DHS
Oregon Department
of Human Services

**Optional Form**

# 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)**
- **List of current medications and pill bottles**
- **Most current lab reports (if they have them)**
- **Photo I.D. (if available)**

DHS
Oregon Department of Human Services

Required Form

# PROGRAM REQUIREMENTS CHECKLIST

| FORM | DATE | DATE OF REVIEW | DATE OF REVIEW | DATE OF REVIEW | DATE OF REVIEW |
|---|---|---|---|---|---|
| First Contact | | | | | |
| Informed Consent | | | | | |
| HIV Verification | | | | | |
| Rights & Responsibilities | | | | | |
| Grievance Procedure | | | | | |
| ROI | | | | | |
| Client Intake / Update | | | | | |
| Psychosocial Assess. / Reassess. | | | | | |
| Nurse Assessment / Reassessment | | | | | |

| CLINICAL OUTCOMES | VALUE | DATE | VALUE | DATE | VALUE | DATE |
|---|---|---|---|---|---|---|
| Acuity Level/Date | | | | | | |
| CD4 / Date | | | | | | |
| VL / Date | | | | | | |
| Weight / Date | | | | | | |
| HIV / AIDS Status / Date* | | | | | | |

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

## INCOME VERIFICATION

**I have verified income to be at or below:**

**Initial eligibility:**

- ☐ **100% of poverty**
- ☐ **200% of poverty**
- ☐ **250% of poverty**
- ☐ **above 250% of poverty**

**Income verified through:**

_____

**Date** _____

**CM** _____

**1st review:**

- ☐ **100% of poverty**
- ☐ **200% of poverty**
- ☐ **250% of poverty**
- ☐ **above 250% of poverty**

**Income verified through:**

_____

**Date** _____

**CM** _____

**2nd review:**

- ☐ **100% of poverty**
- ☐ **200% of poverty**
- ☐ **250% of poverty**
- ☐ **above 250% of poverty**

**Income verified through:**

_____

**Date** _____

**CM** _____

## HIV VERIFICATION

I have verified HIV status through (Western Blot test results or Detectable Viral Load):

- ☐ current CAREASSIST client
- ☐ copy of HIV+ test results
- ☐ 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 undectable viral load, a new Antibody Screening Test must be performed.

**Client Name** _____ **ID#** _____

Required Form

DHS Oregon Department of Human Services

# CLIENT INTAKE / UPDATE

**Check appropriate box:** ☐ Intake ☐ Update

DATE _____ SOC. SEC. # _____

## PERSONAL INFORMATION

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

STREET ADDRESS _____ CITY/STATE _____ ZIP _____

MAILING ADDRESS, IF DIFFERENT _____ CITY/STATE _____ ZIP _____

O.K. to Mail to Mailing Address ☐ Yes ☐ No Anonymous return address requested? ☐ Yes ☐ No

DIRECTIONS/DESCRIPTION OF HOUSE: _____

_____

COUNTY _____ AGE / DOB ____/____/____ GENDER _____

Have you served in the military? ☐ Yes ☐ No

HOME PHONE (____) _____ May we leave message: ☐ Yes ☐ No Message/Day Phone: (____) _____

Discreet message only: ☐ Yes ☐ No May we contact you at work? ☐ Yes ☐ No Work Phone: (____) _____

ETHNICITY: ☐ Hispanic/Latino ☐ Not Hispanic/Not Latino

RACE (Choose all that apply): ☐ White ☐ Black or African-American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian or Alaskan Native

PRIMARY LANGUAGE _____ Need Interpreter ☐ Yes ☐ No

## KEY CONTACTS

☐ NO CHANGE

| CONTACT | NAME/ADDRESS | PHONE NUMBER |
|---|---|---|
| Emergency Contact | Relationship _____ | (____) _____ |
| Aware of Status ☐ Yes ☐ No | HIV/AIDS Provider _____ | (____) _____ |
| Primary Care Provider | _____ | (____) _____ |
| DSO/CFA/SPD Worker | _____ | (____) _____ |
| Dental | _____ | (____) _____ |
| Other Agencies Working with Client | _____ | (____) _____ |

## HOUSEHOLD MEMBERS

☐ NO CHANGE

| NAME | RELATIONSHIP TO CLIENT | DOB | Aware of HIV status |
|---|---|---|---|
| _____ | _____ | ___ ___ ___ | ☐ Yes ☐ No |
| _____ | _____ | ___ ___ ___ | ☐ Yes ☐ No |
| _____ | _____ | ___ ___ ___ | ☐ Yes ☐ No |
| _____ | _____ | ___ ___ ___ | ☐ Yes ☐ No |
| **FAMILY MEMBERS NOT IN HOUSEHOLD** | | | |
| _____ | _____ | ___ ___ ___ | ☐ Yes ☐ No |

**HOUSEHOLD MEMBERS LIVING WITH HIV?** ☐ **Yes** ☐ **No** **Who?** _____

_____

DATE OF FIRST CONTACT: _____ CM INITIAL _____

☐ Phone or ☐ Walk-In

## FAMILY/DEPENDENT CHILDREN

☐ NO CHANGE

Do you have dependent children? ☐ Yes ☐ No Number _____ Ages/Names _____

If yes, do they live with you? ☐ Yes ☐ No Ages/Names _____

Have you had difficulty accessing services for your children? ☐ Yes ☐ No

If yes, explain: _____

Do you have any issues related to child custody? ☐ Yes ☐ No If yes, is CAF involved? ☐ Yes ☐ No

If yes, name and phone number of worker: _____

## HEALTH INSURANCE (Check all that apply)

☐ NO CHANGE

☐ Medicaid/OHP # _____ ☐ Private Ins. _____

- ☐ Standard
- ☐ Plus
- ☐ Open Card

☐ ID # _____

☐ Medicare A & B # _____

☐ Veterans Benefits # _____ ☐ Premium Amt. _____

☐ OMIP # _____ ☐ Dental Insurance _____

☐ Medically Needy Spend Down # _____ ☐ Not Insured CAREAssist ☐ Yes ☐ No

## EMPLOYMENT

☐ NO CHANGE

Employer _____ Aware of Status ☐ Yes ☐ No

Address _____

City/State/Zip _____

Phone (____) _____ O.K. to contact at work? ☐ Yes ☐ No

## HIV STATUS (Check one)

☐ NO CHANGE

☐ HIV - positive not AIDS ☐ HIV - positive, AIDS status unknown ☐ CDC - defined AIDS

Date tested positive _____ Date of AIDS diagnosis _____

## TRANSMISSION CATEGORY (Check one)

☐ NO CHANGE

☐ MSM ☐ MSM/IDU ☐ Heterosexual ☐ Unknown ☐ Occupational Exposure

☐ IDU ☐ Maternal/Child ☐ Undisclosed ☐ Blood Products ☐ Other

## LIVING SITUATION

☐ NO CHANGE

☐ Apartment ☐ Own House ☐ Rental House ☐ HUD/Section8 ☐ Adult Foster Care

☐ With Friends ☐ With Family ☐ Transitional ☐ Hospice ☐ Drug-Free Housing

☐ Emergency ☐ Homeless ☐ Skilled Nursing Facility

Describe current situation (Stability, safety, affordability): _____

_____

Client Name _____ Client # _____ CM Initial _____ Date _____

## EDUCATION

☐ NO CHANGE

Highest grade you completed in school? _____

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

Were you in special education classes in school? ☐ Yes ☐ No

If yes, what type? _____

## LEGAL ISSUES

☐ NO CHANGE

Do you have the following? (Check all that apply) ☐ Trust ☐ Will

☐ Durable Power of Attorney ☐ Healthcare Power of Attorney ☐ Physician's Directive

Guardian/Conservator for: ☐ Self and/or ☐ Dependents

If you have a Power of Attorney, who is Power of Attorney?

Name: _____ Phone #: _____

Address: _____

Do you have a history of arrests, including assault? ☐ Yes ☐ No

If yes, what were the charges? _____

_____

Were you convicted? ☐ Yes ☐ No

Do you have/ever had any restraining orders against you? ☐ Yes ☐ No

Do you have a history of being incarcerated? ☐ Yes ☐ No

Are you currently on probation/parole? ☐ Yes ☐ No

If yes, name of probation or parole officer/phone: _____

## TRANSPORTATION

☐ NO CHANGE

Transportation available? ☐ Yes ☐ No Own car? ☐ Yes ☐ No ☐ Friend/SO ☐ Public transit

☐ None ☐ Other _____ Reliable ☐ Yes ☐ No

What problems have you encountered? _____

_____

## AVAILABILITY OF BASIC NEEDS - (Check if needed):

☐ NO CHANGE

☐ Clothing ☐ Food ☐ Food Stamps $_____/Mo.

