

Program Requirements Checklist
"Confidential- this form must always be saved on a secure network accessible only by Ryan White funded staff"

Forms		Date		Date		Date
First Contact (One time only)			<i>Intentionally left blank</i>			
Informed Consent (One time only)						
HIV Verification (One time only)						
Rights & Responsibilities (One time only)						
Grievance Procedure (One time only)						
Release of Information (ROI)						
Client Intake / Update						
Psychosocial Screening / Re-screen						
Nurse Assessment / Reassessment						
Care Plan Updated (every 6 mo.)						

Clinical outcomes	Value		Date	Value		Date	Value		Date
	Level	Points		Level	Points		Level	Points	
Overall acuity level/points/date									
Adherence acuity level/points/date									
CD4 / date									
Viral Load (VL) / date									
Weight / date									
HIV / AIDS status / date*									

*Choose one of the following: **A** - HIV+/Not AIDS; **B** - HIV+/AIDS status unknown; **C**- CDC - Defined AIDS

Income verification

I have verified income to be at or below:

Initial eligibility:

- CAREAssist/OHP Eligible
- 100% of poverty
- 200% of poverty
- 250% of poverty
- above 250% of poverty

1st review:

- CAREAssist/OHP Eligible
- 100% of poverty
- 200% of poverty
- 250% of poverty
- above 250% of poverty

2nd review:

- CAREAssist/OHP Eligible
- 100% of poverty
- 200% of poverty
- 250% of poverty
- above 250% of poverty

Income verified through: _____

Income verified through: _____

Income verified through: _____

Date _____

Date _____

Date _____

CM _____

CM _____

CM _____

HIV verification

I have verified HIV status through:

- current CAREASSIST client
- copy of HIV+ test results (Western Blot only)
- lab results that show the presence of HIV (A detectable viral load) from lab or physician**
- written verification from another provider who has one of the above documents in client's file

Case Manager Signature _____ Date _____

**If copy of test results not available and lab work shows undetectable viral load, a new Antibody Screening Test must be performed.

Client Name _____ ID# _____

Client Rights and Responsibilities

As a participant in case management, you have the right . . .

- To be treated with respect, dignity, consideration, and compassion.
- To receive case management services free of discrimination on the basis of race, color, sex/gender, ethnicity, national origin, religion, age, class, sexual orientation, physical and or mental ability.
- To participate in creating a plan for case management services.
- To be informed about services and options available to you.
- To reach an agreement with your case manager about the frequency of contact you will have either in person or over the phone.
- To withdraw your voluntary consent to participate in case management, but you will no longer be eligible for Oregon Housing Opportunities in Partnership (OHOP) funded support services.
- To have your medical records and case management records be treated confidentially.
- To have information released only in the following circumstances:
 - When you sign a written release of information.
 - When there is a medical emergency.
 - When a clear and immediate danger to you or to others exists.
 - When there is possible child or elder abuse.
 - When ordered by a court of law.
- To file a grievance about services you are receiving or denial of services.
- To not be subjected to physical, sexual, verbal and/or emotional abuse or threats.

As a participant in case management you have the responsibility ...

- To treat other clients and staff of this agency with respect and courtesy.
- To protect the confidentiality of other clients you encounter at this agency.
- To participate as much as you are able in creating a plan for case management.
- To let your case manager know any concerns you have about your case management plan or changes in your needs.
- To make and keep appointments to the best of your ability, or if possible to phone to cancel or change an appointment time.
- To stay in communication with your case manager by informing him/her of changes in your address or phone number and responding to the case manager's calls or letters to the best of your ability.
- To not subject agency case managers, staff, or other clients to physical, sexual, verbal and/or emotional abuse or threats.

I understand the above information and I have received a copy for my records.

Participant

Date

Case manager

Date



Oregon Department of Human Services
Public Health Division
HIV/STD/TB Program
HIV Care and Treatment Program

Client Intake/Annual Update

Required form

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<input type="checkbox"/> Intake Date:	<input type="checkbox"/> Annual update	Social Security number:	Age:	DOB:
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Personal information

County: _____

Legal last name	Legal first name	Middle initial	Other names used

Street address	City	State	ZIP	O.K. to send mail
				<input type="checkbox"/> Yes <input type="checkbox"/> No

Mailing address, if different	City	State	ZIP	O.K. to send mail
				<input type="checkbox"/> Yes <input type="checkbox"/> No

Home phone number	O.K. to leave message <input type="checkbox"/> Yes <input type="checkbox"/> No	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (M → F) <input type="checkbox"/> Transgender (F → M)
Cell phone number	O.K. to leave message <input type="checkbox"/> Yes <input type="checkbox"/> No	
Message phone number	O.K. to leave message <input type="checkbox"/> Yes <input type="checkbox"/> No	Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino Race <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other
E-mail address	O.K. to leave message <input type="checkbox"/> Yes <input type="checkbox"/> No	

Medical health insurance

<input type="checkbox"/> Private Company: _____ ID #: _____ OMIP #: _____ COBRA (end date): _____ Dental insurance (name): _____	<input type="checkbox"/> Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D _____ <input type="checkbox"/> Low income subsidy <input type="checkbox"/> Qual. Medicare ben.	<input type="checkbox"/> Medicaid <input type="checkbox"/> OHP Standard <input type="checkbox"/> OHP Plus <input type="checkbox"/> OHP open card OHP# _____ <input type="checkbox"/> Dual eligible MCO _____	<input type="checkbox"/> Other public <input type="checkbox"/> VA benefits # _____ <input type="checkbox"/> Champus # _____	<input type="checkbox"/> No insurance Comments:
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CAREAssist Yes No If yes, number: _____

Key contacts

Other emergency contact	Relationship	Phone number	Aware of HIV status
			<input type="checkbox"/> Yes <input type="checkbox"/> No
Primary care physician	Phone number	Pharmacist	Phone number
HIV specialist	Phone number	Other agency	Phone number

House/living arrangement

Permanently housed (describe): _____
 Not permanently housed (describe): _____
 Institution Unknown Unstable Other

Client name: _____ Client #: _____ CM initial: _____ Date: _____

Transportation

- Not available (*describe*): _____
- Available (*describe*): _____
- Access to and funds for transportation (*gas, bus pass, etc ...*): _____
- Needs help arranging transportation (*paratransit, volunteer, etc ...*): _____
- Barriers to accessing transportation: _____

Availability of basic needs (check if needed)

