t Recall

**Current Dental Issue (Indicate):**

- [ ] Client has a dentist and reports seeing dentist at least once in the last 12 months; [OR]
- [ ] Client reports no dental issues.
- [ ] Client has a dentist and requests a referral for general care.
- [ ] Client does not have a dentist and has not been seen in the last 12 months.
- [ ] Client reports having an acute and urgent dental situation and/or mouth pain.

**Dental Issue Causing Problems with Eating:** [ ] Yes [ ] No

<table>
<thead>
<tr>
<th>Dental Issue Causing Problems with Eating</th>
<th>Zero</th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Client has a dentist and reports seeing dentist at least once in the last 12 months; [OR]</td>
<td>[ ] Client reports no dental issues.</td>
<td>[ ] Client has a dentist and requests a referral for general care.</td>
<td>[ ] Client does not have a dentist and has not been seen in the last 12 months.</td>
<td>[ ] Client reports having an acute and urgent dental situation and/or mouth pain.</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**

### Oral Health Needs

- [ ] N/A
- [ ] Referral Needed
  - [ ] Accepted
  - [ ] Declined
- [ ] Client refuses Oral Health Care

**Date of Last Dental Appointment:** / / [OR] Doesn’t Recall

**Current Dental Issue (Indicate):**

- [ ] Client has a dentist and reports seeing dentist at least once in the last 12 months; [OR]
- [ ] Client reports no dental issues.
- [ ] Client has a dentist and requests a referral for general care.
- [ ] Client does not have a dentist and has not been seen in the last 12 months.
- [ ] Client reports having an acute and urgent dental situation and/or mouth pain.

**Dental Issue Causing Problems with Eating:** [ ] Yes [ ] No

<table>
<thead>
<tr>
<th>Dental Issue Causing Problems with Eating</th>
<th>Zero</th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Client has a dentist and reports seeing dentist at least once in the last 12 months; [OR]</td>
<td>[ ] Client reports no dental issues.</td>
<td>[ ] Client has a dentist and requests a referral for general care.</td>
<td>[ ] Client does not have a dentist and has not been seen in the last 12 months.</td>
<td>[ ] Client reports having an acute and urgent dental situation and/or mouth pain.</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**

### Medical Nutrition Needs

(assessment of nutritional needs for improved health)

- [ ] N/A
- [ ] Referral Needed
  - [ ] Accepted (Check all)
    - [ ] RD
    - [ ] RW Pantry
    - [ ] Other Pantry
    - [ ] Declined

**Assistance is Needed to Get Food** (check one): [ ] Yes [ ] No [ ] Already getting assistance (Indicate type):

<table>
<thead>
<tr>
<th>Assistance is Needed to Get Food</th>
<th>Zero</th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Client reports no nutrition problems (e.g., nausea, vomiting, diarrhea).</td>
<td>[ ] Client has had occasional episodes of nausea, vomiting, or diarrhea and may benefit from a nutritional referral; [OR]</td>
<td>[ ] Client reports need for food services assistance to maintain health.</td>
<td>[ ] Client reports on-going nutritional problems; [OR]</td>
<td>[ ] Client reports severe and on-going nutritional problems; [OR]</td>
<td></td>
</tr>
<tr>
<td>[ ] Client has had occasional episodes of nausea, vomiting, or diarrhea and may benefit from a nutritional referral; [OR]</td>
<td>[ ] Client reports need for food services assistance to maintain health.</td>
<td>[ ] Client reports on-going nutritional problems; [OR]</td>
<td>[ ] Client reports severe and on-going nutritional problems; [OR]</td>
<td>[ ] Client has been diagnosed with wasting syndrome.</td>
<td></td>
</tr>
</tbody>
</table>

**For Women Only OR [ ] N/A:**

- [ ] Yes: If Yes, In prenatal care [OR] Referred to prenatal care

**Total Retention in Medical Care Score:**

**Notes:**

(Continued on the next page)
Client ID: ____________________

**Psychosocial Assessment/Acuity Tool**

**Barriers to Care**: Complete for Linkage and Retention in Care. Check one box for each area of assessment below. The assessment below does not constitute diagnoses.

