IDAHO RYAN WHITE MEDICAL CASE MANAGEMENT ASSESSMENT

Client Name:_____ **Date**:_____/_____/_____ **URN:** _____

1. FINANCIAL AND RESOURCE EVALUATION

HOUSEHOLD / FAMILY COMPOSITION				
Name	**Relation to Applicant**	**Date of Birth**	**Gender**	
		_____/_____/_____	Male	Female
		_____/_____/_____	Male	Female
		_____/_____/_____	Male	Female
		_____/_____/_____	Male	Female
		_____/_____/_____	Male	Female
		_____/_____/_____	Male	Female
		_____/_____/_____	Male	Female

MONTHLY HOUSEHOLD / FAMILY GROSS INCOME					
Source	**Applicant**	**Household**	**Source**	**Applicant**	**Household**
Wages	$	$	Pension/Annuities	$	$
Social Security	$	$	TANF/TAFI	$	$
Social Security Disability	$	$	Food Stamps	$	$
Supplemental Security Income	$	$	Alimony	$	$
Unemployment Compensation	$	$	Child Support	$	$
Veteran's Benefits	$	$	Enhanced Rent	$	$
Retirement	$	$	Energy Assistance	$	$
Private Investments					
Total Income	$	$	**Total Income**	$	$

MONTHLY HOUSEHOLD / FAMILY EXPENSES					
Source	**Applicant**	**Household**	**Source**	**Applicant**	**Household**
Housing	$	$	Medical	$	$
Utilities	$	$	Clothing	$	$
Groceries	$	$	Telephone	$	$
Sundry Items	$	$	Cable	$	$
Auto	$	$	Credit Card(s)	$	$
Auto Fuel	$	$	Entertainment	$	$
Auto Insurance	$	$	Miscellaneous / Other:	$	$
Total Expenses	$	$	**Total Expenses**	$	$

Total Applicant Income- Total Applicant Expenses = Net Difference
(_____) – (_____) = (_____)

Total Household/Family Income- Total Household/Family Expenses = Net Difference
(_____) – (_____) = (_____)

PRIVATE INSURANCE			
Client eligible for insurance? ☐NO ☐YES	If YES, is client enrolled? ☐NO ☐YES	If NO, why?	
Medical visit co-pays: $	Does your insurance cover medications? ☐NO ☐YES	Deductible:	Medication co-pays: $
Comments:			

MEDICARE	
Medicare: ☐NO ☐YES If No, eligible? ☐NO ☐YES	If Yes, Effective Date: _____/_____/_____ Medicare Coverage: ☐ Part A ☐ Part B ☐ Part C ☐ Part D
Client eligible for IDAGAP? ☐NO ☐YES	**Comments:**

MEDICAID	
Medicaid: ☐NO ☐YES If No, eligible? ☐NO ☐YES	If yes, effective date: _____/_____/_____ Case Worker: _____ Telephone #: ( ) -
Comments:	

RYAN WHITE PARTS B & C PROGRAM PARTICIPATION				
Applied for RWPB: ☐NO ☐YES	If yes, effective date: ____/_____/_____	No, eligible? ☐NO ☐YES	Medical Case Manager:	Telephone #: ( ) -
Applied for RWPC: ☐NO ☐YES	If yes, effective date: ____/_____/_____	No, eligible? ☐NO ☐YES	Medical Case Manager:	Telephone #: ( ) -
Utilizes ADAP for HIV Medications? ☐NO ☐YES	Comments:			

Which of the following Ryan White services would benefit you?

☐ Medical Case Management	☐ Mental Health Services	☐ Dental Care	☐ Interpreter and Translation Services
☐ Outpatient Medical Care	☐ Short-Term Emergency Assistance	☐ Transportation to Medical Appointments	
☐ Case Management (non-medical)	☐ Referral for Health Care and Supportive Services	☐ Medical Nutrition Services	

If available, would you benefit from any of the following services?

☐ Help with your health insurance costs	☐ Home Health Care	☐ Home & Community Based Health	☐ Hospice Care	
☐ (Outpatient) Substance Abuse Services	☐ Child care during medical & program meetings	☐ Food Bank / Home Delivered Meals	☐ Residential Substance Abuse	
☐ Health Education / Risk Reduction	☐ Housing Services	☐ Legal Services for Access to Eligible Benefits	☐ Outreach Services	☐ Respite Care
☐ Permanency Planning for Minor Children	☐ Psychosocial Support	☐ Rehabilitation Services	☐ Substance Abuse Services (residential)	☐ Adherence Counseling (non-medical site)

Comments:

HOPWA			
Currently receiving HOPWA? ☐NO ☐YES	If no, eligible? ☐NO ☐YES	If yes, application date: _____/_____/_____	**Services:** ☐ STMRU ☐ Mental Health
Comments:			