- Clothing Shelter Food Utilities
- Access to food programs No Yes, which ones: _____
- Safe child care available No Yes
- Other household personal items (*toilet articles, cleaning or pet supplies, etc ...*): _____
- Other basic needs: _____

Employment/education

- Not employed
- Currently seeking employment
- Employer location: _____

Highest grade completed in school High school Diploma GED College Post-graduate

Currently in school? No Yes, school name: _____

Do you have difficulty reading? No Yes Do you have difficulty writing? No Yes

Were you in special education classes in school? No Yes, what type: _____

Legal/criminal issues

Do you have Trust Will Physician's directive Healthcare power of attorney

Durable power of attorney Guardian/conservator for self/dependents

If *power of attorney*, name: _____ Phone: _____

Are you a guardian/conservator for anyone? No Yes If yes, who: _____

Criminal history Arrest(s) Conviction(s) Restraining order(s) Parole/probation(s)

Incarceration

Describe: _____

Family/dependent children

Do you have dependent children (*including children you are paying child support for*)? No Yes, number: _____

If yes, do they live with you? No Yes

Household members

Names	Relationship	Age	Aware of HIV status	Income
			<input type="checkbox"/> No <input type="checkbox"/> Yes	
			<input type="checkbox"/> No <input type="checkbox"/> Yes	
			<input type="checkbox"/> No <input type="checkbox"/> Yes	
			<input type="checkbox"/> No <input type="checkbox"/> Yes	
			<input type="checkbox"/> No <input type="checkbox"/> Yes	



Oregon Department of Human Services
Public Health Division
HIV/STD/TB Program
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Oregon Client Acuity Scale Worksheet

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Client name _____ Date of assessment _____ Total points _____ Assigned acuity level _____

Clients are assigned to a level if they meet one or more of the criteria listed within each level.
Point values are different for different Life Areas by page.

Psychosocial assessment (part A)

Life area	Level #1 (1 point)	Level #2 (2 points)	Level #3 (3 points)	Level #4 (4 points)
Basic needs Level _____ Points _____	<input type="checkbox"/> Food, clothing and other sustenance items available through client's own means. <input type="checkbox"/> Has ongoing access to assistance programs that maintain basic needs consistently. <input type="checkbox"/> Able to perform activities of daily living (ADL) independently.	<input type="checkbox"/> Sustenance needs met on a regular basis with occasional need for help accessing assistance programs. <input type="checkbox"/> Unable to routinely meet basic needs without emergency assistance. <input type="checkbox"/> Needs assistance to perform some ADL weekly.	<input type="checkbox"/> Routinely needs help accessing assistance programs for basic needs. <input type="checkbox"/> History of difficulties in accessing assistance programs on own. <input type="checkbox"/> Often w/o food, clothing or other basic needs. <input type="checkbox"/> Needs in-home ADL assistance daily.	<input type="checkbox"/> Has no access to food. <input type="checkbox"/> Without most basic needs. <input type="checkbox"/> Unable to perform most ADL. <input type="checkbox"/> No home to receive assistance with ADL.
Transportation Level _____ Points _____	<input type="checkbox"/> Has own or other means of transportation consistently available. <input type="checkbox"/> Can drive self. <input type="checkbox"/> Can afford private or public transportation.	<input type="checkbox"/> Has minimal access to private transportation. <input type="checkbox"/> Needs occasional assistance with finances for transportation.	<input type="checkbox"/> No means via self/others. <input type="checkbox"/> In area under or un- served by public transportation. <input type="checkbox"/> Unaware of or needs help accessing transportation services.	<input type="checkbox"/> Lack of transportation is a serious contributing factor to current crisis. <input type="checkbox"/> Lack of transportation is a serious contributing factor to lack of regular medical care.
Risk reduction Level _____ Points _____	<input type="checkbox"/> Abstaining from risky behavior by safer practices. <input type="checkbox"/> Client has good understanding of risks.	<input type="checkbox"/> Occasional risk behavior (<i>unsafe behaviors of any type <=20% of the time</i>). <input type="checkbox"/> Client has fair understanding of risks.	<input type="checkbox"/> Moderate risk behavior (<i>unsafe behaviors of any type >20-50% of the time</i>). <input type="checkbox"/> Client has poor understanding of risks. <input type="checkbox"/> Client with mild/moderate A&D, MH, or relationship barriers to safer behavior.	<input type="checkbox"/> Declines to answer. <input type="checkbox"/> Significant risk behavior (<i>unsafe behaviors of any type >50% of the time</i>). <input type="checkbox"/> Client has little or no understanding of risks. <input type="checkbox"/> Client with significant A&D, MH, or relationship barriers to safer behavior.
Health insurance/medical care coverage Level _____ Points _____	<input type="checkbox"/> Has insurance/medical care coverage. <input type="checkbox"/> Has ability to pay for care on own. <input type="checkbox"/> Enrolled in CAREAssist.	<input type="checkbox"/> Client needs information and referral to insurance or other coverage for medical costs.	<input type="checkbox"/> Case management assistance needed in accessing insurance or other coverage for medical costs (<i>such as prescription drug coverage</i>). No medical crisis.	<input type="checkbox"/> Needs immediate assistance in accessing insurance or other coverage for medical costs due to medical crisis. <input type="checkbox"/> Not currently eligible for insurance or public benefits. Unable to access care.

Client name: _____

Life area	Level #1 (1 point)	Level #2 (2 points)	Level #3 (3 points)	Level #4 (4 points)
Self sufficiency Level _____ Points _____	<input type="checkbox"/> Independently always follows up on referrals. <input type="checkbox"/> Able to complete forms independently. <input type="checkbox"/> Able to live within financial means. Never needs financial assistance. <input type="checkbox"/> Does not burn bridges. Is able to access services eligible for and are available.	<input type="checkbox"/> Sometimes requires assistance in following-up on referrals. <input type="checkbox"/> Sometimes requires assistance in completing forms. <input type="checkbox"/> Needs financial assistance 1-2 times per year. <input type="checkbox"/> Access to some limited services.	<input type="checkbox"/> Follows-up on referrals with difficulty. <input type="checkbox"/> Difficulty completing forms. <input type="checkbox"/> Needs financial assistance 3-6 times per year. <input type="checkbox"/> Difficulty accessing services.	<input type="checkbox"/> Never follows-up on referrals. <input type="checkbox"/> Unable to complete forms. <input type="checkbox"/> Routinely needs financial assistance 6+ times per year. <input type="checkbox"/> Burns bridges. Majority of services not available.