**Brief Mental Health Assessment**: Complete the following based on appearance:

<table>
<thead>
<tr>
<th>Appearance</th>
<th>Neat/Clean</th>
<th>Unkempt</th>
<th>Poor Hygiene</th>
<th>Other: __________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood</td>
<td>Normal</td>
<td>Euphoric</td>
<td>Depressed</td>
<td>Irritable</td>
</tr>
<tr>
<td>Speech</td>
<td>Clear</td>
<td>Loud</td>
<td>Mumbled</td>
<td>Slurred</td>
</tr>
<tr>
<td>Attention</td>
<td>Normal</td>
<td>Distracted</td>
<td>Hyper</td>
<td>Inconsistent</td>
</tr>
</tbody>
</table>

**Brief Mental Health Questionnaire**: Inquire about the following in past year *(If Yes to any of the questions below, offer Mental Health referral.)*

1. Have you felt blue, sad, or depressed for at least two weeks in a row? [ ] Yes [ ] No
2. Have you lost interested in things like hobbies, work, or activities? [ ] Yes [ ] No
3. Have you felt worried or anxious for a period that lasted longer than a month? [ ] Yes [ ] No
4. Have you ever had a sudden feeling of anxiousness or fear? [ ] Yes [ ] No
5. Have you heard voices or seen things others did not hear or see? [ ] Yes [ ] No
6. Have you thought about hurting yourself or other? [ ] Yes [ ] No
7. Have you ever had a Mental Health clinical diagnosis? [ ] Yes [ ] No *(If Yes, check below in assessment section)*
8. Do you see a doctor or talk to a counselor about your feelings or diagnosis? [ ] Yes [ ] No

<table>
<thead>
<tr>
<th>Assessment/Acuity</th>
<th>Doctor/Counselor:</th>
<th>Phone:</th>
<th>OR [ ] None at this time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>Date of Last Appointment: / /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[ ] Referral Needed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[ ] Accepted</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>[ ] Declined</td>
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<td></td>
</tr>
</tbody>
</table>

**Reasons for Missed Appointments** *(check all that apply)* [ ] N/A:

<table>
<thead>
<tr>
<th></th>
<th>Forgot</th>
<th>Didn’t feel good</th>
<th>Felt good</th>
<th>Work/school</th>
<th>No transportation</th>
<th>Cost</th>
<th>Don’t like staff or treatment</th>
<th>Refused to go after being referred</th>
<th>Alcohol/drug use</th>
<th>Didn’t feel like going</th>
<th>Other: __________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zero</td>
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<tr>
<td>Three</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Current Meds:** __________

<table>
<thead>
<tr>
<th>Client reports no history of mental health issues or treatment (Tx).</th>
<th>Client reports history of mental health issues and is currently in Tx or counseling; OR</th>
<th>Client reports history of mental health issues and difficulty adhering to treatment; OR</th>
<th>Client reports or exhibits behavior that indicates danger to self and/or others; OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client reports history of mental health issues but states no current need for Tx or counseling.</td>
<td>Observed behavior or client reports mental health assessment need.</td>
<td>Client’s reported mental health issues may be a barrier to medical treatment or HIV meds adherence; OR</td>
<td>Client reports non-compliance with mental health meds.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment (Tx) Options (Check one)</th>
<th>In Tx</th>
<th>Waiting list</th>
<th>Refused Tx</th>
<th>Completed Tx</th>
<th>Pre-Treatment Process</th>
<th>Dropped out of Tx</th>
<th>No Active Tx</th>
</tr>
</thead>
<tbody>
<tr>
<td>TX Resumed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: __________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:** ____________________________

Page 33 of 46  Rev 4/11/18
**Client ID:** ____________________  

**Psychosocial Assessment/Acuity Tool**

**Barriers to Care (Continued)**

**Self-Reported Use of Non-Prescribed Substances:** Complete for each substance and check off N/A or History and/or Current Use and Frequency

<table>
<thead>
<tr>
<th>Substance</th>
<th>N/A</th>
<th>History</th>
<th>Current Use</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cocaine/Crack</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heroin/Opiates</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amphetamines (Speed, Crystal)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inhalants</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hallucinogens</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Misuse of prescribed drugs (Indicate):</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marijuana</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Indicate):</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**

**Brief Substance Use Questionnaire:** Inquire about the following in past year:

1. Do you think you have a problem with alcohol or other drugs?  
   - Yes  
   - No  
   - Refused to answer

2. Has your alcohol and/or drug use ever interfered with your daily activities?  
   - Yes  
   - No  
   - Refused to answer  
   - N/A

