

**STATE OF IDAHO HIV/AIDS Case Management Standards
Psychosocial Assessment Form**

Intake Date _____

Assessment Date _____

Update Date _____

Client ID _____

DEMOGRAPHICS

Clients Gender

- Male
 Female

Age _____

DOB ____/____/____

Race

- White
 Black
 Asian/Pacific Islander
 Native American/American Indian
 Other/Unreported

Ethnicity

- Non-Hispanic
 Hispanic

Veteran Status _____

Military Branch _____

Dates of Service _____

Insurance Coverage

- Private
 Medicaid
 Medicare
 VA
 Uninsured
 Other _____

HEALTH PROVIDER INFORMATION

Health Insurance Provider _____

Group Number _____ Member ID _____ Phone _____

Prescription Coverage _____ Pharmacy _____ Phone _____
 Yes No

Case Manager _____

Primary Care Provider _____ Phone _____

Address _____

Previous Medical Provider _____ Phone _____

HIV Specialist _____ Phone _____

Address _____

Dentist _____ Phone _____

Address _____

Psychiatrist _____ Phone _____

Address _____

Other Providers _____ Phone _____

EDUCATION / EMPLOYMENT / FINANCIAL INFORMATION

Education

- 8th grade or less
- Some HS
- Finished HS
- GED
- Some college

Employment

- Full time
- Part time
- Disabled
- Unemployed, looking for work
- Unemployed, not looking for work

Level of Satisfaction

- Not at all
- Slightly
- Moderately
- Considerably
- Extremely

Does client want to change his/her employment situation? Yes No
 If yes, explain _____

Does client have any concerns about credit history or debt? Yes No
 If yes, explain _____

Annual Income \$ _____ **Primary Source** _____

Other Resources \$ _____ **Source** _____

BASIC NEEDS ASSESSMENT

- Client is lacking resources to provide for basic needs (food, shelter, clothing). Immediate intervention is needed.
- Client has some resources to provide for basic needs; however, these resources are inadequate. There is a need for intervention, but the need is not critical.
- Client has adequate resources to provide for needs. There is no need for intervention.

LIVING ARRANGEMENTS

Does client currently have stable housing? Yes No If yes, Permanent Temporary

Type of Housing

- House (Rent/Own)
- Apartment
- Healthcare facility
- Correctional facility
- Monthly Housing Payment _____

Living Arrangements

- Lives alone
- Lives with spouse/partner
- Lives with family
- Lives with friends

Level of satisfaction

- Not at all
- Moderately
- Considerably
- Extremely

Information about persons living with client in the home:

_____ Permission to Contact: Y N
 Name Relation

_____ Permission to Contact: Y N
 Name Relation

Are there any environmental conditions that need to be addressed for the client's health and safety? Y N
 If yes, explain _____

Does the client want to change his/her living situation? Y N
 If yes, explain _____

LIVING ARRANGEMENT ASSESSMENT

- Situation is unsafe, and/or unacceptable to the client. Immediate intervention is needed.
- Situation is not permanent or not acceptable to the client. There is a need for intervention, but the need is not critical.
- Situation is stable and acceptable to the client. There is no need for intervention.

CHILDREN/DEPENDENTS

Total Number of Dependents _____

Who is responsible for care if client is not available?

- Spouse Relative _____
 Guardian Other _____
 Partner

Children/Dependents

Name	Age	Relationship	HIV Status	Live In
				O Y O N
				O Y O N
				O Y O N
				O Y O N

Does client have guardianship arrangements made for the children/dependents? Yes No

If yes: Name _____ Address _____ Phone _____

CHILDREN/DEPENDENTS ASSESSMENT

- Client believes the living situation is unsafe, and/or inadequate for the children/dependents. Immediate intervention is needed.
- Client believes the living situation is inadequate, but not unsafe for the children/dependents. There is a need for intervention, but the need is not critical.
- Client believes the living situation is acceptable for the children/dependents. There is no need for intervention.

SOCIAL SUPPORT INFORMATION

Evaluate the strength of the client's social support system.