Life area	Level #1 (1point)	Level #2 (4 points)	Level #3 (6 points)	Level #4 (8 points)
Housing/living arrangement Level _____ Points _____	<input type="checkbox"/> Living in housing of choice: clean, habitable apartment or house. <input type="checkbox"/> Living situation stable; not in jeopardy.	<input type="checkbox"/> Living in stable subsidized housing (<i>public housing, private subsidized housing, or secure Section-8 voucher</i>). <input type="checkbox"/> Safe & secure nonsubsidized housing, but choices limited due to moderate income. <input type="checkbox"/> Housing is habitable, but requires limited improvements. <input type="checkbox"/> Housing is in jeopardy due to projected. Financial strain (>30 days); needs assistance with rent/utilities to maintain housing. <input type="checkbox"/> Living in long-term (>3 mo.) transitional rental housing.	<input type="checkbox"/> Formerly independent person temporarily residing with family or friends. <input type="checkbox"/> Eviction imminent. <input type="checkbox"/> Living in temporary (<3 mo.) transitional shelter. <input type="checkbox"/> Housing is in jeopardy due to immediate projected financial strain (<30 days); needs assistance with rent/utilities to maintain housing.	<input type="checkbox"/> Needs assisted living facility; unable to live independently. <input type="checkbox"/> Home uninhabitable due to health and/or safety hazards. <input type="checkbox"/> Recently evicted from rental or residential program. <input type="checkbox"/> Homeless (<i>living in emergency shelter, car, on street/camping, etc...</i>).
Mental health Level _____ Points _____	<input type="checkbox"/> No history of mental illness, psychological disorders or psychotropic medications. <input type="checkbox"/> No need for counseling referral.	<input type="checkbox"/> History of mental health disorders/treatment in client and/or family. <input type="checkbox"/> Level of client/family stress is high. Needs emotional support to avert crisis. <input type="checkbox"/> Need for counseling referral. <input type="checkbox"/> Depression, functioning. <input type="checkbox"/> Has some trouble getting along with others.	<input type="checkbox"/> Experiencing an acute episode and/or crisis. <input type="checkbox"/> Severe stress or family crisis re:HIV; need for mental health assessment. <input type="checkbox"/> Depression, not functioning. <input type="checkbox"/> Requires significant emotional support. <input type="checkbox"/> Significant trouble getting along with others.	<input type="checkbox"/> Danger to self or others. <input type="checkbox"/> Needs immediate psychiatric assessment/evaluation. <input type="checkbox"/> Active chaos or problems due to violence or abuse. <input type="checkbox"/> Requires therapy, not accessing it.
Addictions Level _____ Points _____	<input type="checkbox"/> No difficulties with addictions including: alcohol, drugs, sex, or gambling. <input type="checkbox"/> Past problems with addiction; >1yr. In recovery. <input type="checkbox"/> No need for treatment referral.	<input type="checkbox"/> Past problems with addiction; < 1 year in recovery.	<input type="checkbox"/> Current addiction but is willing to seek help in overcoming addiction. <input type="checkbox"/> Major addiction impairment of significant other. <input type="checkbox"/> Past problems with addictions; <3 months in recovery.	<input type="checkbox"/> Current addiction; not willing to seek or resume treatment. <input type="checkbox"/> Fails to realize impact of addiction on life/indifference regarding consequences of substance use.

RN assessment (part B)

Life area	Level #1 (1 point)	Level #2 (4 points)	Level #3 (6 points)	Level #4 (8 points)
Knowledge of HIV disease Level _____ Points _____	<input type="checkbox"/> Verbalizes clear understanding about disease.	<input type="checkbox"/> Some understanding verbalized. <input type="checkbox"/> Needs additional information in some areas.	<input type="checkbox"/> Little understanding. <input type="checkbox"/> Needs counseling or referral to make informed decisions about health.	<input type="checkbox"/> Ignorant of HIV disease progression, etc. Unable to make informed decisions about health.
Adherence Level _____ Points _____	<input type="checkbox"/> Adherent to medications as prescribed for more than 6 months without assistance. <input type="checkbox"/> Currently understands medications. <input type="checkbox"/> Able to maintain primary care. <input type="checkbox"/> Keeps medical appointments as scheduled. <input type="checkbox"/> Not currently being prescribed medications.	<input type="checkbox"/> Adherent to medications as prescribed with minimal assistance. <input type="checkbox"/> Keeps majority of medical appointments.	<input type="checkbox"/> Adherent to medications and treatment plan with regular, ongoing assistance. <input type="checkbox"/> Doesn't understand medications. <input type="checkbox"/> Misses taking or giving several doses of scheduled meds weekly. <input type="checkbox"/> Misses at least half of scheduled medical appointments. <input type="checkbox"/> Takes long/extended "drug holidays" AMA. <input type="checkbox"/> Takes non- HIV systemic therapies without MD knowledge.	<input type="checkbox"/> Resistance/minimal adherence to medications and treatment plan even with assistance. <input type="checkbox"/> Refuses/declines to take medications against medical advice. <input type="checkbox"/> Medical care sporadic due to many missed appointments. <input type="checkbox"/> Uses ER only for primary care. <input type="checkbox"/> Inability to take/give meds as scheduled; requires professional assistance to take/give meds and keep appointments.
Medical needs Level _____ Points _____	<input type="checkbox"/> Stable health with access to ongoing HIV medical care. <input type="checkbox"/> Lab work periodically. <input type="checkbox"/> Asymptomatic in medical care.	<input type="checkbox"/> Needs primary care referral. <input type="checkbox"/> HIV care referral needed-stable. <input type="checkbox"/> Short-term acute condition; receiving medical care. <input type="checkbox"/> Chronic non-HIV related condition under control with medication/treatment. <input type="checkbox"/> HIV symptomatic with one or more conditions that impair overall health.	<input type="checkbox"/> Poor health. <input type="checkbox"/> HIV care referral needed-ASAP. <input type="checkbox"/> Needs treatment or medication for non-HIV related condition. <input type="checkbox"/> Debilitating HIV disease symptoms/infections. <input type="checkbox"/> Multiple medical diagnoses. <input type="checkbox"/> Home bound; home health needed.	<input type="checkbox"/> Medical emergency. <input type="checkbox"/> Client is in end-stage of HIV disease. <input type="checkbox"/> Intensive/complicated home care required. <input type="checkbox"/> Hospice services or placement indicated.
Nutrition Level _____ Points _____	<input type="checkbox"/> No signs of wasting syndrome or obvious physical maladies. <input type="checkbox"/> No abdominal pain reported. <input type="checkbox"/> No significant weight problems. <input type="checkbox"/> No problems with eating. <input type="checkbox"/> No problems with nausea or vomiting or diarrhea. <input type="checkbox"/> No need for nutritional intervention.	<input type="checkbox"/> Unplanned weight loss in the past 6 months. <input type="checkbox"/> Requests assistance in improving nutrition. <input type="checkbox"/> Occasional episodes of nausea, vomiting or diarrhea.	<input type="checkbox"/> Visual assessment shows initial signs of wasting syndrome or other obvious physical maladies < not advanced >. <input type="checkbox"/> Abdominal problems reported. <input type="checkbox"/> Changes in eating habits in the past 3 months. <input type="checkbox"/> Chronic nausea, vomiting and/or diarrhea.	<input type="checkbox"/> Visual assessment shows advanced signs of wasting syndrome or other obvious physical maladies. <input type="checkbox"/> Acute abdominal pain. <input type="checkbox"/> Severe problems eating. <input type="checkbox"/> Acute nausea, vomiting and/or diarrhea. <input type="checkbox"/> Significant weight loss in past 3 months.