3. Have you ever injected drugs?  
   - Yes  
   - No  
   - Refused to answer  
   - Don’t Know  
   - N/A

4. Are you currently in treatment?  
   - Yes  
   - No (If Yes, Indicate type of treatment: ____ )  
   - N/A

5. Are you currently in recovery?  
   - Yes  
   - No  
   - N/A

6. Are you willing to go to treatment?  
   - Yes  
   - No  
   - N/A

**Assessment/Acuity Program/Counselor:**

<table>
<thead>
<tr>
<th>Substance Use/Abuse</th>
<th>Program/Counselor:</th>
<th>Phone:</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>See Notes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral Needed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accepted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Declined</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client reports no history of substance abuse (alcohol and/or other drugs).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client reports history of substance abuse/misuse and is currently in treatment; OR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client reports history of substance abuse/misuse and states he/she is in recovery with appropriate support; OR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client reports using alcohol and/or other drugs intermittently but use does not interfere with daily functioning.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zero</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Three</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**

**Treatment (Tx) Options (Check one):**

- In Tx  
- Waiting list  
- Refused Tx  
- Completed Tx  
- Pre-Treatment Process  
- Dropped out of Tx  
- No Active Tx  
- Tx Resumed  
- Unknown  
- Other:  

**Zero:**

**One:**

**Two:**

**Three:**

**Total:**

**Client reports substance abuse problem but is not willing to seek treatment; OR**

**Client denies current substance abuse/misuse but behavior or evidence of current substance use is observed.**

**Notes:**
<table>
<thead>
<tr>
<th>Assessment/Acuity</th>
<th>Zero</th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial</td>
<td>□ Client reports having income or source of financial support is able to meet financial obligations.</td>
<td>□ Client reports having an unstable income but knows how to request/access financial assistance when needed.</td>
<td>□ Client currently does not have enough income to meet financial obligations/meet basic needs and requires a referral for financial assistance.</td>
<td>□ Client has no income or source of financial support; OR □ Client needs frequent follow up to ensure basic needs are met.</td>
<td></td>
</tr>
<tr>
<td>Notes:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living Situation</td>
<td>Lives: □ Homeless □ Alone □ Friend/roommate □ Partner □ Parents □ Relatives □ Other:</td>
<td>□ Client Reports Difficulty With: □ Personal hygiene □ Preparing meals □ Cleaning □ Other:</td>
<td>□ N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notes:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support System</td>
<td>Person(s)/Activities That Provide Most Support: □ Partner □ Family □ Friend □ Church group □ Support group</td>
<td>□ Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notes:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Client ID: ______________________  ______________________  ______________________

## Psychosocial Assessment/Acuity Tool

<table>
<thead>
<tr>
<th>Assessment/Acuity</th>
<th>Zero</th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Linguistic</strong></td>
<td>Client reports no language barriers to care.</td>
<td>Client requests occasional assistance in understanding or completing forms or new information.</td>
<td>Client requires translation or sign interpreters to complete forms or understand medical concepts/directives; <strong>OR</strong> Client is illiterate or has low literacy that interferes with ability to understand medical concepts/directives.</td>
<td>There is no indicator for this level.</td>
<td></td>
</tr>
<tr>
<td>Referral Needed</td>
<td>□ Accepted</td>
<td>□ Declined</td>
<td>□ Declined</td>
<td>□ Declined</td>
<td></td>
</tr>
<tr>
<td>Client is monolingual: But language is not a barrier at this agency but may be for referrals.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

**Notes:**

| Cultural            | Client reports that culture is not a barrier to accessing services. | Client reports that cultural barriers interfere with the ability to access care. | Client reports that he/she is unable to access care due to cultural barriers. | There is no indicator for this level. |                       |
| Referral Needed     | □ Accepted                                | □ Declined                               | □ Declined                               | □ Declined                                 |                        |

**Notes:**

| Medical Transportation | **Primary Type of Transportation:** Own car □ Bus □ Walk □ Bike □ Other: | **Assistance Needed or Received:** Bus pass □ ACCESS □ Van □ Other: | | |                        |
| Referral Needed       | □ Accepted                                | □ Declined                               | □ Declined                               | □ Declined                                 |                        |