1= significant support
2= occasional support

3= weak support
NA= support is not available

- Spouse Partner Parent Child
 Sibling/relative Friends Support Group Guardian
 Church Pets Hospice Staff Other

Level of satisfaction

- Not at all
- Slightly
- Moderately
- Considerably
- Extremely

SOCIAL SUPPORT ASSESSMENT

- Client appears to be isolated and lacking in any significant, reliable source of social support. Client feels the need for support. Immediate intervention is needed.
- Client appears to be lacking in any significant sources of social support, but seems comfortable with the situation. Intervention may be explored at a later time.
- Client has support, but feels the need for more resources. This may be explored more fully.
- Client has an active, acceptable social support network. There is no need for intervention.

MEDICAL INFORMATION

Date of HIV diagnosis _____ Location of HIV diagnosis _____

Any past opportunistic infections? Yes No

If yes, list:

Type	Date

Presently on HIV medications? Yes No

If yes, list:

DATE	MARK IF CURRENT	GENERIC	BRAND	DOSE	TIMES
Nucleoside Analog Reverse Transcriptase Inhibitors (Nucleoside Analogs, NRTIs)					
		Zidovudine (AZT or ZVD)	Retrovir		
		Lamivudine (3TC)	Epivir		
		AZT + 3TC	Combivir		
		Didanosine (ddl)	Videx		
		Zalcitabine (ddC)	Hivid		
		Stavudine (d4T)	Zerit		
		Abacavir (ABC)	Ziagen		
		ABC + 3TC + AZT	Trizivir		
Protease Inhibitors (PIs)					
		Amprenavir	Agenerase		
		Indinavir	Crixivan		
		Lopinavir (ABT-378/r)	Kaletra		
		Nelfinavir	Viracept		
		Ritonavir	Norvir		
		Saquinavir	Fortovase		
Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)					
		Delavirdine	Rescriptor		
		Efavirenz	Sustiva		
		Nevirapine	Viramune		
Nucleotide Reverse Transcriptase Inhibitors					
		Tenofovir	Viread		
Ribonucleotide Reductase Inhibitors					
		Hydroxyruea	Hydrea		

OTHER SCHEDULED MEDS AND PRN MEDICATIONS (including OTC and nutritional/herbals)

DATE	NAME	STRENGTH	DIRECTIONS	DATE DC'd

Health Status

- Any weight loss? Yes No Normal weight_____ Current weight_____
- Any other chronic/ongoing medical problems? Yes No Specify:_____
- Any other health concerns? Yes No Specify:_____
- Is your appetite: Good Poor
- Who primarily prepares food in household? Self Other_____
- Does client want to change any aspect of his/her medical services? Yes No

Level of satisfaction

- Not at all
- Slightly
- Moderately
- Considerably
- Extremely

MEDICAL ASSESSMENT

- Client has critical, unmet medical needs. Immediate intervention is needed.
- Client has unmet medical needs, but they are not critical. There is a need for intervention, but the need is not immediate at this time.
- Client does not have unmet medical needs. No need for intervention at this time.

MENTAL HEALTH INFORMATION

If any of the following questions are answered "No" and client/significant other reports memory loss, refer to psychiatric evaluation.

- Does client know where he/she is? Yes No Does client know why he/she is here? Yes No
- Does client know today's date? Yes No

Are any of the following a problem to the client?

- | | | | |
|-------------------|----------------------------------------------------|-----------------------|----------------------------------------------------|
| Depression | <input type="radio"/> Yes <input type="radio"/> No | Anxiety | <input type="radio"/> Yes <input type="radio"/> No |
| Insomnia | <input type="radio"/> Yes <input type="radio"/> No | Forgetfulness | <input type="radio"/> Yes <input type="radio"/> No |
| Suicidal thoughts | <input type="radio"/> Yes <input type="radio"/> No | Delusional | <input type="radio"/> Yes <input type="radio"/> No |
| Dementia | <input type="radio"/> Yes <input type="radio"/> No | Withdrawal/Isolations | <input type="radio"/> Yes <input type="radio"/> No |

How troubled has the client been with mental health problems in the past 6 months?

- Not at all
- Slightly
- Considerably
- Moderately
- Extremely

Any current mental health treatment? Yes No
If yes, specify provider, facility, diagnosis, and medications:

Prior mental health treatment: Yes No
If yes, specify provider, facility, diagnosis, and medications:

MENTAL HEALTH ASSESSMENT

- Client is in immediate need of psychiatric evaluation.
- Client is in need of psychiatric intervention, but the situation is not critical.
- Client may need psychiatric intervention at a later day, but presently is functioning well within the supports available.
- Client is coping well. There is no need for intervention at this time.