<p>Oral health</p> <p>Level _____</p> <p>Points _____</p>	<p><input type="checkbox"/> Is currently in active dental care.</p> <p><input type="checkbox"/> Has seen dentist in past six months.</p> <p><input type="checkbox"/> No complaints of mouth, tongue, tooth or gum pain and teeth and gums appear healthy as observed during assessment.</p> <p><input type="checkbox"/> Client reports practicing daily oral hygiene.</p>	<p><input type="checkbox"/> Does not have a regular dentist.</p> <p><input type="checkbox"/> No dental insurance.</p> <p><input type="checkbox"/> Has not seen a dentist in more than 6 months.</p> <p><input type="checkbox"/> Client reports not practicing daily oral hygiene.</p> <p><input type="checkbox"/> Dentures need adjusting, but still able to eat.</p>	<p><input type="checkbox"/> Reports episodic pain and/or sensitivity in teeth, gums or mouth.</p> <p><input type="checkbox"/> Missing days from work because of problems with teeth, gums or mouth.</p> <p><input type="checkbox"/> Client reports difficulty interacting with others because oral health problems negatively impact self-esteem.</p> <p><input type="checkbox"/> Observed appearance of dark, discolored teeth; missing teeth; bleeding, red gums; other problems with mouth.</p> <p><input type="checkbox"/> Client reports episodic or moderate difficulty eating.</p>	<p><input type="checkbox"/> Current tooth, gum or mouth pain and severe discomfort.</p> <p><input type="checkbox"/> Very few or no teeth.</p> <p><input type="checkbox"/> Observed appearance or client report of decayed teeth; white, hairy growth or creamy, bump-like patches; oral lesions or bleeding from gums/teeth.</p> <p><input type="checkbox"/> Client reports significant difficulty eating due to oral health problems.</p> <p><input type="checkbox"/> Client has difficulty talking because of oral health problems.</p>
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Acuity level guidelines

Level 1: 13-22 points

- Initial face-to-face nursing assessment and psychosocial screening.
- Annual face-to-face nursing reassessment and psychosocial rescreening.
- Documentation in progress notes or CAREWare case notes.
- Ongoing nurse consultation as needed.
- Nurse and psychosocial Care Plan developed, appropriate intervention identified and ongoing follow-up provided.
- Care Plan Form (DHS 8400) updated annually.

Level 2: 23-42 points

- Initial face-to-face nursing assessment and psychosocial screening.
- Annual face-to-face nursing reassessment and psychosocial screening.
- Minimum contact (telephone or face-to-face) every 6 months to verify address/phone number and to check on client's current status.
- Ongoing nurse consultation as needed.
- Nurse and psychosocial Care Plan developed, appropriate intervention identified and ongoing follow-up provided.
- Care planning, goals, activities and outcomes documented on the Care Plan Form (DHS 8400) and updated every 6 months.

Level 3: 43-63 points

- Initial face-to-face nursing assessment and psychosocial screening.
- Minimum annual face-to-face nursing reassessment and psychosocial re-screening.
- Minimum contact (telephone or face-to-face) every 30 days.
- Minimum evaluation of goals, activities and outcomes every 30 days.
- Nurse must be consulted (see Nurse Roles and Responsibilities in Standards) on client's care planning goals, activities and outcomes (care plan). A nursing note and signature to show consultation must be in the client's file a minimum of every 90 days.
- Nurse and psychosocial Care Plan (Care Plan form) developed, appropriate intervention identified and ongoing follow-up provided.
- Care planning, goals, activities and outcomes documented on the Care Plan Form (DHS 8400) and updated every 6 months.

Level 4: 64-84 points

- Initial face-to-face nursing assessment and psychosocial screening.
- Minimum annual face-to-face nursing reassessment and psychosocial rescreening.
- Minimum contact (telephone or face-to-face) every 2 weeks.
- Minimum evaluation of goals, activities and outcomes every 2 weeks.
- Nurse is consulted (see Nurse Roles and Responsibilities in Standards) on client's care planning goals, activities and outcomes (care plan). A nursing note and signature to show consultation must be in the client's file a minimum of every 30 days.
- Nurse and psychosocial Care Plan (Care Plan form) developed, appropriate intervention identified and ongoing follow-up provided.
- Care planning, goals, activities and outcomes documented on the Care Plan Form (DHS 8400) and updated every 6 months.

Exceptions: * At the discretion of the Nurse Case Manager, release from a correctional facility may be a condition warranting an Acuity Level 3 during the first 90 days after release. The Nurse Case Manager may assign an overall acuity of 3 or 4 if a client is assessed a level 3 or level 4 in the "Medical Needs" life area. Follow-up standards for these acuity levels will apply.