**Notes:**

**Total Barriers to Care Score:**

(Continued on next page)
### Other Risks and Issues

#### Assessment

<table>
<thead>
<tr>
<th>Sexual Risk Behaviors</th>
<th>Sexual Risk Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Declined to have conversation regarding sexual risk behaviors</td>
<td></td>
</tr>
</tbody>
</table>

- **See Notes**
- **Referral Needed**
- **Accepted**
- **Declined**

#### Scale of Least to Highest (1-10), Importance of Protecting Oneself from STDs/STIs:

- Reduce number of partners
- Don’t have sex with strangers
- Have sex with steady partner
- Abstain
- Use condoms or other barriers
- Ask partners about their STDs/HIV status
- Other:

#### Scale of Least to Highest (1-10), Importance of Reducing Risk of Transmitting HIV to Others:

- Have types of sex less likely to transmit HIV
- Tell Partner HIV status
- Abstain
- Take HIV medications
- Only have sex with other HIV+ individuals
- Use condoms or other barriers
- Other:

#### Number of Sex Partners in Last Three (3) Months:

<table>
<thead>
<tr>
<th>Sex Partners:</th>
<th>□ Men</th>
<th>□ Women</th>
<th>□ TG (M-F)</th>
<th>□ TG (F-M)</th>
<th>□ Sex workers</th>
<th>□ Other:</th>
<th>N/A</th>
</tr>
</thead>
</table>

#### In Past Three (3) Months, Has Had Sex For:

- □ Money
- □ Alcohol/drugs
- □ Basic needs
- □ Housing
- □ Other: | N/A |

#### Condom Use:

- □ Always
- □ Often
- □ Sometimes
- □ Never
- □ Only when not with primary partner

#### How Often do you Know HIV Status of Partners:

- □ Always
- □ Often
- □ Sometimes
- □ Never
- □ N/A

#### Reasons for Unprotected Sex:

- □ Alcohol/drug use
- □ No condoms available
- □ Partner refused
- □ Other: | N/A |

#### Reports Knowing How to Use Condom Correctly:

- □ Yes
- □ No
- □ Not Sure

#### Reports Ability to Negotiate Safer Sex Activities with Partner(s):

- □ Yes
- □ No
- □ Not Sure

#### STDs Diagnosed or an Outbreak in Last 12 Months:

- □ Syphilis
- □ Gonorrhea
- □ Chlamydia
- □ Herpes
- □ Other: | N/A |

#### Partner Services (PS)

- □ Referral Needed
- □ Accepted
- □ Declined

#### Reports Comfort Disclosing HIV-Status to Partners:

- □ Yes
- □ No
- □ N/A

#### Reports Needing Help Disclosing HIV-Status to Partners (Sex and/or Needle Sharing):

- □ Yes
- □ No
- □ N/A

- □ Discussed Partner Services
- □ Helped With Disclosure (2nd Party)
- □ Referred for Partner Services (2nd or 3rd Party)

#### Domestic Violence

- □ N/A
- □ Referral Needed
- □ Accepted
- □ Declined

#### Client Reports Partner/Parent/Friend/Roommate Makes Them Feel Afraid/Unsafe:

- □ Always
- □ Often
- □ Sometimes
- □ Never
- □ N/A

#### Client Needs/Requests:

- □ Help with getting restraining order
- □ Help with filing charges
- □ Help with a moving out of current home
- □ N/A

#### Notes:

- Partner Services (PS)
- Domestic Violence
- Other Risks and Issues
Other Risks and Issues (Continued)

<table>
<thead>
<tr>
<th>Legal Issues</th>
<th>Current Legal Issues</th>
<th>Pending Legal Issue</th>
<th>Client Needs/Requests the Following OR N/A</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>□ On probation □ On parole □ Recently released □ N/A</td>
<td>□ Yes □ No (Indicate Issue if Yes):</td>
<td>□ Health Care Directive □ Will □ Arrangement for guardianship □ Power of attorney □ Bankruptcy □ Help with discrimination case/issue □ Other:</td>
<td></td>
</tr>
<tr>
<td>Referral Needed</td>
<td>□ Accepted □ Declined</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Immigration Status | Immigration Status: | Immigration Issue/Concern: | Notes: |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>□ US Citizen □ Lawful US Resident (Indicate Type):</td>
<td>□ Yes □ No (Indicate Issue if Yes):</td>
<td></td>
</tr>
<tr>
<td>Referral Needed</td>
<td>□ Accepted □ Declined</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Case Summary Notes: (Continued on the next page)
Medical Case Management (Linkage to Care or Medical Retention Services)

Linkage to Care (LTC) services are intended for individuals who are:
- Newly diagnosed;
- New to Orange County and have not linked to a HIV medical provider;
- Returning to HIV care; and/or
- Transitioning to another payer source and have not linked to a HIV medical provider.