2. SAMISS[1] (Substance Abuse and Mental Illness Symptoms Screener)

SUBSTANCE ABUSE ITEMS: **SCORE**

1. How often do you have a drink containing alcohol? (*Alcoholic drinks include one beer, one glass of wine, a mixed drink of hard liquor, or wine cooler. Each of these counts as one drink, unless they have double shots, which would equal two drinks.*) (**If you do not drink, go to question #4.**)

0	[ ]	Never	**3**	[ ]	2-3 times a week
1	[ ]	Monthly or less	**4**	[ ]	4 or more times a week
2	[ ]	2-4 times a month			

2. How many drinks do you have on a typical day when you are drinking?

0	[ ]	1 or 2	**3**	[ ]	7 to 9
1	[ ]	3 or 4	**4**	[ ]	10 or more
2	[ ]	5 or 6			

3. How often do you have four or more drinks on one occasion?

0	[ ]	Never	**3**	[ ]	2-3 times a week
1	[ ]	Monthly or less	**4**	[ ]	4 or more times a week
2	[ ]	2-4 times a month			

Sum of responses for Questions 1 -3: **[ ]**

4. In the past year, how often did you use nonprescription drugs to get high to change the way you feel?

0	[ ]	Never	**3**	[ ]	2-3 times a week
1	[ ]	Monthly or less	**4**	[ ]	4 or more times a week
2	[ ]	2-4 times a month			

5. In the past year, how often did you use drugs prescribed to you or to someone else to get high or change the way you feel?

0	[ ]	Never	**3**	[ ]	2-3 times a week
1	[ ]	Monthly or less	**4**	[ ]	4 or more times a week
2	[ ]	2-4 times a month			

Sum of responses for Questions 4 -5: **[ ]**

6. In the last year, how often did you drink or use drugs more than you meant to?

0	[ ]	Never	**3**	[ ]	2-3 times a week
1	[ ]	Monthly or less	**4**	[ ]	4 or more times a week
2	[ ]	2-4 times a month			

7. How often did you feel you wanted or needed to cut down on your drinking or drug use in the last year, and not been able to?

0	[ ]	Never	**3**	[ ]	2-3 times a week
1	[ ]	Monthly or less	**4**	[ ]	4 or more times a week
2	[ ]	2-4 times a month			

Sum of responses for Questions 6 -7: **[ ]**

Patient considered positive for substance abuse symptoms if <u>any</u> of the following criteria are met:

a) The **sum** of responses for **Questions 1-3 is ≥ 5**

b) The **sum** of responses for **Questions 4-5 is ≥ 3**

c) The **sum** of responses for **Questions 6-7 is ≥ 1**

[1] Whetten, K., Reif, S., Swartz, M., Stevens, R., Ostermann, J., Hanisch, L., Eron, J.J. (2005). A brief mental health and substance abuse screener for persons with HIV. *AIDS Patient Care and STDs 19*(2), 89-99.

MENTAL HEALTH ITEMS:

Medications/antidepressants

8. During the past 12 months, were you ever on medication/antidepressants for depression or nerve problems?
1. YES
2. NO

Major depression

9. During the past 12 months, was there ever a time when you felt sad, blue, or depressed for two weeks or more in a row?
1. YES
2. NO

10. During the past 12 months, was there ever a time lasting 2 weeks or more when you lost interest in most things like hobbies, work, or activities that usually give you pleasure?
1. YES
2. NO

Generalized anxiety disorders

11. During the past 12 months, did you ever have a period lasting 1 month or longer when most of the time you felt worried and anxious?
1. YES
2. NO

Panic disorder

12. During the past 12 months, did you have a spell or an attack when all of a sudden you felt frightened, anxious, or very uneasy when most people would not be afraid or anxious?
1. YES
2. NO

13. During the past 12 months, did you ever have a spell or an attack when for no reason your heart suddenly started to race, you felt faint, or you couldn't catch your breath? (If respondent volunteers "only when having a heart attack or due to physical causes," mark "NO")
1. YES
2. NO

Patient considered positive for symptoms of mental illness if he/she responded yes to <u>any</u> mental health question.

3. HOMELESS PREVENTION SCREENING TOOL[2]

The following questions will help me to understand the stability of your housing situation. These questions can help to determine to what extent you are at risk of homelessness. Please answer each question honestly. You are not required to answer any of the questions.

