

# Client Intake / Annual Update

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

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

## Personal information

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

## Medical health insurance

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

## 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) \_\_\_\_\_

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 \_\_\_\_\_

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 |        |