Medical Retention Services (MRS) are intended for individuals who are:
- Not HIV medication adherent;
- Medically compromised or have a viral load greater than 100,000 copies/mL; and/or
- Dealing with medical co-morbidities, mental health, or substance use that impede medical care adherence.

MRS must be provided by medically credentialed or other healthcare staff who are part of a clinical team.

<table>
<thead>
<tr>
<th>Score</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Linkage to Care clients will receive up to six (6) months LTC services, regardless of acuity score.</td>
</tr>
<tr>
<td></td>
<td>Case Manager can refer to a different level of case management at any time.</td>
</tr>
</tbody>
</table>

Medical Retention Services (MRS)

Minimum psychosocial every three (3) months.
Minimum contact once a month.

Individual Service Plan (ISP) every six (6) months.

A score of 10 and above in Retention in Care section (first five assessment sections HIV Med Adherence to Disease Co-Morbidities only) requires MRS.

Case Manager can refer to a different level of case management based on client needs/progress at any time.

Barriers to Care

Client should be referred to service(s) that can potentially address barrier(s). Follow up should be conducted at minimum two (2) weeks from referral to confirm linkage to service(s). A face-to-face assessment should be conducted three (3) months from the date of referral to assess status. During assessments, if the services needed do not directly impact medical care, a referral to Non-Medical Case Management (Client Support) may be appropriate.

OR

Non-Medical Case Management (Client Support or Client Advocacy)

Client Support Services are intended for individuals who are medically stable but require psychosocial support to ensure medical care adherence (e.g., housing, substance use, and food instability). Client Advocacy is available to answer basic questions and provide referrals to services for individuals who do not need on-going case management. Non-Medical Case Management may be provided by non-medically credentialed and unlicensed trained professionals.

Client Support

<table>
<thead>
<tr>
<th>Score</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A score of 14 and above in Barriers to Care requires Client Support.</td>
</tr>
<tr>
<td></td>
<td>Scores below 14 should be referred to Client Advocacy.</td>
</tr>
</tbody>
</table>

Client Advocacy

No minimum psychosocial assessment.
No minimum contact.

Service is provided on an as needed basis.

Override Rationale: 
<table>
<thead>
<tr>
<th>Referrals (Check all referrals made)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits Counseling</td>
</tr>
<tr>
<td>Housing</td>
</tr>
<tr>
<td>Substance Use/Abuse Services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CM Name and Licensure (Print)</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>CM Name and Licensure (Print)</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Clinical Supervisor Signature, If required</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Next Psychosocial/Acuity:</th>
<th>/</th>
<th>/</th>
<th>Next ISP:</th>
<th>/</th>
<th>/</th>
<th>Next Eligibility:</th>
<th>/</th>
<th>/</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full OR Self-Attestation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Appendix C Continued: Follow-Up Psychosocial Assessment

Assessment Conducted at (Check one): [ ] Office  [ ] Client’s Home  [ ] Hospital  [ ] Other: _________  Date: _______/_____/_____

First Name  Last Name  MI  OR  No MI  AKA  Mother’s MN

Date of Birth: _______/_____/_____  Age: _________  Gender (Check one): [ ] M  [ ] F  [ ] TG (M-F)  [ ] TG (F-M)

Marital Status: [ ] Married  [ ] Single  [ ] Divorced  [ ] Other: _________  Sexual Orientation: _________

[ ] Information in “double line” section is documented elsewhere and not completed below.  Indicate Location:

Race: [ ] White  [ ] Black/African Amer.  [ ] Asian  [ ] Pacific Islander/Hawaiian  [ ] Native Amer.  [ ] Other: _________

Ethnicity: [ ] Hispanic/Latino  [ ] Not Hispanic/Latino  [ ] Unknown  [ ] Decline to State

Primary Language: ____________________________  Requires Translation Services: [ ] Yes  [ ] No