Gender: ☐☐ Male ☐ Female

1. Are you homeless right now? (If answered NO, skip to question #2) ☐NO ☐YES

a. How long have you been homeless? Days: _____ Weeks: _____ Months: ____ Years: _____

b. Which shelter are you staying at today? _____

2. Do you have difficulty meeting your food, rent, utility and/or transportation needs? ☐ NO ☐ YES

3. Do you have housing problems? ☐ NO ☐ YES If yes, what are they? _____

☐ Legal eviction notice within the past 30 days
☐ Did not pay last month's rent
☐ Did not pay utility bill(s)
☐ Building in bad condition (Windows, locks, plumbing, insects, rodents, hot/cold water, electricity, etc)
☐ Doubled up with family or friends
☐ Overcrowded living situations
☐ Threats of being kicked out
☐ Other:

4. In the past 30 days (or 30 days prior to hospitalization / incarceration, etc.) where did you live?

☐ Owned apartment, room or house	Number of Days: _____
☐ Rented apartment, room or house	Number of Days: _____
☐ Family of friend's home / apartment	Number of Days: _____
☐ Shelter	Number of Days: _____
☐ Hotel or SRO	Number of Days: _____
☐ Abandoned building, park, train station, car, streets	Number of Days: _____
☐ Institution (hospital, halfway house, nursing home)	Number of Days: _____
☐ Foster home or group home	Number of Days: _____
☐ Jail, prison or detention center	Number of Days: _____
☐ Other:	Number of Days: _____

5. Have you ever been homeless as an adult? ☐ NO ☐ YES

a. How many times have you been homeless in your life? _____

b. In what year(s) were you homeless?

c. What was the longest period of time you were homeless? (including shelter days) Days: _____ Weeks: _____ Months: _____ Years: _____

6. Were you ever homeless as a child? ☐ NO☐☐ YES

7. Before you were 18, did you ever live out of your home and away from your family? ☐ NO ☐ YES

8. Is there anyone you can contact in an emergency or time of need? ☐ NO ☐ YES

Who is that person? Name: _____ Relationship: _____

9. Have you ever been picked up or arrested by the police? ☐ NO ☐ YES

10. Have you ever spent time in jail, prison or a juvenile detention center? ☐ NO ☐ YES

11. Are you currently suffering from a chronic illness or physical disability? If yes, what kind of illness or disability? _____ ☐ NO ☐ YES

12. Did you drink or use street drugs in the last 30 days? (If No, skip to #13). ☐ NO ☐ YES

[2] Developed by the Office of Mental Health – Homeless Action Committee

a. What kind of substance did you use? _____

b. How often did you use the substance?

☐ Daily ☐ Once a week

☐ Less than once a week ☐ 4 – 6 times a week

☐ 2 -3 times a week

c. How much of the substance did you use? _____

13. Did you ever live in or participate in a detox program, a halfway house or a residential substance abuse treatment program? ☐ NO ☐YES

14. Before you were 18, were you ever physically, emotionally or sexually abused? ☐ NO ☐YES

15. Have you experienced domestic violence, abuse or assault in last 30 days? ☐ NO ☐YES

16. Have you ever received treatment for an emotional or psychiatric problem? ☐ NO ☐YES

a. When and were you most recently treated?

b. Where did you receive treatment? _____

c. Were you prescribed medication for that emotional / psychiatric problem? ☐ NO ☐ YES

d. Medication(s) prescribed: _____

_____

17. Have you ever spent time in a hospital overnight for an emotional / psychiatric problem? ☐ NO ☐ YES

RISK OF HOMELESSNESS:
Total number of boxes checked "YES" **a. High = 8 +** Boxes checked "YES" **b. Moderate = 3 – 7** Boxes checked "YES" **c. Mild = 1 – 2** Boxes checked "YES" **Score**: **Level**: _____ _____ **Do not count question 1 towards the number of boxes checked "YES." If question checked "YES" client is currently homeless.**

4. DOMESTIC VIOLENCE (The HITS Scale[3] (Hurts, Insults, Threatens & Screams Domestic Violence))

1. **HURT:** How often does your partner physically hurt you?

☐ **1 = Never** ☐ **2 = Rarely** ☐ **3 = Sometimes** ☐ **4 = Fairly Often** ☐ **5 = Frequently**

2. **INSULT:** How often does your partner insult or talk down to you?

☐ **1 = Never** ☐ **2 = Rarely** ☐ **3 = Sometimes** ☐ **4 = Fairly Often** ☐ **5 = Frequently**

3. **THREATEN:** How often does your partner threaten you with physical harm?

☐ **1 = Never** ☐ **2 = Rarely** ☐ **3 = Sometimes** ☐ **4 = Fairly Often** ☐ **5 = Frequently**

4. **SCREAM:** How often does your partner scream or curse at you?