Oregon Department of Human Services
Public Health Division
HIV/STD/TB Program
HIV Care and Treatment Program

Oregon Client Acuity Scale Worksheet

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Required if not using DHS 8397,
“Acuity Scale Worksheet”

Life area	Level 1 (1 point)	Eval # (1st, 2nd...)			Level 2 (2 points)	Eval # (1st, 2nd...)			Level 3 (3 points)	Eval # (1st, 2nd...)			Level 4 (4 points)	Eval # (1st, 2nd...)		
Basic needs	Food, clothing, other sustenance items thru own means				Sustenance needs met on regular basis with occasional help accessing resources				Routinely needs help accessing assistance programs for basic needs				No access to food			
Eval #:														Without most basic needs		
Date:	Has on-going access to assistance programs that maintain needs consistently				Unable to routinely meet basic needs w/o emergency assistance				History of difficulties accessing services on own				Unable to perform most ADLS			
Lev: Pts:														No home to receive assistance with ADLS		
Eval #:									Often w/o food, clothing or other basic needs.							
Date:																
Lev: Pts:							Needs assistance to perform some ADLs weekly									
Eval #:	Able to perform ADLs (activities of daily living) independently															
Date:	Has own or other means of transportation consistently available				Has minimal access to private transportation				No means via self or others				Lack of transportation is a serious contributing factor to current crisis			
Lev: Pts:																
Eval #:	Can drive self				Needs occasional assistance with finances for transportation				In area unserved or under served by public transportation				Lack of transportation is a serious contributing factor to lack of regular medical care			
Date:																
Lev: Pts:									Unaware of or needs help accessing transportation services							
Eval #:																
Date:																
Lev: Pts:																
Risk reduction	Abstaining from risky behavior by safer practices				Practices occasional risk behaviors (unsafe behaviors of any type < 20% of time)				Moderate risk behaviors (unsafe behaviors of any type 20-50% of time)				Significant risk behaviors (unsafe behaviors of any type <50% of time)			
Eval #:																
Date:	Good understanding of risks				Fair understanding of risks				Poor understanding of risks				Little/no understanding of risk			
Lev: Pts:																
Eval #:									Mild/moderate A&D, MH or relationship barriers to safe behaviors				Significant A&D, MH or relationship barriers to safe behaviors			
Date:																
Lev: Pts:																
Eval #:																
Date:																
Lev: Pts:																
Total page points																
Eval #:		Eval #:		Eval #:		Eval #:		Client name:								

Care Plan

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Client name _____

Care plan date ____ / ____ / ____

Problem/primary barriers (check all that apply)			
<input type="checkbox"/> Basic needs <input type="checkbox"/> Lack food <input type="checkbox"/> Difficulty accessing assistance <input type="checkbox"/> Lack of household/personal items <input type="checkbox"/> Work related issues <input type="checkbox"/> Home support/placement <input type="checkbox"/> Language <input type="checkbox"/> Legal <input type="checkbox"/> Transportation <input type="checkbox"/> No personal transportation <input type="checkbox"/> Unable to pay for personal transportation <input type="checkbox"/> Risk Reduction <input type="checkbox"/> High risk behaviors <input type="checkbox"/> No understanding of risks <input type="checkbox"/> Undisclosed HIV status	<input type="checkbox"/> Health insurance/medical coverage <input type="checkbox"/> No insurance/medical coverage <input type="checkbox"/> Disability determination <input type="checkbox"/> Lack of eligibility documents <input type="checkbox"/> Self sufficiency <input type="checkbox"/> Burned bridges <input type="checkbox"/> Communication issues <input type="checkbox"/> Difficulty w/follow-through <input type="checkbox"/> Unable to fill out own forms <input type="checkbox"/> Needs financial assistance <input type="checkbox"/> Housing <input type="checkbox"/> Housing in jeopardy <input type="checkbox"/> Homeless <input type="checkbox"/> Knowledge of HIV disease <input type="checkbox"/> Ignorant of HIV disease	<input type="checkbox"/> Mental health <input type="checkbox"/> Depression <input type="checkbox"/> Social/emotional support <input type="checkbox"/> Discrimination <input type="checkbox"/> Willing to get help, none available <input type="checkbox"/> Unwilling to get help <input type="checkbox"/> Addictions <input type="checkbox"/> Willing to get help, none available <input type="checkbox"/> Unwilling to get help <input type="checkbox"/> Adherence <input type="checkbox"/> Lacks a regular schedule <input type="checkbox"/> Medication side effects <input type="checkbox"/> Doubts med. Effectiveness <input type="checkbox"/> Complex regimen	<input type="checkbox"/> Medical needs <input type="checkbox"/> Poor health <input type="checkbox"/> Needs HIV care referral <input type="checkbox"/> Needs treatment for non-HIV condition <input type="checkbox"/> Medical emergency <input type="checkbox"/> Nutrition <input type="checkbox"/> Wasting syndrome <input type="checkbox"/> Problems with nutrition <input type="checkbox"/> Severe problems eating <input type="checkbox"/> Oral health <input type="checkbox"/> No regular dentist <input type="checkbox"/> Current tooth/gum pain <input type="checkbox"/> Difficulty eating/taking <input type="checkbox"/> Other <input type="checkbox"/> Care giving responsibilities <input type="checkbox"/> Child care/child welfare

Prioritized issues/problem descriptions

Tasks/description	Owner	Target date	Resolution date/outcome
		/ /	/ / -
		/ /	/ / -
		/ /	/ / -
		/ /	/ / -
		/ /	/ / -

(Optional) Client signature may be obtained based on the discretion of the case manager. Case manager signature is required.

Client's Responsibility/Agreement: I have participated in the creation of this plan for my care. I understand that I have to take responsibility for MY plan in order for the plan to succeed. My case manager/health advocate has explained to me what portions of the plan I am solely responsible for and those that my case manager/health advocate will assist me with. I agree to follow all aspects of this plan and advise my case manager/health advocate if there are significant changes in my life that make it necessary to change this plan. I agree to stay in contact with my case manager/health advocate as planned. My case manager/health advocate has discussed with me the consequences if I don't keep this agreement.

Client signature _____

Date ____ / ____ / ____

Nurse case manager signature _____

Date ____ / ____ / ____



Psychosocial Screening

"Confidential — this form must always be saved on a secure network accessible only by Ryan White funded staff."

Client name: _____ Client #: _____ CM initial: _____ Date: _____
 Initial screening Annual re-screening Date of screening: _____

Mental health screening

If "no" to any of the following questions and client reports memory loss, refer for mental health evaluation.

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

Does the client report any of the following a problem in the past year?