Address  City or location if homeless  Zip Code  Ok to Mail

[ ] Yes  [ ] No  [ ] Yes  [ ] No  [ ] Yes  [ ] No  [ ] Yes  [ ] No

Preferred Number OR [ ] None  Ok to Call  Ok to Leave Message  Ok to Text  Email  Ok to Email

Monthly Income (Reported or Based on ARIES-Eligibility): ____________________________  Federal Poverty Level Percentage: ____________________________

Income Type (Check all that apply): [ ] Employment  [ ] Unemployment  [ ] Disability  [ ] Retirement  [ ] Gen. Assist/TANF  [ ] Other: _________

Disability: [ ] None  [ ] Type (List): ____________________________  Permanent  [ ] Temporary  Expiration: _______/_____/_____

Emergency Contact
[ ] ROI on File OR [ ] Refused:
[ ] HIV Aware
[ ] HIV Unaware

[ ] HIV Aware  Phone: ____________________________  Language of Emergency Contact:

[ ] HIV Unaware

Employment Info OR [ ] N/A  Employment Type: ____________________________  [ ] Full Time  OR  [ ] Part Time  Benefits: [ ] Yes  [ ] No

Current Living Situation:
[ ] Stable/Permanent Housing  [ ] Homeless/Unstable  [ ] Other: ____________________________

[ ] Temporary/Transitional Housing - Indicate Date Housing Ends: _______/_____/_____

Education Completed: [ ] Elementary/Primary  [ ] Jr. High  [ ] High School/GED  [ ] Trade/Vocational  [ ] College  [ ] Other: ____________________________
## Core Medical Issues

<table>
<thead>
<tr>
<th>Access to HIV Medical Care: Describe any pertinent information regarding access to HIV Medical Care, including change in employment, health insurance, or provider</th>
<th>□ Referral Needed</th>
<th>□ Accepted</th>
<th>□ Declined</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Access to Other Medical Care: Describe any pertinent information regarding access to other Medical Care, for example, Mental Health, Oral Health, etc.</th>
<th>□ Referral Needed</th>
<th>□ Accepted</th>
<th>□ Declined</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Medical Condition: Describe any pertinent information regarding medical condition, including viral load/CD4, co-morbidities, medication adherence, etc.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Viral Load(^1) (Suppressed is under 200 copies/mL):</th>
<th>Date of Test: / /</th>
<th>Unknown</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>CD4 (Prophylaxis required under 200 cell/mm(^3)):</th>
<th>Date of Test: / /</th>
<th>Unknown</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Mental Health Status: Describe any pertinent information regarding mental health status</th>
<th>□ Referral Needed</th>
<th>□ Accepted</th>
<th>□ Declined</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Substance Use Activities: Describe any pertinent information regarding substance use activities</th>
<th>□ Referral Needed</th>
<th>□ Accepted</th>
<th>□ Declined</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Risk Behaviors: Describe any pertinent information regarding risk behaviors</th>
<th>□ Referral Needed</th>
<th>□ Accepted</th>
<th>□ Declined</th>
</tr>
</thead>
</table>

\(^1\)HRSA Viral Load suppression definition is used for consistency.
### Psychosocial Issues

**Financial:** Describe any pertinent information regarding financial situation that may impact health

- Referral Needed
  - □ Accepted
  - □ Declined

**Housing:** Describe any pertinent information regarding housing/living situation

- Referral Needed
  - □ Accepted
  - □ Declined

**Support System:** Describe any pertinent information regarding support system

- Referral Needed
  - □ Accepted
  - □ Declined

**Transportation:** Describe any pertinent information regarding transportation needed to access medical services

- Referral Needed
  - □ Accepted
  - □ Declined

**Legal:** Describe any pertinent information regarding legal situation or need, including immigration status

- Referral Needed
  - □ Accepted
  - □ Declined

**HIV Knowledge:** Describe any pertinent information regarding HIV knowledge, disease treatment, or medication effects

- Referral Needed
  - □ Accepted
  - □ Declined

### Recommended Level of Case Management:
- LTC
- Medical Retention Services
- Client Support
- Client Advocacy

### Additional Notes or Goals:

---

**CM Name and Licensure (Print)**

**Signature**

**Date**

**Clinical Supervisor Signature, If required**

**Next Psychosocial/Acuity:** / / 

**Next ISP:** / / 

**Next Eligibility:** / / 

**Date**

□ Full OR □ Self-Attestation

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Page 43 of 46

Rev 4/11/18
The Individual Service Plan (ISP) is intended to be a living document to develop goals in collaboration with the client that will lead toward improvements along the HIV Care Continuum (Linkage to Care, Retention in HIV Care, Taking ART, and Viral Load Suppression) and ultimately client self-sufficiency. Case Managers should consider the following in working with the client. A copy of page two may be printed for the client.