Access to Food Programs? ☐ Yes ☐ No If yes, which ones? _____

☐ Other Household/Personal Items (toilet articles, cleaning or pet supplies, etc.) _____

☐ Other Basic Needs _____

_____

Client Name _____ Client # _____ CM Initial _____ Date _____

**INCOME/EXPENSES -** Do you feel that your income is adequate to meet your needs? ☐ Yes ☐ No

| INCOME | | EXPENSES | |
|---|---|---|---|
| **SOURCE** | **AMOUNT** | **ITEMIZATION** | **AMOUNT** |
| Salary | $ | Rent/Mortage | $ |
| Spouse's Salary | $ | Phone | $ |
| Short-Term Disability | $ | Utilities | $ |
| Long-Term Disability | $ | Car Payment | $ |
| SSI | $ | Insurance Premiums | $ |
| SSDI | $ | CARE Assist Cost Share | $ |
| AFDC | $ | Food | $ |
| VA Pension | $ | Day Care | $ |
| Child Support | $ | Child Support | $ |
| General Assistance | $ | Alimony | $ |
| Savings/Investments | $ | Medical Expenses | $ |
| Rental Income | $ | Medical Expense Co-Pay | $ |
| Unemployment | $ | Medical Equipment | $ |
| Retirement Benefits | $ | Prescription Meds | $ |
| Family Support | $ | Over The Counter Meds | $ |
| Other | $ | Credit Card | $ |
| | $ | Other | $ |
| **TOTAL** | $ | **TOTAL** | $ |

Do you have a payee? ☐ Yes ☐ No If yes, name/phone: _____

Documentation Attached: (Check all that are attached)

☐ Bank statements that show deposits
☐ Copy of SS check
☐ Accounting paperwork
☐ Copy of Federal income tax return
☐ Social Security (SS) award letter
☐ Year end 1099 form
☐ W-2 tax form from employer
☐ Pay stubs

Federal Poverty Level: _____ % of poverty.

**Signature and Credentials:** _____ **Date** _____

DHS
Oregon Department of Human Services

**Required Form**

# 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 eligibile for CAREAssist or Title II 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 |
|---|---|---|---|

DHS
Oregon Department
of Human Services

**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** _____

DHS Oregon Department of Human Services

Required Form

# PSYCHOSOCIAL ASSESSMENT / REASSESSMENT

**Check appropriate box:** ☐ Assessment ☐ Reassessment

## I. MENTAL HEALTH ASSESSMENT:

(check all that apply to the client, both "Past History" and "Current")

| History | | | ☐ NO CHANGE |
|---|---|---|---|
| **Past** | **Current** | **Cognitive** | **Comments** |
| | | Problems staying alert or focused | |
| | | Disorientation/Confusion | |
| | | Concentration/Attention problems | |
| | | Memory challenges | |
| | | Speech problems(slow, slurred, mumbling) | |
| | | Problems with physical coordination | |
| | | Other: | |

| History | | | ☐ NO CHANGE |
|---|---|---|---|
| **Past** | **Current** | **Depression** | **Comments** |
| | | Prolonged or pronounced sadness | |
| | | Blunted or flat affect | |
| | | Difficulty taking pleasure in things | |
| | | Problems with sleep | |
| | | Appetite changes | |
| | | Mood swings | |
| | | Other: | |

| History | | | ☐ NO CHANGE |
|---|---|---|---|
| **Past** | **Current** | **Anxiety** | **Comments** |
| | | Anxiety feelings | |
| | | Panic episodes or attacks | |
| | | Extensive or continual worry | |
| | | Irrational fears | |
| | | Ideas that preoccupy (obsessive) | |
| | | Other: | |
| | | | |
| | | | |
| | | | |

Client Name _____ Client # _____ Date _____ CM Initial _____

## I. MENTAL HEALTH ASSESSMENT (Continued):

(check all that apply to the client, both "Past History" and "Current")

| History | | | ☐ NO CHANGE |
|---|---|---|---|
| **Past** | **Current** | **Disorders of Thought** | **Comments** |
| | | Hallucinations (auditory, visual) | |
| | | Grandiosity | |
| | | Confusion/Incoherence | |
| | | Delusions (false beliefs) | |
| | | Problems staying present (dissociation) | |
| | | Other: | |
| | | | |

| History *(Ask only if written Agency policy is in place)* | | | ☐ NO CHANGE |
|---|---|---|---|
| **Past** | **Current** | **Suicidality** | **Comments** |
| | | Recurring thoughts of suicide | |
| | | Attempts at self-harm | |
| | | Plan/Intent | |
| | | Passive self-harm behaviors | |
| | | Future - based Plans/Hopes | |
| | | Reason(s) to live | |
| | | Other: | |

| History | | | ☐ NO CHANGE |
|---|---|---|---|
| **Past** | **Current** | **Social Support** | **Comments** |
| | | Inadequate family support | |
| | | Lack of contact with close friends | |
| | | Inadequate community resources/support | |
| | | Availability of people to talk with/confide in | |
| | | Undisclosed HIV status or other personal issue(s) | |
| | | Other: | |
| | | | |
| | | | |
| | | | |

## II. MENTAL HEALTH TREATMENT ASSESSMENT AND HISTORY:

(check all that apply to the client, both "Past History" and "Current")

### Past/Current Counseling or Psychiatric Treatment:

| History | | | | ☐ NO CHANGE |
|---|---|---|---|---|
| **Past** | **Current** | **Place and Type of Treatment** | **Dates** | **Comments** |
| | | Psychiatry | | |
| | | Professional Counseling | | |
| | | Substance Use Counseling | | |
| | | Other: | | |
| | | | | |

| History | | | ☐ NO CHANGE |
|---|---|---|---|
| **Past** | **Current** | **Known Mental Health Dignosis**<br>(Also list in medical condition symptoms history of Core form) | **Comments** |
| | | (List Diagnoses) | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| History | | | ☐ NO CHANGE |
|---|---|---|---|
| **Past** | **Current** | **Medications for Mental Health Conditions** | **Comments** |
| | | (List Meds and also in Meds list) | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Reasons for discontinuing mental health meds. _____

_____

_____

_____

Client Name _____ Client # _____ CM Initial _____ Date _____

## III. SUBSTANCE USE ASSESSMENT AND HISTORY:

☐ NO CHANGE

Do you believe drugs/ETOH are a problem for you? ☐ Yes ☐ No

Ever had A&D related justice contacts? ☐ Yes ☐ No

Ever had a DUII? ☐ Yes ☐ No Ever had a blackout? ☐ Yes ☐ No

Have you ever used a needle to inject drugs? ☐ Yes ☐ No

Have any of your sex partners ever used needles to inject drugs? ☐ Yes ☐ No ☐ I don't know

Drug/ETOH related ER or hospitalizations? ☐ Yes ☐ No

Ever been told drugs/ETOH are a problem for you? ☐ Yes ☐ No

Ever experience financial difficulty due to gambling? ☐ Yes ☐ No

Ever been told gambling is a problem for you? ☐ Yes ☐ No

Do you believe gambling is a problem for you? ☐ Yes ☐ No

Ever been in a treatment program? ☐ Yes ☐ No

If yes, for what addiction/when? _____

Ever attended a recovery program? ☐ Yes ☐ No

If yes, for what addiction/when? _____

| SUBSTANCE USE/ ABUSE/ ADDICTION | IF CURRENT (circle the X) | AMOUNT FREQUENCY (daily/weekly/monthly) | | DURATION (<1yr, 1-2yrs, >2yrs) | LAST USE (<1mo,1-6 mos, 6mos-2yrs, >2yrs) |
|---|---|---|---|---|---|
| **Gambling** | ☐ Yes ☐ No | | | | |
| **Nicotine** | ☐ Yes ☐ No | cigs | | | |
| **Alcohol** | ☐ Yes ☐ No | ozs | | | |
| **Marijuana** | ☐ Yes ☐ No | | | | |
| **Cocaine** | ☐ Yes ☐ No | | | | |
| **Opiates** | ☐ Yes ☐ No | | | | |
| **Speed/Meth** | ☐ Yes ☐ No | | | | |
| **Hallucinogens** | ☐ Yes ☐ No | | | | |
| **Rx Drugs** | ☐ Yes ☐ No | | | | |
| **IDU** | ☐ Yes ☐ No | | | | |
| **Share Equipment** | ☐ Yes ☐ No | | | | |

**Are you using shared equipment?** ☐ Yes ☐ No

If yes, how much of the time are you able to use clean needles? _____

Are you interested in receiving information about needle exchange or safe needle practices? ☐ Yes ☐ No