SUBSTANCE USE INFORMATION

- Current substance use: Does client identify drugs/alcohol as a problem? Yes No
 Currently using Does significant other/family identify
 Not using, in recovery drugs/alcohol as a problem? Yes No
 Not using, not in recovery Has client had previous substance abuse
 Never used treatment? Yes No
If yes to prior treatment, specify: _____

If using:

Drug of choice	Amount/Frequency
1.	
2.	
3.	

SUBSTANCE USE ASSESSMENT

- Client is currently using drugs/alcohol but does not feel treatment is necessary and is not interested in obtaining treatment.
- Client is currently using drugs/alcohol and is interested in obtaining treatment.
- Client is currently in treatment.
- Client is currently not using drugs.

LEGAL INFORMATION

Does client need assistance with the following legal issues?

- Guardianship Yes No
 Living will Yes No
 Power of attorney Yes No

- Has client ever been convicted of civil or criminal charges? Yes No
 Does client have any court cases pending? Yes No
 Is client on probation or parole? Yes No

LEGAL ASSESSMENT

- Client needs assistance with several legal issues. Immediate intervention is needed.
- Client needs assistance with legal issues within the next month.
- Client may need legal assistance in the future.
- Client has no legal needs at this time.

INDEPENDENT LIVING SKILLS

Does client need assistance with any of the following daily activities?

- | | |
|--------------------------------------------------------------|---------------------------------------------------------------|
| Feeding <input type="radio"/> Yes <input type="radio"/> No | Cooking <input type="radio"/> Yes <input type="radio"/> No |
| Bathing <input type="radio"/> Yes <input type="radio"/> No | Medication <input type="radio"/> Yes <input type="radio"/> No |
| Walking <input type="radio"/> Yes <input type="radio"/> No | Cleaning <input type="radio"/> Yes <input type="radio"/> No |
| Dressing <input type="radio"/> Yes <input type="radio"/> No | Finances <input type="radio"/> Yes <input type="radio"/> No |
| Toileting <input type="radio"/> Yes <input type="radio"/> No | Shopping <input type="radio"/> Yes <input type="radio"/> No |

Is assistance already provided for any of these items? Yes No

INDEPENDENT LIVING ASSESSMENT

- Client needs assistance with many basic functions. He/She is not able to continue living independently. Immediate intervention is needed.
- Client needs assistance with many basic functions, but can manage with in-home help.
- Client needs some assistance, but is still able to manage with support services and assistance.
- Client is able to live independently.

HIV BACKGROUND AND PREVENTION EDUCATION INFORMATION

Client ID _____

Indicate mode of transmission: MSM Heterosexual contact Prenatal
 IDU IDU/ MSM Hemophilia
 Transfusion Other _____ Unknown

Has client been sexually active in the past 12 months? Yes No
 Anal Oral Vaginal

Number of partners in the past year? 0 1 2-3 4-10 10+
 Same sex Other sex Both sexes

In the last year has the client ever been worried that he/she might have gotten a sexually transmitted infection?

Yes No

If yes, did they get it checked out?

Yes No

What was the result? _____

CONDOM USE	
1. Do you use protection?	<input type="radio"/> Yes <input type="radio"/> No
2. If yes, what type of protection do you use?	
3. What percentage of the time do you use protection?	
<i>If client responds no to question 1, they should be considered for PCM.</i>	
SHARING NEEDLES	
1. Have you ever shared needles?	<input type="radio"/> Yes <input type="radio"/> No
2. If yes, are you actively sharing needles now?	<input type="radio"/> Yes <input type="radio"/> No
3. What percentage of the time do you share needles?	
4. Do you know how to clean your needles?	<input type="radio"/> Yes <input type="radio"/> No
5. If yes, please explain:	
<i>If client responds yes to questions 1 or 2, or no to question 4, they should be considered for PCM.</i>	
DISCLOSING STATUS	
1. Do you feel comfortable sharing your status with your primary partner(s)?	<input type="radio"/> Yes <input type="radio"/> No
2. Do you feel comfortable sharing your status with your casual partner(s)?	<input type="radio"/> Yes <input type="radio"/> No
3. Would you like more information on how to share your status with your partner(s)?	<input type="radio"/> Yes <input type="radio"/> No
4. If yes, please explain:	
<i>If client responds no to questions 1 or 2, or yes to question 3, they should be considered for PCM.</i>	
TRANSMISSION RESPONSIBILITY	
1. Do you feel responsible in preventing the transmission of HIV?	<input type="radio"/> Yes <input type="radio"/> No
2. If yes, why:	
3. If no, why:	
<i>If client responds no to question 1, they should be considered for PCM.</i>	