- Depression Anxiety Eating patterns Withdrawal from others
 Forgetfulness Delusions Sleep patterns Thoughts or actions of harm to self or others*
 Insomnia Confusion Feeling isolated (*Self harm screening)

Has client ever had a mental health (MH) diagnosis? Yes No

If yes, describe: _____

Does client have a current MH diagnosis? Yes No

If yes, describe: _____

Has client ever been hospitalized for a MH condition? Yes No

If yes, describe: _____

Has client ever been prescribed medication for a MH condition? Yes No

If yes, what conditions? _____

Reasons for discontinuing MH medication(s): _____

Is client taking medications for a MH condition now? Yes No

If yes, what medication(s)? _____

Is client currently (last 3 months) enrolled in a treatment program? Yes No

If yes, describe: _____

How troubled have you been in the past three months with any mental health problems? (*check one*)

Not at all	Extremely
<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10	

Do you think that counseling or a support group would be helpful? (*check one*)

Not at all	Extremely
<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10	

Plan: Refer for mental health assessment Yes No

Provider referred to: _____

Comments/details/other: _____

Mental health treatment options (*complete for CAREWare*):

- In treatment Waiting list Refused treatment Completed treatment Dropped out
 Pre-treatment process No active treatment or counseling
 Other: _____

***Self harm screening**

If client has had suicidal thoughts and IF agency has written policy on suicide in place, ask:

- Has client ever attempted to hurt (*check one*) self or others in past? Yes No
- Does client currently have thoughts of hurting (*check one*) self or others? Yes No
- Does the client have a specific plan? Yes No
- Does the client have the means to carry out the plan? Yes No

Comments: _____

Domestic safety

Oregon has a law that requires us to report child/elder abuse/neglect. This is called mandatory reporting. If you are younger than 18 or older than 65 years of age, based on your response to the next three questions, I may be required to report your situation.

- Has your partner/ex-partner ever physically hurt or threatened to hurt you? Yes No Current
- Do you feel controlled by your partner or feel you are in danger? Yes No Current
- Has your partner forced you to have sex or refused to practice safe sex? Yes No Current

Comments: _____

Substance use/addiction history and screening

Substance use/abuse/addiction	Use P = past; C = current	Amount	Frequency daily/weekly monthly	Duration <1 yr; 1-2 yr; >2 yr	Last use <1 mo; 1-6 mo; 6 mo - 2 yr; >2yr	Problem for client? X = yes	Others say a problem? X = yes	Wants treatment? X = yes
Gambling						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nicotine (cigs/chew)						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical marijuana with card						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speed/meth						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogens						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rx medications						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Ever had A&D related justice contacts? Yes No Past year
- Ever had DUI? Yes No Past year
- Ever had a blackout? Yes No Past year
- A&D related ER or hospitalizations? Yes No Past year
- Ever been in treatment or support program? Yes No Past year

Describe: _____

Do you think that addiction counseling or a support group would be helpful? (*check one*)

Not at all	Extremely
<input type="checkbox"/> 1	<input type="checkbox"/> 10

Client name: _____ Client#: _____ CM initial: _____ Date: _____

Plan: Refer for substance abuse treatment Yes No

Provider referred to: _____

Comments/details/other: _____

Risk assessment

Currently in intimate relationship? Yes No If yes, how long? _____

Number of sexual partners in past year: 0 1 2-3 4-10 10+

Type of partners: Other sex Same sex Both sexes Anonymous encounters

Type of sex: Vaginal Oral Anal

Does client inject drugs with needles? Yes No

Does client share needles? Yes No

Have all of client's sexual/needle sharing partners been informed of client's HIV status? Yes No

In the past 12 months

Did any of the client's partners have sex with another person while they were still in a relationship with the client?

Yes No Don't know

Has the client been told they have a sexually transmitted disease?

Yes No Don't know

If yes, which ones? _____

Has any of the client's sex partners been told they had a sexually transmitted disease? Yes No Don't know

If yes, which ones? _____

How does client protect themselves and their partners from infection?

Abstinence One partner Condoms Clean needles and works Oral, not anal

Top anal, not bottom Other: _____

How often does client and/or partner engage in these strategies? (check one)

<i>Never</i>										<i>Always</i>
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	

Harm reduction

What are some things that you are doing that put you at risk? _____

Do you know some ways to reduce the risk of transmission? _____

What is one thing you could do to reduce the risk? _____

How likely is it that you will be able to do this? (check one)

<i>Not likely</i>										<i>Very likely</i>
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	

Plan: Refer to Supporting Health Options for Prevention (SHOP) 1-877-795-7700 Yes No

Comments/details/other: _____

Summary (complete for entry into CAREWare after screening done)

Mental health history:

None Unknown Yes, active within last 3 months Yes, but not active with last 3 months

Substance abuse history:

None Unknown Yes, active within last 3 months Yes, but not active with last 3 months

Client name: _____

Client#: _____

CM initial: _____

Date: _____

Social support system

Current spouse or partner: _____ Is partner aware of client's HIV status? Yes No

What other support systems does client have available to them?

- Family, local Family, distant Church Support groups
 Friends, local Friends, distant Clubs Other: _____

Comments: _____

Signature and credentials: _____ Date: _____



Nursing Assessment

"Confidential — this form must always be saved on a secure network accessible only by Ryan White funded staff."

Client name: _____ Client #: _____ CM initial: _____ Date: _____

Vitals

Height	Current weight	Ideal weight	Current CD4	Date	Current VL	Date	Lowest CD4	Date	Highest VL	Date

Physical appearance

Skin: _____ Posture and position: _____
 Obvious physical deformities: _____ Mobility: _____
 Speech: _____ Hearing: _____
 Personal hygiene: _____ Facial expression: _____

Allergies

Medication/drug Yes No List: _____
 Food Yes No List: _____
 Environmental Yes No List: _____

HIV status

HIV positive (*not AIDS*) dx date: _____
 HIV positive (*AIDS unknown*) dx date: _____
 CDC – defined AIDS dx date: _____

HIV risk factors *(check all that apply)*

MSM Heterosexual IDU Perinatal
 Receipt of blood or tissue
 Hemophilic coagulation disorder
 Unknown or not reported/identified
 Other: _____

Medical care

None Publicly-funded clinic or HD Private practice Hospital outpatient ER Other

Last medical visit: Provider _____ Date _____

Care provider contact information *(name and phone number):*

Primary care provider		
HIV/AIDS provider		
Pharmacy		
Dentist		

Activities of daily living *(self, assistance needed or dependent)*

Activity	Self	Asst.	Dep.	Activity	Self	Asst.	Dep.	Activity	Self	Asst.	Dep.
Ambulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meal prep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Current complaints (*nutritional assessment required if yes)

