

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: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Refused to Report <input type="checkbox"/> 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: <input type="checkbox"/> Y <input type="checkbox"/> N				
Client Preference for Contact: <input type="checkbox"/> phone <input type="checkbox"/> phone message <input type="checkbox"/> office visit <input type="checkbox"/> home visit <input type="checkbox"/> mail <input type="checkbox"/> email (_____)				
Can talk to: 1) _____ 2) _____				
Are there any concerns related to the above contacts? If yes, please explain.				
Ethnicity: <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown/unreported		Preferred Language: _____ Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Race (may mark more than one): <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown				
Relationship Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow				
Occupation: _____ Employer: _____				
Status of Employment: <input type="checkbox"/> None <input type="checkbox"/> Retired <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed				
Veteran Status: <input type="checkbox"/> Veteran <input type="checkbox"/> Disabled veteran <input type="checkbox"/> 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)

Is client currently prescribed ARVs?

HIV Positive (AIDS status unknown)

HIV Indeterminate (0-2 years)

Yes No

CDC-Defined AIDS

Unknown

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

Annual Gross Household Income: _____

(For state office use only)

Individual Annual Gross Income: _____

_____ Percent Poverty Level

Household / Family Size: _____

Copy of Income Documentation

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.

<i>Informational Forms (client provided copies and time for questions & answers):</i>	<i>Client's Initials</i>
<i>Client Rights and Responsibilities</i>	
<i>Complaint Grievance Procedures</i>	
<i>What You Need to Know About Idaho Laws on HIV</i>	
<i>Acknowledgement of Notice of Privacy Practices (agency specific)</i>	
<i>Other:</i>	

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

 Medical Case Manager

 Date

 Date