Are there things about reducing your risk you would like to know more about? Yes No

If yes, what are they? _____

Is there anything about safer practices that you would like to know more about? Yes No

If yes, what are they? _____

HIV EDUCATION ASSESSMENT

- Client has minimal to no knowledge of HIV/AIDS and puts self/others at risk. Immediate intervention is needed.
- Client has minimal knowledge of HIV/AIDS, but is not an immediate risk to self/others. There is need for prevention education at some point, but the need is not critical.
- Client has adequate knowledge of HIV/AIDS, no intervention is needed.

If client declines participation or provider decides not to pursue PCM with client, explanation must be documented in case notes.

TRANSPORTATION

- Does client have own transportation? Yes No
Does client have access to and funds for public transportation? Yes No
Does client need specially arranged transportation through Title III or Medicaid? Yes No
Does client need other transportation arrangements? Yes No
If yes, specify: _____

TRANSPORTATION ASSESSMENT

- Client lacks resources and needs specially arranged transportation through Title 3.
- Client has Medicaid and needs specially arranged transportation.
- Client has adequate transportation for most needs but may need occasionally assistance.
- Client has adequate transportation.

DRUG ADHERENCE INFORMATION

MEDICATIONS		
Is client currently taking meds? <input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
<input type="radio"/> Manages own meds	<input type="radio"/> Taking HIV meds but having problems	<input type="radio"/> Wants to start meds
<input type="radio"/> Reports missed doses		<input type="radio"/> Not recommended by provider at this time
Further intervention needed? <input type="radio"/> Yes <input type="radio"/> No		<input type="radio"/> Thinking about starting meds
		<input type="radio"/> Does not want to take HIV meds

Is client responsible for setting up own medication? Yes No
 If no, who would assist? _____

Client understanding of medication:
 Thorough Average Basic Confused

Are medications properly stored? Yes No
 Are bottles in childproof containers? Yes No
 Are bottles easy to open? Yes No
 Are meds outdated? Yes No
 Prescribed by multiple physicians? Yes No
 Is visual dosage chart used? Yes No
 Has client ever "borrowed" medications from another person? Yes No
 If yes, how many times? _____
 Who is responsible for ordering refills? Self and/or _____
 Who picks up refills? Self and/or _____
 Pharmacies used: _____
 Prescriptions refilled by: Pharmacy Mail Physician

Client Daily Living Style

Are meds taken on schedule every day/every time? Yes No
 Number of doses taken late in last week? _____

Has client missed doses? Yes No
 If so, how many times in the past week? _____

Is client a MORNING or AFTERNOON person? am pm

Is medical provider aware of adherence problems? Yes No

What complementary therapies does the client use? _____

Is the medical provider aware of complementary therapies? Yes No

Does client eat: Breakfast Lunch Dinner Snack
 Is water taken with meds? Yes No Other

Is client having any side effects from taking the medications? Yes No
 Dizziness Nausea Rash Diarrhea Drowsiness Headache Other _____

Contraindications _____

Medical Provider notified? Date _____ Time _____
 Pharmacy contacted? Date _____ Time _____

Barriers

- Depression/mental health
- Works outside the home
- Alcohol and drug use/abuse
- Complex medication regimen
- Care giving responsibilities
- Difficulty getting refills
- Lack of regular schedule
- Taste of medication
- Number of pills
- Undisclosed HIV status
- Side effects
- Lack of information
- Mental status changes
- Lack of social support
- Doubts medication effectiveness
- Needs assistance with ADL's (activities of daily living)
- Size of pills

DRUG ADHERENCE ASSESSMENT

- Client lacks understanding of medication regimen and has several barriers which make adherence difficult. Immediate intervention is needed.
- Client has minimal understanding of medication regimen and some barriers which make adherence more difficult to manage. There is a need for intervention within the month.
- Client has adequate understanding and support to maintain medication adherence. No intervention is needed.

ACTION STEPS

Education/Employment
Living Arrangements
Children/Dependents
Social Support Systems
Medical
Mental Health
Substance Use
Legal
Independent Living Skills
HIV Prevention Education
Transportation
Drug Adherence