Client Name _____ Client # _____ CM Initial _____ Date _____

## IV. INTIMATE PARTNER VIOLENCE ASSESSMENT AND HISTORY:

☐ **NO CHANGE**

Before asking the following questions, it is helpful to make the following statements. The third statement (**in bold**) is an informed consent statement and is **mandatory.**

- "Because violence is so common in many people's lives, and because help is available, we now ask everyone about it."
- "I'm going to ask you some questions about how you've been treated in your relationships. It's important to us that our clients be safe, or, if not, that they know this is a safe place to talk about it."
- **"Please understand that if you are under 18 and you answer YES to questions 4, 5, or 6, the health department staff are required to report your situation to the police and/or Child Protetive Services."**

1. Does your partner try to control where you go, what you do, or your money? ☐ Yes ☐ No

   Comments: _____

2. Have you ever been in a relationship where you were threatened or made to feel afraid? ☐ Yes ☐ No

   Comments: _____

3. Were you physically hurt or forced to have sex when you were a child? ☐ Yes ☐ No

   Comments: _____

4. Does your partner frequently insult you, blame you, or put you down? ☐ Yes ☐ No

   Comments: _____

5. Have you ever been forced to have sex when you didn't want to? (sex = oral, anal, vaginal or unwanted touching?) **(Mandatory report if under 18 years of age and they say "Yes")** ☐ Yes ☐ No

   Comments: _____

6. Has your partner ever threatened to hurt him/her self, you, the children, or the pets? **(Mandatory report if under 18 years of age and they say "Yes" to you or the children)** ☐ Yes ☐ No

7. Have you ever been hit, kicked, choked, punched, pushed, or physically hurt by a partner or family member? **(Mandatory report if under 18 years of age and they say "Yes")** ☐ Yes ☐ No

Client Name _____ Client # _____ CM Initial _____ Date _____

☐ NO CHANGE

## V. SEXUAL AND SEXUALLY TRANSMITTED DISEASE (STD) RISK ASSESSMENT:

Is client currently in a relationship? ☐ Yes ☐ No If yes, how long? _____

Has the client had additional sexual/needle partners in the past year? ☐ Yes ☐ No

Additional information client shares about these partners: _____

_____

Number of sexual partners in the past year? ☐ 0 ☐ 1 ☐ 2-3 ☐ 4-10 ☐ 10+

☐ Same sex ☐ Other sex ☐ Both sexes

☐ Vaginal sex ☐ Anal sex ☐ Both

☐ Anonymous encounters

What does the client think they are doing that may be a risk for transmitting HIV to a partner (sexual or needle sharing partners)? _____

_____

_____

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

What is the client doing to protect themselves and their partner from infection?

☐ Condoms ☐ Clean needles and works ☐ Abstinence ☐ One partner

☐ Oral sex instead of anal sex ☐ Top anal instead of bottom anal

☐ Other risk reduction Describe: _____

If the client states that they are using condoms: In the last 3 months, how often did the client use condoms during sex? ☐ Always ☐ Most times ☐ Sometimes ☐ Never

In the last 3 months, how often did the client's partner use a condom?

☐ Always ☐ Most times ☐ Sometimes ☐ Never ☐ Don't know

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

In the past 12 months, have any of the client's sex partners been told they had a sexually transmitted infection? ☐ Yes ☐ No ☐ Don't know If yes, which ones: _____

Does the client currently have any of these symptoms? (check all that apply)

☐ Genital ulcers, warts, blisters or other lesions ☐ Pain with sex

☐ Pain or burning with urination ☐ Oral lesions

☐ Pain in the lower abdomen ☐ New or unusual skin rash

**For men:**

☐ Urethral discharge ☐ Testicular or groin pain

**For women:**

☐ Increased bloddy or foul-smelling vaginal discharge ☐ Vulvar itching

☐ Bleeding between periods ☐ Changes in periods

## V. SEXUAL AND SEXUALLY TRANSMITTED DISEASE (STD) RISK ASSESSMENT: (Continued)

Has the client ever been told by a doctor or nurse that they had a sexually transmitted infection?

☐ Yes ☐ No ☐ Unsure If yes, check all that apply:

- ☐ Herpes Simplex Date: _____
- ☐ Chlamydia Date: _____
- ☐ Gonorrhea Date: _____
- ☐ Syphilis Date: _____
- ☐ Trichomonasomavirus Date: _____
- ☐ Lymphogranuloma Verereum Date: _____
- ☐ Pelvic Inflammatory Disease Date: _____

What additional information has the client requested about their sexual risk? _____

_____

_____

What's the one thing the client thinks they can do to reduce the risk to themselves and their partners?

_____

_____

## VI. BRIEF DESCRIPTION OF EMOTIONAL/SPIRITUAL/SOCIAL SUPPORT/COPING:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

**Case Manager Signature & Credentials:** _____

Client Name _____ Client # _____ CM Initial _____ Date _____

DHS Oregon Department of Human Services

# NURSE ASSESSMENT / REASSESSMENT

Required Form

**Check appropriate box:** ☐ Assessment ☐ Reassessment

## VITALS

Height _____ Baseline Weight _____ Current Weight _____

CD4 count _____ Date _____ Lowest CD4 _____ Date _____

Viral Load _____ Date _____ Highest Viral Load _____ Date _____

☐ CDC Defined AIDS Diagnosis ☐ Date _____

☐ **NO CHANGE**

| ACTIVITY | SELF | NEEDS ASSIST. | DEPENDENT | | ACTIVITY | SELF | NEEDS ASSIST. | DEPENDENT |
|---|---|---|---|---|---|---|---|---|
| Ambulation | | | | | Laundry | | | |
| Bathing | | | | | Meal Prep. | | | |
| Dressing/ Grooming | | | | | Shopping | | | |
| Driving | | | | | Toileting | | | |
| Eating | | | | | Transfers | | | |
| Housekeeping | | | | | | | | |

## GENERAL HISTORY: Current symptions/complaints:

☐ **NO CHANGE**

- ☐ Abdominal Pain _____
- ☐ Change in eating habits _____
- ☐ Nausea/vomiting _____
- ☐ Diarrhea _____
- ☐ Wasting/weight loss _____
- ☐ Difficulty swallowing _____
- ☐ Dental problems: _____
  - Date of last dental exam: _____
- ☐ White patches or sores in mouth, throat or tongue _____
- ☐ Sore throat or mouth _____
- ☐ Hearing changes _____
- ☐ Headache, describe: _____
- ☐ Fever _____
- ☐ Chills _____
- ☐ Fatigue _____
- ☐ Night Sweats _____
- ☐ Swollen lymph glands _____
- ☐ Seizures or Tremors _____
- ☐ Balance changes/falls _____
- ☐ Dizziness _____
- ☐ Strength changes _____
- ☐ Numbness _____
- ☐ Pain _____
- ☐ Chest pain _____
- ☐ Cough _____
- ☐ Shortness of breath _____
- ☐ Skin changes/rashes _____
- ☐ Vision changes _____
- ☐ Other _____

## ALLERGIES

☐ **NO CHANGE**

Does client suffer from any allergies? ☐ Yes ☐ No **IF YES, PLEASE INCLUDE SYMPTOMS:**

_____

| | | | |
|---|---|---|---|
| Medication/drug | ☐ Yes | ☐ No | Which? _____ |
| Food | ☐ Yes | ☐ No | Which? _____ |
| Environmental | ☐ Yes | ☐ No | Which? _____ |

Client Name _____ Client # _____ Date _____ CM Initial _____

## MEDICATION PROFILE

☐ NO CHANGE

Pharmacy: _____ Phone: _____

Physician: _____ Phone: _____

| Date | Medication | Dose | Freq | Route | Date / / | Date / / | Date / / | Date / / | Date / / |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

Medications Administered By: _____

**Legend:** **C** = Medication continues w/o changes **Dc'd** = Medication discontinued

What complementary therapies does the client use? _____

_____

Is the medical provider aware of complementary therapies? ☐ Yes ☐ No

History of elevated LIPIDS (Cholesterol/Triglyceride) ☐ Yes ☐ No

Client Name _____ Client # _____ CM Initial _____ Date _____

# OREGON CAREAssist Formulary - August 2004

**ANTI-RETROVIRALS**

**Protease Inhibitors:**
- nelfinavir (Viracept)
- indinavir (Crixivan)
- ritonavir (Norvir & Kaletra)
- saquinavir (Invirase & Fortovase)
- amprenavir (Agenerase)
- lopinavir (kaletra)
- atazanvir (reyataz)†
- fosamprenavir (Lexiva)†

**Non-Nucleoside Reverse Transcriptase Inhibitors:**
- delavirdine (Rescriptor, DLV)
- nevirapine (Viramune, NVP)
- efavirenz (Sustiva)