X = Yes	Description	X = Yes	Description	X = Yes	Description
<input type="checkbox"/>	*Abdominal pain	<input type="checkbox"/>	Changes in headache pattern	<input type="checkbox"/>	Falls
<input type="checkbox"/>	*Changes in eating habits	<input type="checkbox"/>	Fever	<input type="checkbox"/>	Changes in strength
<input type="checkbox"/>	*Nausea/vomiting	<input type="checkbox"/>	Chills	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	*Diarrhea	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Pain
<input type="checkbox"/>	*Unexplained weight loss	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	*Difficulty swallowing	<input type="checkbox"/>	Swollen lymph glands	<input type="checkbox"/>	Cough
<input type="checkbox"/>	*Sores in throat or mouth	<input type="checkbox"/>	Seizures/tremors	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	Changes in hearing	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Skin changes/rashes
<input type="checkbox"/>	Changes in vision	<input type="checkbox"/>	Changes in balance	<input type="checkbox"/>	Other:

Comments:

Medical history

Has client ever been diagnosed with opportunistic infections or conditions? (C=current; P=past) None

<input type="checkbox"/> C <input type="checkbox"/> P	ACD (AIDS Dementia complex)	<input type="checkbox"/> C <input type="checkbox"/> P	Candidiasis	<input type="checkbox"/> C <input type="checkbox"/> P	Cervical cancer
<input type="checkbox"/> C <input type="checkbox"/> P	Cholesterol - elevated	<input type="checkbox"/> C <input type="checkbox"/> P	Chronic/recurrent sinusitis	<input type="checkbox"/> C <input type="checkbox"/> P	CMV (Cytomegalovirus)
<input type="checkbox"/> C <input type="checkbox"/> P	Coccidioidomycosis	<input type="checkbox"/> C <input type="checkbox"/> P	Cryptococcal meningitis	<input type="checkbox"/> C <input type="checkbox"/> P	Cryptosporidiosis
<input type="checkbox"/> C <input type="checkbox"/> P	Diabetes	<input type="checkbox"/> C <input type="checkbox"/> P	Encephalopathy	<input type="checkbox"/> C <input type="checkbox"/> P	Herpes simplex
<input type="checkbox"/> C <input type="checkbox"/> P	Herpes zoster	<input type="checkbox"/> C <input type="checkbox"/> P	Hepatitis A, B or C	<input type="checkbox"/> C <input type="checkbox"/> P	Histoplasmosis
<input type="checkbox"/> C <input type="checkbox"/> P	Kaposi's sarcoma	<input type="checkbox"/> C <input type="checkbox"/> P	Leukeon cephalopathy	<input type="checkbox"/> C <input type="checkbox"/> P	Lymphoma
<input type="checkbox"/> C <input type="checkbox"/> P	MAC (Mycobacterium Avian Complex)	<input type="checkbox"/> C <input type="checkbox"/> P	Myopathy	<input type="checkbox"/> C <input type="checkbox"/> P	Oral hairy leukoplakia
<input type="checkbox"/> C <input type="checkbox"/> P	Parasitic infection	<input type="checkbox"/> C <input type="checkbox"/> P	PCP (Pneumocystis carinii pneumonia)	<input type="checkbox"/> C <input type="checkbox"/> P	Toxoplasmosis
<input type="checkbox"/> C <input type="checkbox"/> P	Bacterial pneumonia	<input type="checkbox"/> C <input type="checkbox"/> P	PML (Progressive multifocal leukoencephalopathy)	<input type="checkbox"/> C <input type="checkbox"/> P	Tuberculosis
<input type="checkbox"/> C <input type="checkbox"/> P	STDs (sexually transmitted diseases)	<input type="checkbox"/> C <input type="checkbox"/> P	Thrombocytopenia	<input type="checkbox"/> C <input type="checkbox"/> P	Other:

Comments:

Client name: _____

Client#: _____

CM initial: _____

Date: _____

Has client had **positive results** for any of the following tests: None
 Hepatitis B Hepatitis C Tuberculin skin test Anal pap Last test date: _____

Has client had any of the following **treatments**:
 Chemotherapy Infusion Radiation
 Hepatitis C Treatment for LTBI (*latent TB*) Treatment for TB disease (*active*)

Has client had any of the following **immunizations**:
 Hepatitis A (HAV) Hepatitis B (HBV) Influenza
 Measles/Mumps/Rubella (MMR) Polysaccharide pneumococcal Other: _____
 Tetanus/diphtheria/pertussis (Tdap) Tetanus/diphtheria (Td)

Comments:

Current sexually transmitted disease history

Does the client have any of the following symptoms: None
 Genital ulcers, warts, blisters or other lesions Pain with sex Pain in lower abdomen
 Pain/burning with urination Oral lesions New/usual skin rash
Men: Testicular or groin pain Urethral discharge
Women: Increased vaginal discharge Vaginal order Vulvar itching
 Changes in menses Bleeding between periods

Has client been told by a health care provider that they have any of the following in the past year: None
 Chlamydia Pelvic Inflammatory Disease (PID) Herpes simplex
 Trichomonasovirus Lymphogranuloma Verereum (LGV) Syphilis
 Gonorrhea Human Papilloma Virus (HPV)

Has client been treated for any of the above? _____

Current gynecological history

Is client currently pregnant? Yes No Is client currently breastfeeding? Yes No

Type of birth control: _____

Last PAP: _____ Results: Normal Abnormal

Last breast exam: _____ Results: _____

Last mammogram: _____ Results: _____

Comments:

Nutritional assessment

Current weight: _____

Ideal weight: _____

X = Yes	Description	Comments
<input type="checkbox"/>	Access to food: is client getting enough to eat?	
<input type="checkbox"/>	Does client have an appetite?	
<input type="checkbox"/>	Does client have abdominal pain?	
<input type="checkbox"/>	Does client have nausea, vomiting or diarrhea?	
<input type="checkbox"/>	Does client have difficulty swallowing?	
<input type="checkbox"/>	Does client have difficulty chewing?	
<input type="checkbox"/>	Has client experienced change in eating habits?	
<input type="checkbox"/>	Does client have dental issues?	See oral health assessment

Visual assessment of client's appearance (*build, underweight, overweight, signs of wasting syndrome*):

Nutritional summary may include: Supplements w/regular wt. Checks Referral to RD Referral for dental care
 Referral for counseling (*eating disorder, MH concern, substance abuse concern*) Referral to dentist
 Nutritional incentive contract Referral to primary HIV care provider Other

Liver health assessment

X = Yes	Description	Comments
<input type="checkbox"/>	History of Hep A, B, C or other liver problems?	
<input type="checkbox"/>	Has client seen a doctor in the past six months about liver problems?	
<input type="checkbox"/>	Has client had liver function tested in the past six months?	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't know
	Does client have:	
<input type="checkbox"/>	• Jaundice	
<input type="checkbox"/>	• Abdominal pain	
<input type="checkbox"/>	• Gum bleeding and icterus	
<input type="checkbox"/>	• Edema	
<input type="checkbox"/>	• Skin changes	