- Goals should be **SMART**: Specific, Measurable, Attainable, Realistic, and Timely.
- ISP goals should lead toward the overall long-term goals for the client.
- Clients should have enough time to develop long-term goals, it is not expected that a long-term goal will be completed within a set timeframe.

The following are suggested questions that can help guide goal development:

- Who are the individuals in your life that can help you meet your goals?
- Who are the individuals in your life that can cause a barrier to you meeting your goals?
- How would your life look if you could meet your goals?
- How would your life look if you could not meet your goals?
- What problems or difficulties do you have right now and how do they affect your life?

<table>
<thead>
<tr>
<th>Long-Term Goal 1: Indicate client’s goal: _____</th>
<th>OR</th>
<th>☐ Long-term goal was not developed during this session</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicate barriers to achieving goal:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notes:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Long-Term Goal 2: Indicate client’s goal: _____</th>
<th>OR</th>
<th>☐ Long-term goal was not developed during this session</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicate barriers to achieving goal:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notes:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Please indicate **Goal Area(s)** from the list below:

- Medical Care
- Mental Health
- Support System
- Legal Issues
- Medication Adherence
- Substance Use
- Transportation
- Immigration Status
- Oral Health
- Financial
- Sexual Risk/Partner Services
- Education/Job Training
- Nutrition
- Living Situation
- Safety Issues
- Other:

### Step 1 Area:

Indicate client’s goal for this area:

Indicate at least three actions to reach this goal:

<table>
<thead>
<tr>
<th>Action</th>
<th>Person(s) Responsible for Helping to Achieve Goal</th>
<th>Target Date</th>
<th>Date Achieved or Modified</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes:

Referral(s) Made OR [ ] N/A:

### Step 2 Area:

Indicate client’s goal for this area:

Indicate at least three actions to reach this goal:

<table>
<thead>
<tr>
<th>Action</th>
<th>Person(s) Responsible for Helping to Achieve Goal</th>
<th>Target Date</th>
<th>Date Achieved or Modified</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
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<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes:

Referral(s) Made OR [ ] N/A:

---

**Client Name (Print) - Optional**

**Client Name (Signature) - Optional**

**Date**

**CM Name and Licensure (Print)**

**Next ISP:**  /  /  /  

**Next Psychosocial/Acuity:**  /  /  

**Next Eligibility:**  /  /  

**Clinical Supervisor Signature, If appropriate**

[ ] Full OR [ ] Self-Attestation

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Page 45 of 46
Appendix E: Flowchart for Case Management Services

Flowchart for Case Management Services – Revised 03/05/18

What is the Individual’s Medical Need and/or Situation?

- Newly Diagnosed
  - New to Area
  - Returning to Care
  - Change in Insurance
  - Change in Medical Care Provider

  Provide Linkage to Care (LTC)

  What is required follow-up?

  Contact once a month

- HIV Medically Unstable
  - Not Adherent to HIV Medication
  - Unmanaged Co-Morbidities

  Provide Medical Retention Services (MRS)

  What is required follow-up?

  Assessment every 3 months
  - Contact once a month

- HIV Medically Stable
  - HIV Viral Load (VL) is suppressed based on HRSA definition of 200 copies/mL

  Does client need assistance or follow-up to access support services?

  Yes
  - Provide Client Support Services (CSS)

  No
  - Client Advocacy/Self-Advocacy (CA)
    - Provide Information and Referrals, as requested

  What is timeframe limit for this service?

  Maximum 6 months for LTC
  - Successful engagement may be defined by sustained VL suppression or acuity scores consistent with CSS/CA.

  What if client still needs support?

  Refer Client to MRS or Client Support, as appropriate

  What is required follow-up?

  Assessment every 6 months
  - Contact every 3 months for Client Support

  No assessment or contact is required for Client Advocacy

  There is no timeframe limit for Client Support or Client Advocacy
  - Service provided as needed

\(^3\) Limit for service is suggested and may change based on an individual’s assessment.