**Reverse Transcriptase Inhibitors:**
- zidovudine (Retrovir, ZDV, AZT, Combivir, Trizivir)
- zalcitibine (Hivid, ddC)
- didanosine (Videx, ddI)
- stavudine (Zerit, d4T)
- lamivudine (Epivir, 3TC, Combivir, Trizivir, Epzicom†)
- abacavir (Ziagen, Trizivir, Epzicom†)
- emtricitabine (Emtriva†, Truvada†)

**Nucleotide Analogue Reverse Transcriptase Inhibitors:**
- tenofovir (Viread, Truvada†)

**HIV-1 Entry Inhibitors:**
- enfuvirtide (Fuzeon, T20)*†

**OPPORTUNISTIC INFECTION PROPHYLAXIS/TREATMENT:**

**Anemia**
- epoetin alfa (Epogen, Procrit)**
- filgrastim (Neupogen)**

**KS**
- daunorubicin citrate (DaunoXome)
- doxorubicin HCI (Doxil, Adriamycin, Rubex)
- interferon alfa-2b, 2a (Intron A, Roferon A)

**PCP**
- atovaquone (Mepron)**
- aerosolized pentamidine (Nebupent)
- clindamycin (Cleocin)
- trimetrexate glucuronate (Neutrexin)
- sulfa/trimethoprim (Bactrim, Septra, Cotrim)
- dapsone

**MAC**
- rifabutin (Mycobutin)
- clarithromycin (Biaxin)
- axithromycin (Zithromax)
- ethambutol (Myambutol)

**CMV**
- ganciclovir (Cytovene)**
- foscarnet (Foscavir)**
- cidofovir (Vistide)
- fomivirsen sodium intravitreal injectable (Vitravene)**
- valganciclovir HC1 (Valcyte)

**TB**
- isoniazid (Nydrazid, Rifamate, Rifater)
- rifampin (Rifamate, Rifater, Rifadin, Rimactane)
- levofloxacin (Levoquin)
- pyrazinamide (Rifater)
- ethambutol (Myambutol)
- aminosalicylic acid (PASER)
- cyloserine (Seromycin)
- streptomycin
- ethionamide (Trecator)

**Fungi**
- fluconazole (Diflucan)
- ketoconazole (Nizoral)
- intraconazole (Sporanox)
- clotrimazole (Mycelex)

**Herpes**
- acyclovir (Zovirax)
- famciclovir (Famvir)
- valacyclovir (Valtrex)

**Toxo**
- pyrimethamine (Daraprim, Fansidar)
- leucovorin
- clindamycin (Cleocin, ClindaDerm)
- sulfadiazine (Microsulfon)

**NOTES**

† Drugs **not** on Medically Needy Spend-Down Formulary.

* Prior authorization required.

** Very expensive drug, please use only as last resort. Use may generate a utilization review contact from a CAREAssist Provider Panel.

✔ Generic substitution will occur whenever available.

✔ All drugs must be transmitted through CAREAssist's on-line claims processor.

✔ CAREAssist cannot pay for drugs that are eligible for reimbursement from another source such as Medicare or Medicaid.

✔ CAREAssist provides prescription drugs only, over-the-counter medications are not covered.

Client Name _____ Client # _____ CM Initial _____ Date _____

☐ NO CHANGE

## HIV MEDICATION ADHERENCE ASSESSMENT *(check appropriate responses)*

Is client currently taking HIV meds? ☐ Yes ☐ No

If "No:"

- ☐ Client wants to start HIV meds
- ☐ Not recommended by provider at this time
- ☐ Thinking about starting HIV meds
- ☐ Does not want to take HIV meds

If "Yes:"

Is client taking HIV meds but having problems? ☐ Yes ☐ No

Is client responsible for setting up own medication? ☐ Yes ☐ No

If no, who? _____

**Comments**

**Client understanding of medication:**

☐ thorough ☐ average ☐ basic ☐ confused

Are medicines properly stored? ☐ Yes ☐ No

Are bottles in childproof containers? ☐ Yes ☐ No

Are bottles easy to open? ☐ Yes ☐ No

Are meds outdated? ☐ Yes ☐ No

Prescribed by multiple physicians? ☐ Yes ☐ No

Is a visual dosage chart used? ☐ Yes ☐ No

Has client ever "borrowed" medicines from another person? ☐ Yes ☐ No

If yes, how many times? _____

Who is responsible for ordering refills? ☐ Self and/or _____

Who picks up refills? ☐ Self and/or _____

Pharmacies used: 1. _____ 2. _____ 3. _____

Prescriptions refilled by: ☐ Pharmacy ☐ Mail ☐ Physician

Are meds taken on schedule every day/every time? ☐ Yes ☐ No

Number of doses taken late in last week? _____

Has client missed a dose? ☐ Yes ☐ No If so, how many times in the past week? _____

Why? _____

Eating Habits: ☐ B ☐ L ☐ D ☐ Snacks Is water taken with meds? ☐ Yes ☐ No ☐ Other

Is client a MORNING, AFTERNOON or NIGHTOWL person? ☐ am ☐ pm ☐ Nightowl

Is medical provider aware of adherence problems? ☐ Yes ☐ No

Further intervention needed? ☐ Yes ☐ No

**Comments**

Client Name _____ Client # _____ CM Initial _____ Date _____

## MEDICATION SIDE EFFECTS

☐ NO CHANGE

Is client having any side effects from taking the medications? ☐ Yes ☐ No If yes, continue --

☐ Dizziness ☐ Nausea ☐ Rash ☐ Diarrhea ☐ Drowsiness ☐ Headache ☐ Other _____

Contraindications _____

Medical provider notified? Date _____ Time _____

Pharmacy contacted? Date _____ Time _____

## BARRIERS TO HIV MEDICATION ADHERENCE *(Check all that apply)*

☐ NO CHANGE

- ☐ Depression/mental health
- ☐ Works outside the home
- ☐ Alcohol and drug use/abuse
- ☐ Complex medication regimen
- ☐ Care giving responsibilities
- ☐ Difficulty getting refills
- ☐ Lack of regular schedule
- ☐ Taste of medication
- ☐ Number of pills
- ☐ Undisclosed HIV status
- ☐ Side effects
- ☐ Lack of information
- ☐ Mental status changes
- ☐ Lack of social support
- ☐ Doubts medication effectiveness
- ☐ Needs assistance with ADLs
- ☐ Size of pills
- ☐ Eating habits

## ADHERENCE PLAN:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Client Name _____ Client # _____ CM Initial _____ Date _____

## NUTRITIONAL ASSESSMENT:

☐ NO CHANGE

Current weight _____ Ideal weight _____

☐ Assess Access to food; Is client getting enough to eat? ☐ Yes ☐ No

☐ Visual assessment of client's physical appearance (signs of wasting syndrome or other obvious physical maladies): _____

_____

_____

_____

_____

☐ Assess abdominal pain issues (any problems, diagnosis, and/or treatment regimen):

_____

_____

_____

_____

_____

☐ Change in eating habits (eating less, more, can't eat specific foods, allergies to foods, what meals eaten, types of food eaten, any nutritional supplements with amount and frequency, difficulty chewing or swallowing and why): _____

_____

_____

_____

_____

_____

☐ Assess for nausea and vomiting (frequency, if possible, what is causing condition, if acute or chronic):

_____

_____

_____

_____

_____

☐ Assess for dental problems (teeth missing, dentures or partial dentures that may be old or do not fit correctly or have not been assessed by a dentist or denturist for over one year):

_____

_____

_____

_____

_____

_____

## NUTRITIONAL ASSESSMENT (continued):

☐ Assess for wasting diagnosis or significant weight loss (is weight loss significant based on period of time of weight loss, how much weight was lost, build of client, possible causes for the weight loss, client's appetite, and assessment of all of the above): _____

_____

_____

_____

_____

☐ Further intervention needed? ☐ Yes ☐ No

Possible Interventions:

1. Nutritional plan including vitamines, minerals and regular wieght checks.
2. Nutritional assessment with a registered dietician.
3. Referral to dental care.
4. Referral to a denturist to assess dentures.
5. Referral to primary care or HIV care.
6. Referral to counseling if an eating disorder, depression or other mental health concern is a possible issure.
7. Nutritional Incentive Contract, if appropriate.

