IDAHO RYAN WHITE MEDICAL CASE MANAGEMENT
INTAKE AND ELIGIBILITY DETERMINATION

Date of Intake/Eligibility Initiated
_____/____/_____

Client URN: _____

ADAP ID: _____

PERSONAL/CONTACT INFORMATION

Legal Last Name:	**Legal First Name:**	**MI:**
Preferred Name:	**Social Security Number:**	
Date of Birth: _____/_____/_____	**Gender**: □ Male □ Female □ Transgender □ Refused to Report □ Unknown	
Address:	**City:**	
County:	**State:**	**Zip Code:**

Mailing address if different from above:

Phone (H) (____) _____-_____ **(W)** (____) _____-_____ **Cell/Pager** (____) _____-_____

Emergency Contact/ Legal Guardian: _____ **Phone** (____) _____-_____
Aware of HIV+ Status: □ **Y** □ **N**

Client Preference for Contact: □ phone □ phone message □ office visit
□ home visit □ mail □ email (_____)

Can talk to: 1) _____ 2) _____

Are there any concerns related to the above contacts? If yes, please explain.

Ethnicity: □ Non-Hispanic □ Hispanic □Unknown/unreported

Preferred Language: _____
Interpreter Needed? □ Yes □ No

Race (may mark more than one): □ White □ Asian □ Black or African American
□ American Indian or Alaska Native □ Native Hawaiian or Other Pacific Islander □ Other □ Unknown

Relationship Status: □ Single □ Married □ Partner □ Divorced □ Separated □ Widow

Occupation: _____ **Employer:** _____
Status of Employment: □ None □ Retired □ Employed □ Unemployed

Veteran Status: □ Veteran □ Disabled veteran □ Non-veteran

HIV STATUS

Proof of HIV Diagnosis? ☐ Yes ☐ No

Date of Original HIV Diagnosis (☐ Self-Report ☐ Medical Records) _____/_____/_____ (☐ Estimated)

State where diagnosed: _____ **Original CD4 count:** _____

AIDS Diagnosis? ☐ Yes ☐ No

Date of Original HIV Diagnosis (☐ Self-Report ☐ Medical Records) _____/_____/_____ (☐ Estimated)

Year first accessed care: _____ **Original CD4 count at AIDS diagnosis:** _____

HIV Status:

☐ HIV Positive (not AIDS) ☐ HIV Negative (affected)

☐ HIV Positive (AIDS status unknown) ☐ HIV Indeterminate (0-2 years)

☐ CDC-Defined AIDS ☐ Unknown

Is client currently prescribed ARVs?

☐ Yes ☐ No

Risk Factor (check all that apply):

☐ MSM ☐ IDU ☐ Hemophilia/Coagulation Disorder ☐ Heterosexual Contact

☐ Receipt of transfusion blood, blood components or tissue ☐ Mother with/at Risk for HIV

☐ Other (specify): _____ ☐ Unknown

Initial Idaho Ryan White Lab:

Current CD4: _____ Date of test: _____/_____/_____

Current Viral Load: _____ Date of test: _____/_____/_____

HIV Care Provider:

Name: _____ Phone: (____) _____-_____

Clinic Name: _____

Address: _____

HOUSING STATUS

Most Recent/Current Housing Status:

☐ Stable/ Permanently Housed ☐ Non-permanently Housed ☐ Institution

☐ Unstable ☐ Other (specify) _____ ☐ Unknown/Unreported

FINANCE INFORMATION

	(For state office use only)
Annual Gross Household Income: _____	_____ Percent Poverty Level
Individual Annual Gross Income: _____	☐ Copy of Income Documentation
Household / Family Size: _____	☐ Copy of Photo Identification
	☐ Copy of Insurance Card (front and back)

CLIENT QUALIFIES FOR: RWPB Medical Case Management _____ ADAP _____ RWPC Medical Case Management _____

INSURANCE INFORMATION

Do you have private health insurance? □ Yes □ No

If **yes**, is your health insurance through your current or previous employer? □ Yes □ No

If through previous employer, date COBRA Coverage began: _____/_____/_____

If **yes**, does your health insurance cover medications? □ Yes □ No

If **yes**, is there a total expense limit for medications? □ Yes □ No

Patient Insurance Information:

□ Patient □ Guarantor (Name: _____) Birth Date of Insured: _____/____/_____

Address (if different from above) City & State, Zip Code: _____

_____

Home Phone: (_____) _____-_____ Work Phone (if applicable): (_____) _____-_____

Name of Primary Insurance: □ Uninsured □ Blue Cross □ Blue Shield □ Idaho Physicians Network
□ Medicaid □ Medicare □ Tricare □ VA/CHAMPUS □ Applied for Medicaid (Date: _____/_____/_____)
□ Other (specify) _____

Please indicate information has been gathered and shared by having client initial the appropriate box.	
Informational Forms (client provided copies and time for questions & answers):	***Client's Initials***
Client Rights and Responsibilities	
Complaint Grievance Procedures	
What You Need to Know About Idaho Laws on HIV	
Acknowledgement of Notice of Privacy Practices (agency specific)	
Other:	

Client Acknowledgement:

As a partner in this process, I acknowledge that:

1) The above information is true to the best of my knowledge (_____).
2) The purpose of my participation in medical case management is to assure my engagement in HIV medical care (_____).
3) I will notify my medical case manager of any change in my health insurance status, financial situation, income, or living arrangements (_____).
4) I authorize this agency to share information and to coordinate care with the Ryan White Part B and Part C programs (_____).
5) This program involves the receipt of federal and/or state funds; any person supplying false information is subject to state and/or federal criminal prosecution, which may result in fines, imprisonment, or both. Additionally, there will be an automatic six month suspension from RWPB Programs and ADAP (_____).

_____ _____
Client/Guardian Signature Date

_____ _____
Medical Case Manager Signature Date