

Ryan White Part A Client Reassessment Form



Today's Date:	Client URN:	Does the client need an interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what language:
<input type="checkbox"/> Newly Diagnosed or New to Care <input type="checkbox"/> Returning Client (out of care for 12 months or more)		Assigned Case Manager:
DEMOGRAPHICS		
Last Name:	First Name:	Middle Name:
Date of Birth: / / (<input type="checkbox"/> check if estimated)	Age:	Social Security Number:
Home Address:	Apt #	City:
State:	County:	Zip Code:
<input type="checkbox"/> check if same as home address	Apt #	City:
Mailing Address:		
State:	County:	Zip Code:
May we contact you by mail at this address? <input type="checkbox"/> Yes, contact via mailing address <input type="checkbox"/> No		
Home phone#: ()	Other phone#: ()	
May we leave you a message at this phone number? <input type="checkbox"/> Yes, contact via home phone # <input type="checkbox"/> Yes, contact via other phone # <input type="checkbox"/> No		
What is your primary source of transportation: <input type="checkbox"/> Own a car <input type="checkbox"/> Public Transportation (bus) <input type="checkbox"/> Friends/relatives <input type="checkbox"/> Walking <input type="checkbox"/> Other: _____		

HIV/AIDS STATUS AND MEDICAL INFORMATION		
Who is your Primary HIV Medical Provider or where do you go for HIV medical Care:		
Location Name:		
Results of your most recent Viral Load:	What is the date of that Viral Load:	
Results of your most recent CD4 Count:	What is the date of that CD4 Count:	
Are you currently taking any prescribed medications? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes If so, what medications are you taking:		
What is your HIV/AIDS status: <input type="checkbox"/> HIV-positive (not yet AIDS) <input type="checkbox"/> HIV-positive (AIDS status unknown) <input type="checkbox"/> AIDS <input type="checkbox"/> HIV-negative (affected) <input type="checkbox"/> Unknown <input type="checkbox"/> HIV-indeterminate (only if under 2 years of age)	Who is your primary insurance provider: <input type="checkbox"/> Medicaid/AHCCCS <input type="checkbox"/> Medicare <input type="checkbox"/> No Insurance <input type="checkbox"/> Other, please specify: _____ <input type="checkbox"/> Other public (e.g. Champus, VA) <input type="checkbox"/> Private Insurance <input type="checkbox"/> Unknown	Other Insurance (if any): <input type="checkbox"/> Medicaid/AHCCCS <input type="checkbox"/> Medicare <input type="checkbox"/> No Insurance <input type="checkbox"/> Other, please specify: _____ <input type="checkbox"/> Other public (e.g. Champus, VA) <input type="checkbox"/> Private Insurance <input type="checkbox"/> Unknown

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EMERGENCY CONTACT INFORMATION			
Contact name:		Relationship to you:	
Address:		City:	State: Zip Code:
Home phone#: ()	Other phone#: ()		Is this contact aware of your diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No

HOUSEHOLD AND INCOME INFORMATION
Have there been any household or income changes since you were last seen? (Household income includes spouses, domestic partners and any dependents that could be claimed on your taxes) <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what are those changes?

CURRENT SERVICE NEEDS																		
What services are you in need of today, (please check all that apply):																		
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> HIV/AIDS Medical Provider</td> <td style="width: 33%;"><input type="checkbox"/> Nutrition Therapy</td> <td style="width: 33%;"><input type="checkbox"/> Transportation Assistance</td> </tr> <tr> <td><input type="checkbox"/> HIV/AIDS Medication</td> <td><input type="checkbox"/> Housing Assistance</td> <td><input type="checkbox"/> Employment Assistance</td> </tr> <tr> <td><input type="checkbox"/> Assistance with Medication Co-Pays</td> <td><input type="checkbox"/> Emergency Financial Assistance</td> <td><input type="checkbox"/> Food Bank</td> </tr> <tr> <td><input type="checkbox"/> Substance Use Treatment/Counseling</td> <td><input type="checkbox"/> Support Groups</td> <td><input type="checkbox"/> HIV/AIDS Information</td> </tr> <tr> <td><input type="checkbox"/> Mental Health Treatment/Counseling</td> <td><input type="checkbox"/> Individual Counseling</td> <td><input type="checkbox"/> Vision Care</td> </tr> <tr> <td><input type="checkbox"/> Six month redetermination of eligibility for Ryan White services appointment</td> <td><input type="checkbox"/> Other:</td> <td></td> </tr> </table>	<input type="checkbox"/> HIV/AIDS Medical Provider	<input type="checkbox"/> Nutrition Therapy	<input type="checkbox"/> Transportation Assistance	<input type="checkbox"/> HIV/AIDS Medication	<input type="checkbox"/> Housing Assistance	<input type="checkbox"/> Employment Assistance	<input type="checkbox"/> Assistance with Medication Co-Pays	<input type="checkbox"/> Emergency Financial Assistance	<input type="checkbox"/> Food Bank	<input type="checkbox"/> Substance Use Treatment/Counseling	<input type="checkbox"/> Support Groups	<input type="checkbox"/> HIV/AIDS Information	<input type="checkbox"/> Mental Health Treatment/Counseling	<input type="checkbox"/> Individual Counseling	<input type="checkbox"/> Vision Care	<input type="checkbox"/> Six month redetermination of eligibility for Ryan White services appointment	<input type="checkbox"/> Other:	
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ADDITIONAL REFERRALS	
Please list any additional referrals (not listed above) provided to the client for Ryan White or non-Ryan White Community Resources.	
Service Needed:	Organization Referred to:

CASE MANAGEMENT NOTES
If documented in CAREWare or another location please specify.

<input type="checkbox"/> Client agrees to participate in Case Management Services. <input type="checkbox"/> Client elects not to participate in the program at this time. <input type="checkbox"/> Client is not eligible for Ryan White Part A and will be referred to resources they are eligible for. Today's Date: _____ Case Managers Signature: _____ Next Eligibility Redetermination Date: _____	The Case Management Program has been explained to me and any questions I had have been answered. I agree to participate in Case Management Services. Today's Date: _____ Clients Signature: _____ Parent or Guardian Signature: _____
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