## NUTRITIONAL PLAN:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Client Name _____ Client # _____ CM Initial _____ Date _____

## Does the client now, or has the client ever had any of the following:

☐ NO CHANGE

- ☐ ADC (AIDS Dementia Complex)
- ☐ Candidiasis (Esophageal, Oral, Vaginal)
- ☐ Cervical Cancer
- ☐ Cholesterol (Elevated)
- ☐ Chronic/recurrent Sinusitis
- ☐ CMV (Cytomegalovirus)
- ☐ Coccidioidomycosis
- ☐ Cryptococcal Meningitis
- ☐ Crytosporidiosis
- ☐ Diabetes
- ☐ Encephalopathy
- ☐ Herpes Simplex
- ☐ Herpes Zoster
- ☐ Histoplasmosis
- ☐ Kaposi's Sarcoma
- ☐ Lymphoma
- ☐ Mycobacterium Avium Complex (MAC)
- ☐ Myopathy
- ☐ Oral Hairy Leukoplakia
- ☐ Parasitic Infection
- ☐ PML
- ☐ Pneumoncystis Carinii Pneumonia (PCP)
- ☐ Pneumonia (Bacterial)
- ☐ Sexually Transmitted Disease, which one(s)? _____
  _____
- ☐ Thrombocytopenia
- ☐ Toxoplasmosis (Toxo)
- ☐ Tuberculosis
- ☐ Other _____
  _____

Chemotherapy ☐ Yes ☐ No Date: _____
Infusion ☐ Yes ☐ No Date: _____
Radiation ☐ Yes ☐ No Date: _____

☐ Hepatitis C test Date: _____ Results: _____
☐ PPD test for TB Date: _____ Results: _____
If tesed positive, did client have a Chest X-Ray? ☐ Yes ☐ No Date: _____
☐ RPR blood test for Syphilis Date: _____ Results: _____
☐ Urinary test for Gonorrhea Date: _____ Results: _____
☐ Urinary test for Chlamydia Date: _____ Results: _____
☐ Influenza vaccine Date: _____
☐ Pneumonia vaccine Date: _____
☐ Hepatitis A vaccine Date: _____
☐ Hepatitis B vaccine Date: _____

## GYNECOLOGICAL (Women only)

☐ NO CHANGE

☐ Vaginal discharge ☐ Vaginal itching/burning Currently pregnant ☐ Yes ☐ No
No. of pregnancies _____ No. of live births _____ Currently breastfeeding ☐ Yes ☐ No
☐ Birth control use (type _____) Date of last breast exam _____
Last menstrual period _____ Hx of abnormal menstrual bleeding? ☐ Yes ☐ No
Hx of abnormal PAP smear? ☐ Yes ☐ No Date of last PAP _____
Result of last PAP _____

## Nurse Signature & Credentials: _____

Client Name _____ Client # _____ CM Initial _____ Date _____

## NURSING DIAGNOSIS:

## ADDITIONAL COMMENTS / NURSING PLAN:

**Nurse Signature & Credentials:** _____

Client Name _____ Client # _____ CM Initial _____ Date _____

# Oregon Client Acuity Scale Worksheet

**Required Form**

Date of Assessment _____ Client Name _____

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 (Part A) Pages 1-5

| Life Area | Level #1 (1 point) | Level #2 (4 points) | Level #3 (6 points) | Level #4 (8 points) | Comments |
|---|---|---|---|---|---|
| **Basic Needs**<br>Level<br>_____<br>Points<br>_____ | ___ Food, clothing, and other sustenance items available through client's own means<br>___ Has ongoing access to assistance programs that maintain basic needs consistently.<br>___ Able to perform activities of daily living (ADL) independently. | ___ Sustenance needs met on a regular basis with occasional need for help accessing assistance programs.<br>___ Unable to routinely meet basic needs without emergency assistance.<br>___ Needs assistance to perform some ADL weekly. | ___ Routinely needs help accessing assistance programs for basic needs.<br>___ History of difficulites in accessing assistance programs on own.<br>___ Often w/o food, clothing or other basic needs.<br>___ Needs in-home ADL assistance daily. | ___ Has no accesss to food.<br>___ Without most basic needs.<br>___ Unable to perform most ADL.<br>___ No home to receive assistance with ADL. | |
| **Living Situation**<br>Level<br>_____<br>Points<br>_____ | ___ Living in housing of choice: clean, habitable apartment or house.<br>___Living situation stable; not in jeopardy. | ___ Living in stable subsidized housing (public housing, private subsidized housing, or secure Section-8 voucher)<br>___ Safe & secure non-subsidized housing, but choices limited due to moderate income.<br>___ Housing is habitable, but requires limited improvements.<br>___ Housing is in jeopardy due to projected financial strain (>30 days); needs assistance with rent/ utilities to maintain housing.<br>___ Living in long-term (>3 mo.) transitional rental housing. | ___ Formerly independent person temporarily residing with family or friends.<br>___ Eviction imminent.<br>___ Living in temporary (<3 mo.) transitional shelter.<br>___ Housing is in jeopardy due to immediate projected financial strain (<30 days); needs assistance with rent/utilities to maintaim housing. | ___ Needs assisted living facility; unable to live independently.<br>___ Home uninhabitable due to health and/or safety hazards.<br>___ Recently evicted from rental or residential program.<br>___ Homeless, (living in emergency shelter, car, on street/camping, etc.). | |
| **Mental Health**<br>Level<br>_____<br>Points<br>_____ | ___ No history of mental illness, psychological disorders or psychotropic medications.<br>___No need for counseling referral. | ___ History of mental health disorders/treatment in client and/ or family.<br>___ Level of client/family stress is high. Needs emotional support to avert crisis.<br>___Need for counseling referral.<br>___ Depression, functioning. | ___ Experiencing an acute episode and/or crises.<br>___ Severe stress or family crisis re: HIV; need for mental health assessment.<br>___ Depression, not functioning. | ___Danger to self or others.<br>___Needs immediate psychiatric assessment/ evaluation. | |

Client Name _____ Page Total _____

| Life Area | Level #1 (1 point) | Level #2 (4 points) | Level #3 (6 points) | Level #4 (8 points) | Comments |
|---|---|---|---|---|---|
| **Health Insurance /Medical Care coverage**<br><br>Level _____<br><br>Points _____ | ___ Has insurance/ medical care coverage.<br>___Has ability to pay for care on own<br>___ Enrolled in CAREAssist. | ___ Client needs information and guidance accessing insurance or other coverage for medical costs. | ___ Assistance needed in accessing insurance or other coverage for medical costs (such as prescription drug coverage). No medical crisis. | ___ Needs immediate assistance in accessing insurance or other coverage for medical costs due to medical crisis.<br>___ Not currently eligible for insurance or public benefits. Unable to access care. | |
| **Addictions**<br><br>Level _____<br><br>Points _____ | ___ No difficulties with addictions including: alcohol, drugs, sex, or gambling.<br>___Past problems with addiction; >1yr. in recovery.<br>___No need for treatment referral. | ___ Past problems with addiction; <1 year in recovery. | ___ Current addiction but is willing to seek help in overcoming addiction.<br>___ Major addiction impairment of significant other. | ___Current addiction; not willing to seek or resume treatment.<br>___fails to realize impact of addiction on life. | |
| | | | | | |
| | | | | | |

Client Name _____ Page Total _____

| Life Area | Level #1 (1 point) | Level #2 (3 points) | Level #3 (4 points) | Level #4 (5 points) | Comments |
|---|---|---|---|---|---|
| **Transportation**<br><br>Level _____<br><br>Points _____ | ___ Has own or other means of transportation consistently available.<br>___ Can drive self.<br>___ Can afford private or public transportation. | ___ Has minimal access to private transportation.<br>___ Needs occasional assistance with finances for transportation. | ___ No means via self/ others.<br>___ In area un or under-served by public transportation.<br>___ Unaware of or needs help accessing transportation services. | ___ Lack of transportation is a serious contributing factor to current crisis.<br>___ Lack of transportation is a serious contribution factor to lack of regular medical care. | |
| **Culture & Language**<br><br>Level _____<br><br>Points _____ | ___ Understands service system and is able to navigate it.<br>___Language is not a barrier to accessing services (including sign language)<br>___ No cultural barriers to accessing services. | ___ Needs culturally appropriate interpretation services for medical/case management services.<br>___Family needs education and/or interpretation to provide support to the client.<br>___ Some cultural barriers to accessing services. | ___ Culturally appropriate interpretation servcies are needed for client to accesss additional services.<br>___Family's lack of understanding is barrier to care.<br>___ Non-disclosure of HIV to family is barrier to care. | ___ Cultural factors significantly impair client and/or family's ability to effectively access and utilize services.<br>___Crisis intervention is necessary.<br>___ Many cultural barriers to accessing services. | |
| **Dependents**<br><br>Level _____<br><br>Points _____ | ___ Stable. Information given about permanency planning.<br>___ No dependents.<br>___ Have dependents stable, no permanency planning needed. | ___ Permanency planning referral needed.<br>___ Refer to legal/family counseling.<br>___ Disclosure needs.<br>___ Occasional child care/ respite needs.<br>___ Needs referral to parenting classes. | ___ Needs assistance accessing permanency planning.<br>___ Ongoing child care/ day care needs.<br>___ Grief, transition care, therapeutic intervention needed.<br>___ Needs assistance accessing parenting classes. | ___ Involvement with DHS/CAF.<br>___ Crisis related to dependent.<br>___ DHS/CAF prepared to remove children.<br>___ Runaway children.<br>___ Dependent is danger to self and others.<br>___ Dependent involved with other issues such as Youth Authority/Juvenile Hall and Youth Services Team. | |