☐ **1 = Never** ☐ **2 = Rarely** ☐ **3 = Sometimes** ☐ **4 = Fairly Often** ☐ **5 = Frequently**

RISK OF DOMESTIC VIOLENCE: Score ranges from 4 to a maximum of 20

Score:_____ ***(A score equal to or greater than 10 is considered diagnostic of abuse)***

[3] Kevin M. Sherin, MD, MPH; James M. Sinacore, PhD; Xiao-Qiang Li, MD; Robert E. Zitter, PhD; Amer Shakil, MD (1998). HITS: A Short Domestic Violence Screening Tool for Use in a Family Practice Setting. *Family Medicine* 30(7):508-12.

5. VACCINATION HISTORY

Does client have immunization card with them?	□NO □YES
If client does not have immunization card, can he/she bring it?	□NO □YES (Date: _____/_____/_____)
If immunization card is not available, will client sign a release of information in order to obtain vaccination history?	□NO □YES

6. TRANSPORTATION EVALUATION

How do you get to your medical or support service visits?

☐ Public transportation
☐ Medicaid taxi
☐ Taxi (non-Medicaid)
☐ Own vehicle
☐ Ride from family member or friend
☐ Ride from program volunteer
☐ Walk
☐ Other _____

Do you have difficulty arranging transportation? ☐ No ☐ Yes

If yes, why? _____

Note any transportation barriers or concerns below:

7. NUTRITION AND BASIC NEEDS EVALUATION

Tell me how you are meeting your nutritional needs. Do you need assistance with any of the following?

Obtaining enough nutritious food to eat? ☐ No ☐ Yes
Preparing food/cooking? ☐ No ☐ Yes
Grocery shopping? ☐ No ☐ Yes
Food storage? ☐ No ☐ Yes

Do you receive or use any of the following types of food assistance?

Food Assistance			
Assistance type	**Receive/Use?**	**How often?**	**From where?**
Food stamps	☐ No ☐ Yes		
Food pantry	☐ No ☐ Yes		
Home delivered meals	☐ No ☐ Yes		
Congregate meals	☐ No ☐ Yes		
Food voucher	☐ No ☐ Yes		
Other _____	☐ No ☐ Yes		

Do you have any dietary limitations or food allergies? ☐ No ☐ Yes

Do you have any problems eating due to medications? ☐ No ☐ Yes

Have you ever seen a nutritionist/registered dietician? ☐ No ☐ Yes

How is your appetite?

Do you need any assistance with "activities of daily living," e.g., bathing, dressing and bathroom, or eating? ☐ No ☐ Yes

Do you need assistance with housekeeping, shopping, remembering appointments, or using the telephone? ☐ No ☐ Yes

Do you have adequate clothing? ☐ No ☐ Yes
Do you have any other basic needs? ☐ No ☐ Yes

Note any additional nutrition or basic needs concerns below:

8. ADHERENCE ASSESSMENTS[4]

(REALM-R, Medication Knowledge, Readiness Ruler, Duke-UNC FSSQ)

REALM-R (Rapid Estimate of Adult Literacy in Medicine - Revised)	
Fat	
Flu	
Pill	
Allergic	
Jaundice	
Anemia	
Fatigue	
Directed	
Colitis	
Constipation	
Osteoporosis	
Scoring: Fat, Flu, and Pill are not scored. A score <u>of 6 correct or less</u> is used to identify patients at risk for poor literacy.	

MEDICATION KNOWLEDGE SURVEY

First column: Filled in by MCM

Next: Check all boxes patients can answer successfully and fill in the information they provide to you about each of their medications.

Medication	Name of Medication?	Why are you taking medication?	How much to take each time?	When to take the medication?	Effects to look out for		Where do you keep the medication?	When is the next refill? Record date.
					P	N		

P = Positive effects of taking medication, N = Negative effects of taking medication

[4] Case Management Society of America, *Case Management Adherence Guidelines, 2006.*

DUKE – UNC FUNCTIONAL SOCIAL SUPPORT QUESTIONNAIRE (FSSQ)					
	5	**4**	**3**	**2**	**1**
	As much as I would like	Almost as much as I would like	Some, but would like more	Less than I would like	Much less than I would like
1. I have people who care what happens to me.					
2. I get love and affection.					
3. I get chances to talk to someone about problems at work or with my housework.					
4. I get chances to talk to someone I trust about my personal or family problems.					
5. I get chances to talk about money matters.					
6. I get invitations to go out and do things with other people.					
7. I get useful advice about important things in life.					
8. I get help when I am sick in bed.					

FSSQ Scoring Instructions
1. All questions must be completed to score the FSSQ.
2. Add the numeric scores for all 8 questions.
3. Divide the total score by 8 to achieve an average score.
Scoring: As social support increases, the score should increase. If the number is low, please address on the Wellness Plan.

Medical Case Manager Signature

Date