Liver health summary may include: Referral to HIV care provider Referral to dietician
 Referral for counseling (*A&D concern*) Education about appropriate use of herbs, vitamins, supplements, etc ...
 Education about hepatitis C treatment Education about eating raw or undercooked shellfish Other

Client name: _____

Client#: _____

CM initial: _____

Date: _____

Oral health assessment

When was the last time the client saw a dentist? _____

Does client have dental insurance or other access to dental care? Yes No

Does client report practicing daily oral hygiene? Yes No

Does client report oral health problems? Yes No

Dentures need re-alignment

Episodic pain and/or sensitivity with teeth, gums or mouth

Missing days from work (*or other activities*) because of problems with teeth, gums or mouth

Difficulty interacting with others due to oral health problems that negatively impact self-esteem

Difficulty eating or speaking

Visual exam:

Has few teeth or missing teeth

Has dark, discolored teeth, missing teeth, bleeding red gums or decayed teeth

Has white, hairy growth or creamy bump-like patches or other oral lesions

Oral health summary:

Current medication profile (see DHS 8417)

Adherence profile

Is client currently taking antiretroviral medications? Yes Sometimes No

If no, why? Not recommended Does not want to take Wants to/considering taking

If yes/sometimes, client's understanding of medication: Thorough Average Basic Confused

If yes/sometimes, who is responsible for ordering/picking up refills? Self Other: _____

If yes/sometimes, are:

Medication outdated? Yes No Medication prescribed by multiple providers? Yes No

Medication properly stored? Yes No Medication borrowed from others? Yes No

If yes/sometimes, are medications taken on schedule ever day/every time? Yes No

If no, number of missed doses in past week: _____ Number of late doses in past week: _____

Possible reason(s) for late or missed doses:

Medication side effects: Dizziness Nausea Diarrhea Drowsiness

Headache Other: _____

Barriers: Depression/mental health

Complex medication regime

Substance use/abuse

Number of pills

Mental status changes

Size of pills

Doubts medication effectiveness

Taste of medication

Lack of information

Eating habits (*e.g., loss of appetite*)

Works outside the home

Lack of regular schedule

Caregiving responsibilities

Needs assistance with ADLs

Lack of social support

Undisclosed HIV status

Difficulty getting refills

Other: _____

Adherence summary :

Client name: _____

Client#: _____

CM initial: _____

Date: _____

HIV Care and Treatment Program Information Sheet

The Oregon Department of Human Services (DHS) HIV Care and Treatment Program runs several programs that help people living with HIV/AIDS gain access to HIV-related medical care and other supportive services.

If you are a client of any of the following programs, you are a client of the DHS HIV Care and Treatment Program:

- CAREAssist (Oregon's AIDS Drug Assistance Program)
- Ryan White Program Part B-funded Case Management (through your local HIV case manager), including financial assistance and State Managed Services
- Oregon Housing Opportunities in Partnership (OHOP)

When you participate in any of these programs, we will collect information from you that includes, but is not limited to, information about your:

- medical information, including HIV status, physician visit dates and lab results
- contact information, including name(s), address(es), and phone number(s)
- demographic information, including your age, race and ethnicity
- sources and amounts of income, assets, or financial assistance
- participation in our programs and other assistance programs in your community, including your case notes that describe your work with your HIV case manager, your OHOP Housing Coordinator, and your CAREAssist worker
- case management screening, including information on mental health, substance abuse, HIV risk behaviors, and social supports
- ongoing needs and your satisfaction with our programs and services

We will also verify the information that we collect from you by collecting information from other sources, including information from:

- other DHS programs, including assistance programs run by the Seniors and People with Disabilities Division; the Children, Adults, and Families Division; and the Public Health Division
- the Oregon Employment Department, including information regarding your reported wages and earnings or any compensation received through the Unemployment Insurance Center
- the Oregon Department of Motor Vehicles, including your current address
- any other publicly-available sources of information or specific sources of information that you have given us written permission to contact

We use this information to:

- determine whether you qualify for our programs and other assistance programs in your community
- provide program assistance (including HIV case management, OHOP housing assistance, and payment of health insurance premiums and drug copays)
- offer you referrals to other assistance available in your community
- help us evaluate our programs, improve services and understand your needs
- attempt to contact you when you leave our programs or are lost to follow up
- meet the reporting requirements of the agencies that fund our program, such as the U.S. Health Resources and Services Administration (HRSA) and the U.S. Department of Housing and Urban Development (HUD)

Participating in the HIV Care and Treatment Program is voluntary. At any time you may cancel your participation in these services.

If you have questions regarding this information please contact the HIV Care and Treatment Program at 971-673-0144 or at 1-800-805-2313.

Oregon Client Acuity Scale Summary Worksheet

Client name _____ Date of assessment _____

Clients are assigned to a stage if they meet one or more of the criteria listed within each stage.

Point values are different for different **life areas** by page.

Date	Life area	Life area	Life area	Life area	Life area	Life area
	<u>Psychosocial assessment</u>	Basic needs	Transportation	Risk reduction	Health ins/medical care coverage	Housing/living arrangement
		Self sufficiency	Mental health	Addictions		
	<u>Nurse assessment</u>	Knowledge of HIV disease	Adherence	Medical needs	Nutrition	Oral health

Stage 1:	13-22 Points
Stage 2:	23-42 Points
Stage 3:	43-63 Points
Stage 4:	64-84 Points

Date _____	Assigned acuity level _____
Date _____	Assigned acuity level _____
Date _____	Assigned acuity level _____
Date _____	Assigned acuity level _____



Optional Form

TO BE COMPLETED BY CLIENT:

What are the problems that are getting in your way right now?

1.

2.

3.

How do you think these problems can be resolved?

What resources do you have for solving these problems?

Which problems would you most like help with right now?

Client Name _____ Date _____

**WHEN PHONING TO SET INTAKE INTERVIEW,
ASK CLIENTS TO BRING WITH THEM:**

- ☛ **Income verification (Social Security print out, paystubs, tax forms, bank statements that show direct deposits, etc.)**
- ☛ **Insurance information (copy of insurance card with policy number, Medicaid card, Medicare card)**
- ☛ **Social security card (if available)**
- ☛ **Photo I.D. (if available)**
- ☛ **List of current medications and pill bottles (or bring all pill bottles in a bag)**
- ☛ **Most current lab reports**
- ☛ **Date of last doctor's visit**
- ☛ **Name, address and phone numbers of all doctors they see**