Client Name _____ Page Total _____

| Life Area | Level #1 (1 point) | Level #2 (3 points) | Level #3 (4 points) | Level #4 (5 points) | Comments |
|---|---|---|---|---|---|
| **Intimate Partner Violence**<br><br>Level _____<br><br>Points _____ | ___ No history of abuse or domestic violence. | ___ History (>6 mo.), past relationships with violence.<br>___History (>6 mo.) and pattern in current relationship. | ___ DHS/CAF, or other agency involved due to signs of potential abuse (emotional, sexual, physical).<br>___ Violence in current relationship. | ___ Medical and/or legal intervention has occurred.<br>___ Life-threatening violence and/or abuse chronically and presently occurring. | |
| **Risk Reduction**<br><br>Level _____<br><br>Points _____ | ___ Abstaining from risky behavior by safer practices.<br>___ Client has good understanding of risks.<br>___ Declines to answer. | ___ Occasional risk behavior (unsafe behaviors of any type <=20% of the time).<br>___ Client has fair understanding of risks. | ___ Moderate risk behavior (unsafe behaviors of any type >20-50% of the time).<br>___ Client has poor understanding of risks.<br>___ Client with mild/ moderate A&D, MH, or relationship barriers to safe behavior. | ___ Significant risk behavior (unsafe behaviors of any type >50% of the time).<br>___ Client has little or no understanding of risks.<br>___ Client with significant A&D, MH, or relationship barriers to safer behavior. | |
| | | | | | |

Client Name _____ Page Total _____

| Life Area | Level #1 (1 point) | Level #2 (2 points) | Level #3 (3 points) | Level #4 (4 points) | Comments |
|---|---|---|---|---|---|
| **Developmental Disability/ Cognitive Impairment**<br>Level _____<br>Points _____ | ___ No signs of impairment.<br>___ Has abilty to function independently. | ___ Signs of impairment with no diagnosis, refer for evaluation. | ___ Diagnosis of Developmental (DD) Disability/Cognitive impairment with DD Services in place. | ___ DD Diagnosis/ Cognitive impairment without DD Services. | |
| **Legal**<br>Level _____<br>Points _____ | ___ No recent or current legal problems.<br>___ All legal documents client desires are completed. | ___ Wants assistance completing standard legal documents.<br>___ Possible recent or current legal problems. | ___ Present involvement in civil or criminal matters.<br>___ Incarcerated.<br>___ Unaware of standard legal documents which may be necessary. | ___ Immediate crisis involving legal matters, e.g. legal altercation with landlord/employers, civil & criminal matters, immigration and family/ spouse. | |
| **Financial Planning/ Counseling**<br>Level _____<br>Points _____ | ___ Steady source of income which is not in jeopardy.<br>___ Has savings/ resources.<br>___ Able to meet monthly obligations.<br>___ No financial planning or counseling required. | ___ Has steady source of income which is in jeopardy.<br>___ Occasional need for financial assistance or awaiting outcome of benefits applications.<br>___ Needs information about benefits, financial matters.<br>___ Has short-term benefits. | ___ No income.<br>___ Benefits denied.<br>___ Unfamiliar with application process.<br>___ Unable to apply without assistance.<br>___ Needs financial planning & counseling. | ___ Immediate need for emergency financial assistance.<br>___ Needs referral to representative payee. | |
| **Support System (to include emotional, spiritual, and other)**<br>Level _____<br>Points _____ | ___ Dependable emotional and physical availability of relatives and friends to support client. | ___ Gaps exist in support system.<br>___ Family and/or significant others often unavailable when crises occur. | ___ No stable support system accessible.<br>___ Only support is provided by professional caregivers. | ___ Acute situation where client is unable to cope without professional support within a particular situation/time frame. | |

Client Name _____ Page Total _____

| RN ASSESSMENT (Part B) Pages 6-7 | | | | | |
|---|---|---|---|---|---|
| **Life Area** | **Level #1 (1 point)** | **Level #2 (4 points)** | **Level #3 (6 points)** | **Level #4 (8 points)** | **Comments** |
| **Knowledge of HIV Disease**<br><br>Level _____<br><br>Points _____ | ___ Verbalizes clear understanding about disease. | ___ Some understanding verbalized.<br>___ Needs additional information in some areas. | ___ Little understanding.<br>___ Needs counseling or referral to make informed decisions about health. | ___ Ignorant of HIV disease progression, etc. Unable to make informed decisions about health. | |
| **Adherence**<br><br>Level _____<br><br>Points _____ | ___ Adherent to medications as prescribed for more than 6 months without assistance.<br>___ Currently understands medications.<br>___Able to maintain primary care.<br>___ Keeps medical appointments as scheduled.<br>___ Not currently being prescribed medications. | ___ Adherent to medications as prescribed less than 6 months/more than 3 months with minimal assistance.<br>___ Keeps majority of medical appointments. | ___ Adherent to medications and treatment plan with regular, ongoing assistance.<br>___Doesn't understand medications.<br>___Misses taking or giving several doses of scheduled meds weekly.<br>___ Misses at least half of scheduled medical appointments.<br>___ Takes long/extended *drug holidays* AMA.<br>___ Takes non-HIV systemic therapies without MD knowledge. | ___ Resistance/minimal adherence to medications and treatment plan even with assistance.<br>___Refuses/declines to take medications against medical advice.<br>___Medical care sporadic due to many missed appointments.<br>___ Uses ER only for primary care.<br>___ Inablility to take/give meds as scheduled; requires professional assistance to take/ give meds and keep appointments. | |
| **Medical Needs**<br><br>Level _____<br><br>Points _____ | ___ Stable health with access to ongoing HIV medical care.<br>___ Lab work periodically<br>___ Asymptomatic in medical care. | ___ Needs primary care referral.<br>___ HIV care referral needed - stable.<br>___ Short-term acute condition; receiving medical care.<br>___ Chronic non-HI/V related condition under control with medication/ treatment.<br>___ HIV symptomatic with one or more conditions that impair overall health. | ___ Poor health.<br>___ HIV care referral needed - ASAP.<br>___ Needs treatment or medication for non-HIV related condition.<br>___ Debilitating HIV disease symptoms/ infections.<br>___ Multiple medical diagnoses.<br>___ Home bound; home health needed. | ___ Medical emergency.<br>___ Client is in end-stage of HIV disease.<br>___ Intensive/complicated home care required.<br>___ Hospice services or placement indicated. | |

Client Name _____ Page Total _____

| Life Area | Level #1 (1 point) | Level #2 (4 points) | Level #3 (6 points) | Level #4 (8 points) | Comments |
|---|---|---|---|---|---|
| **Nutrition**<br><br>Level _____<br><br>Points _____ | ___ No signs of wasting syndrome or obvious physical maladies.<br>___ No abdominal pain reported.<br>___ No significant weight problems<br>___ No problems with eating.<br>___ No problems with nausea or vomiting.<br>___ No dental problems.<br>___ No need for nutritional intervention. | ___ Unplanned weight loss in the past 6 months.<br>___ Dentures have not been assessed by dentist or denturist in over 1 year.<br>___ Requests assistance in improving nutrition. | ___ Visual assessment shows initial signs of wasting syndrome or other obvious physical maladies < not advanced >.<br>___ Abdominal problems reported.<br>___ Changes in eating habits in the past 3 months.<br>___ Chronic nausea and/ or vomiting.<br>___ Teeth missing, dentures do not fit correctly. | ___ Visual assessment shows advanced signs of wasting syndrome or other obvious physical maladies.<br>___ Acute abdominal pain.<br>___ Severe problems eating.<br>___ Acute nausea and/or vomiting.<br>___ Severe dental problems.<br>___ Significant weight loss in past 3 months. | |
| | | | | | |
| | | | | | |

Client Name _____ Page Total _____

**Acuity Level Guidelines:**

**Level 1: 18-30 points**

- Initial fact-to-face nursing and psychosocial assessments.
- Annual fact-to-face nursing and psychosocial reassessments.
- Documentation in progress notes or CAREWare care notes.

**Level 2: 31-59 points**

- Initial fact-to-face nursing and psychosocial assessments.
- Annual fact-to-face nursing and psychosocial reassessments.
- Minimum contact (telephone or face-to-face) every 6 months to verify address/phone number and to check on client's current status.
- Care planning goals, activities and outcomes (care plan) documented either in progress notes, the Care Plan form or CAREWare care notes.

**Level 3: 60-86 points**

- Initial fact-to-face nursing and psychosocial assessments.
- Minimum annual fact-to-face nursing and psychosocial reassessments.
- Minimum contact (telephone or face-to-face) **every 30 days**.
- Minimum evaluation of goals, activities and outcomes **every 30 days.**
- 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 90 days.**
- Nurse signature is required on every updated Acuity Scale Worksheet.
- Care planning goals, activities and outcomes (care plan) documented either in progress notes, the Care Plan form or CAREWare care notes.

**Level 4: 87-113 points**

- Initial fact-to-face nursing and psychosocial assessments.
- Minimum annual fact-to-face nursing and psychosocial reassessments.
- 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 signature is required on every updated Acuity Scale Worksheet.
- Care planning goals, activities and outcomes (care plan) documented either in progress notes, the Care Plan form or CAREWare Care notes.

**Exceptions:** At the discretion of the case manager, release from a correctional facility may be a condition warranting an Acuity Level 3 during the first 90 days after release.

Level Total: _____ Asssigned Acuity Level: _____

Client Name: _____ Date: _____

Case Manager Signature: _____ Date: _____

Nurse Signature (if different than Case Manager): _____ Date: _____

# Oregon Minor Client Acuity Scale Worksheet

**Optional Form**

DHS Oregon Department of Human Services

Date of Assessment _____ Client Name _____

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 (Part A) Pages 1-5

| Life Area | Level #1 (1 point) | Level #2 (4 points) | Level #3 (6 points) | Level #4 (8 points) | Comments |
|---|---|---|---|---|---|
| **Basic Needs**<br>Level<br>_____<br>Points<br>_____ | ___ Food, clothing, and other sustenance items available through client's own means<br>___ Has ongoing access to assistance programs that maintain basic needs consistently.<br>___ Able to perform activities of daily living (ADL) independently. | ___ Sustenance needs met on a regular basis with occasional need for help accessing assistance programs.<br>___ Unable to routinely meet basic needs without emergency assistance.<br>___ Needs assistance to perform some ADL weekly. | ___ Routinely needs help accessing assistance programs for basic needs.<br>___ History of difficulites in accessing assistance programs on own.<br>___ Often w/o food, clothing or other basic needs.<br>___ Needs in-home ADL assistance daily. | ___ Has no accesss to food.<br>___ Without most basic needs.<br>___ Unable to perform most ADL.<br>___ No home to receive assistance with ADL. | |
| **Living Situation**<br>Level<br>_____<br>Points<br>_____ | ___ Living in housing of choice: clean, habitable apartment or house.<br>___Living with biological/ adoptive parent(s).<br>___Living with stable foster family. | ___ Living in stable subsidized housing (public housing, private subsidized housing, or secure Section-8 voucher)<br>___ Safe & secure non-subsidized housing, but choices limited due to moderate income.<br>___ Housing is habitable, but requires limited improvements.<br>___ Housing is in jeopardy due to projected financial strain (>30 days); needs assistance with rent/ utilities to maintain housing.<br>___ Living in long-term (>3 mo.) transitional rental housing. | ___ Formerly independent family temporarily residing with family or friends.<br>___ Eviction imminent.<br>___ Living in temporary (<3 mo.) transitional shelter.<br>___ Housing is in jeopardy due to immediate projected financial strain (<30 days); needs assistance with rent/utilities to maintaim housing.<br>___ No stable family to live with. | ___ Needs assisted living facility; unable to live independently.<br>___ Home uninhabitable due to health and/or safety hazards.<br>___ Recently evicted from rental or residential program.<br>___ Homeless, (living in emergency shelter, car, on street/camping, etc.). | |
| **Mental Health**<br>Level<br>_____<br>Points<br>_____ | ___ No history of mental illness, psychological disorders or psychotropic medications.<br>___No need for counseling referral. | ___ History of mental health disorders/treatment in client and/ or family.<br>___ Level of client/family stress is high. Needs emotional support to avert crisis.<br>___ Need for counseling referral.<br>___ Need for family counseling. | ___ Experiencing an acute episode and/or crises.<br>___ Severe stress or family crisis re: HIV; need for mental health assessment. | ___Danger to self or others.<br>___Needs immediate psychiatric assessment/ evaluation. | |

Client Name _____ Page Total _____

| Life Area | Level #1 (1 point) | Level #2 (4 points) | Level #3 (6 points) | Level #4 (8 points) | Comments |
|---|---|---|---|---|---|
| **Health Insurance /Medical Care coverage**<br>Level _____<br>Points _____ | ___ Has insurance/ medical care coverage.<br>___ Enrolled in CAREAssist. | ___ Family needs information and guidance accessing insurance or other coverage for medical costs. | ___ Assistance needed in accessing insurance or other coverage for medical costs (such as prescription drug coverage). | ___ Needs immediate assistance in accessing insurance or other coverage for medical costs due to medical crisis. | |
| **Addictions**<br>Level _____<br>Points _____ | ___ No difficulties with addictions/use including: alcohol, drugs, sex, or gambling.<br>___Past problems with addiction; >1yr. in recovery.<br>___No need for treatment referral. | ___ Past problems with addiction; <1 year in recovery.<br>___ At high risk for substance abuse. | ___ Current addiction but is willing to seek help in overcoming addiction.<br>___ Major addiction impairment of family.<br>___ Currently using substances at a rate which could lead to addiction. | ___Current addiction; not willing to seek or resume treatment.<br>___fails to realize impact of addiction/use on life. | |
| Level _____<br>Points _____ | | | | | |
| Level _____<br>Points _____ | | | | | |

Client Name _____ Page Total _____

| Life Area | Level #1 (1 point) | Level #2 (3 points) | Level #3 (4 points) | Level #4 (5 points) | Comments |
|---|---|---|---|---|---|
| **Transportation**<br><br>Level _____<br><br>Points _____ | ___ Has own or other means of transportation consistently available.<br>___ Can drive self.<br>___ Can afford private or public transportation.<br>___ Has consistent means to transport to school. | ___ Has minimal access to private transportation.<br>___ Needs occasional assistance with finances for transportation. | ___ No means via self/ others.<br>___ In area un or under-served by public transportation.<br>___ Unaware of or needs help accessing transportation services. | ___ Lack of transportation is a serious contributing factor to current crisis.<br>___ Lack of transportation is a serious contribution factor to lack of regular medical care. | |
| **Culture & Language**<br><br>Level _____<br><br>Points _____ | ___ Understands service system and is able to navigate it.<br>___Language is not a barrier to accessing services (including sign language)<br>___ No cultural barriers to accessing services. | ___ Needs culturally appropriate interpretation services for medical/case management services.<br>___Family needs education and/or interpretation to provide support to the client.<br>___ Some cultural barriers to accessing services. | ___ Culturally appropriate interpretation servcies are needed for client to accesss additional services.<br>___Family's lack of understanding is barrier to care. | ___ Cultural factors significantly impair client and/or family's ability to effectively access and utilize services.<br>___Crisis intervention is necessary.<br>___ Many cultural barriers to accessing services. | |
| **Dependents**<br><br>Level _____<br><br>Points _____ | ___ Stable. Information given about permanency planning.<br>___ Family make-up is stable. | ___ Permanency planning referral needed.<br>___ Refer to legal/family counseling.<br>___ Family needs referral to parenting classes.<br>___ Family make-up is not stable. | ___ Needs assistance accessing permanency planning.<br>___ Grief, transition care, therapeutic intervention needed.<br>___ At risk for running away. | ___ Involvement with DHS/CAF.<br>___ Crisis related to family.<br>___ DHS/CAF prepared to remove child.<br>___ Runaway.<br>___ Involved with other issues such as Youth Authority/Juvenile Hall and Youth Services Team. | |

Client Name _____ Page Total _____

| Life Area | Level #1 (1 point) | Level #2 (3 points) | Level #3 (4 points) | Level #4 (5 points) | Comments |
|---|---|---|---|---|---|
| **Intimate Partner Violence**<br><br>Level _____<br><br>Points _____ | ___ No history of being abuse.<br>___ No domestic abuse in household. | ___ History of being abused.<br>___ History of domestic abuse in household. | ___ DHS/CAF, or other agency involved due to signs of potential abuse (emotional, sexual, physical).<br>___ Reports current abuse episodes. | ___ Medical and/or legal intervention has occurred.<br>___ Violence/abuse has been or is being reported. | |
| **Risk Reduction**<br><br>Level _____<br><br>Points _____ | ___ Family takes precautions in home and school.<br>___ Client has good understanding of risks.<br>___ Risk reduction is age appropriate. | ___ Client is able to comprehend risk to others.<br>___ Client has fair understanding of risks. | ___ Client has poor understanding of risks.<br>___ Client with safe behavior. | ___ Significant risk behavior.<br>___ Client has little or no understanding of risks.<br>___ Client with significant barriers to safer behavior. | |
| Level _____<br><br>Points _____ | | | | | |

Client Name _____ Page Total _____

| Life Area | Level #1 (1 point) | Level #2 (2 points) | Level #3 (3 points) | Level #4 (4 points) | Comments |
|---|---|---|---|---|---|
| **Developmental Disability/ Cognitive Impairment**<br><br>Level _____<br><br>Points _____ | ___ No signs of impairment.<br>___ Has abilty to function independently.<br>___ Enrolled and attending school. | ___ Signs of impairment with no diagnosis, refer for evaluation. | ___ Diagnosis of Developmental (DD) Disability/Cognitive impairment with DD Services in place.<br>___ Diagnosis of learning disabilities.<br>___ Diagnosis of behaviorial disability affecting school performance. | ___ DD Diagnosis/ Cognitive impairment without DD Services. | |
| **Legal**<br><br>Level _____<br><br>Points _____ | ___ No recent or current legal problems.<br>___ All legal documents client desires are completed. | ___ Wants assistance completing standard legal documents.<br>___ Possible recent or current legal problems. | ___ Present involvement in civil or criminal matters.<br>___ Incarcerated.<br>___ Unaware of standard legal documents which may be necessary. | ___ Immediate crisis involving legal matters, e.g. legal altercation with landlord/employers, civil & criminal matters, immigration and family/ spouse. | |
| **Financial Planning/ Counseling**<br><br>Level _____<br><br>Points _____ | ___ Steady source of income which is not in jeopardy.<br>___ Parent receiving TANF.<br>___ No financial planning or counseling required. | ___ Has steady source of income which is in jeopardy.<br>___ Occasional need for financial assistance or awaiting outcome of benefits applications.<br>___ Needs information about benefits, financial matters.<br>___ Has short-term benefits. | ___ No income.<br>___ Benefits denied.<br>___ Unfamiliar with application process.<br>___ Unable to apply without assistance.<br>___ Needs financial planning & counseling.<br>___ Not eligible for TANF. | ___ Immediate need for emergency financial assistance.<br>___ Needs referral to representative payee. | |
| **Support System (to include emotional, spiritual, and other)**<br><br>Level _____<br><br>Points _____ | ___ Dependable emotional and physical availability of relatives and friends to support client. | ___ Gaps exist in support system.<br>___ Family often unavailable when crises occur.<br>___ Need for big brother/ sister referral. | ___ Only support is provided by professional caregivers.<br>___ Family not capable of providing adequate support. | ___ Acute situation where client is unable to cope without professional support within a particular situation/time frame. | |

Client Name _____ Page Total _____

| RN ASSESSMENT (Part B) Pages 6-7 | | | | | |
|---|---|---|---|---|---|
| **Life Area** | **Level #1 (1 point)** | **Level #2 (4 points)** | **Level #3 (6 points)** | **Level #4 (8 points)** | **Comments** |
| **Knowledge of HIV Disease**<br><br>Level _____<br><br>Points _____ | ___ Verbalizes age appropriate understanding about the disease. | ___ Some understanding verbalized.<br>___ Needs continuing reinforcement of information. | ___ Little understanding.<br>___ Parent is unwilling to communicate about HIV with child. | ___ Does not understand HIV progression.<br>___ Does not understand risk to others. | |
| **Adherence**<br><br>Level _____<br><br>Points _____ | ___ Adherent to medications as prescribed for more than 6 months without assistance.<br>___ Currently understands medications.<br>___Able to maintain primary care.<br>___ Keeps medical appointments as scheduled.<br>___ Not currently being prescribed medications. | ___ Adherent to medications as prescribed less than 6 months/more than 3 months with minimal assistance.<br>___ Keeps majority of medical appointments. | ___ Adherent to medications and treatment plan with regular, ongoing assistance.<br>___Doesn't understand medications.<br>___Misses taking or giving several doses of scheduled meds weekly.<br>___ Misses at least half of scheduled medical appointments.<br>___ Takes long/extended *drug holidays* AMA.<br>___ Takes non-HIV systemic therapies without MD knowledge. | ___ Resistance/minimal adherence to medications and treatment plan even with assistance.<br>___Refuses/declines to take medications against medical advice.<br>___Medical care sporadic due to many missed appointments.<br>___ Uses ER only for primary care.<br>___ Inablility to take/give meds as scheduled; requires professional assistance to take/ give meds and keep appointments. | |
| **Medical Needs**<br><br>Level _____<br><br>Points _____ | ___ Stable health with access to ongoing pediatric HIV medical care.<br>___ Lab work periodically<br>___ Asymptomatic in medical care. | ___ Needs primary care referral.<br>___ HIV care referral needed - stable.<br>___ Short-term acute condition; receiving medical care.<br>___ Chronic non-HI/V related condition under control with medication/ treatment.<br>___ HIV symptomatic with one or more conditions that impair overall health. | ___ Poor health.<br>___ HIV care referral needed - ASAP.<br>___ Needs treatment or medication for non-HIV related condition.<br>___ Debilitating HIV disease symptoms/ infections.<br>___ Multiple medical diagnoses.<br>___ Home bound; home health needed. | ___ Medical emergency.<br>___ Client is in end-stage of HIV disease.<br>___ Intensive/complicated home care required.<br>___ Hospice services or placement indicated. | |

Client Name _____ Page Total _____

| Life Area | Level #1 (1 point) | Level #2 (4 points) | Level #3 (6 points) | Level #4 (8 points) | Comments |
|---|---|---|---|---|---|
| **Nutrition**<br><br>Level _____<br><br>Points _____ | ___ No signs of wasting syndrome or obvious physical maladies.<br>___ No abdominal pain reported.<br>___ No significant weight problems<br>___ No problems with eating.<br>___ No problems with nausea or vomiting.<br>___ No dental problems.<br>___ No need for nutritional intervention. | ___ Unplanned weight loss in the past 6 months.<br>___ Dentures have not been assessed by dentist or denturist in over 1 year.<br>___ Requests assistance in improving nutrition. | ___ Visual assessment shows initial signs of wasting syndrome or other obvious physical maladies < not advanced >.<br>___ Abdominal problems reported.<br>___ Changes in eating habits in the past 3 months.<br>___ Chronic nausea and/ or vomiting.<br>___ Teeth missing, dentures do not fit correctly. | ___ Visual assessment shows advanced signs of wasting syndrome or other obvious physical maladies.<br>___ Acute abdominal pain.<br>___ Severe problems eating.<br>___ Acute nausea and/or vomiting.<br>___ Severe dental problems.<br>___ Significant weight loss in past 3 months. | |
| Level _____<br><br>Points _____ | | | | | |
| Level _____<br><br>Points _____ | | | | | |

Client Name _____ Page Total _____

## Acuity Level Guidelines:

**Level 1: 18-30 points**

- Initial fact-to-face nursing and psychosocial assessments.
- Annual fact-to-face nursing and psychosocial reassessments.
- Documentation in progress notes or CAREWare care notes.

**Level 2: 31-59 points**

- Initial fact-to-face nursing and psychosocial assessments.
- Annual fact-to-face nursing and psychosocial reassessments.
- Minimum contact (telephone or face-to-face) every 6 months to verify address/phone number and to check on client's current status.
- Care planning goals, activities and outcomes (care plan) documented either in progress notes, the Care Plan form or CAREWare care notes.

**Level 3: 60-86 points**

- Initial fact-to-face nursing and psychosocial assessments.
- Minimum annual fact-to-face nursing and psychosocial reassessments.
- Minimum contact (telephone or face-to-face) **every 30 days**.
- Minimum evaluation of goals, activities and outcomes **every 30 days.**
- 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 90 days.**
- Nurse signature is required on every updated Acuity Scale Worksheet.
- Care planning goals, activities and outcomes (care plan) documented either in progress notes, the Care Plan form or CAREWare care notes.

**Level 4: 87-113 points**

- Initial fact-to-face nursing and psychosocial assessments.
- Minimum annual fact-to-face nursing and psychosocial reassessments.
- 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 signature is required on every updated Acuity Scale Worksheet.
- Care planning goals, activities and outcomes (care plan) documented either in progress notes, the Care Plan form or CAREWare Care notes.

**Exceptions:** At the discretion of the case manager, release from a correctional facility may be a condition warranting an Acuity Level 3 during the first 90 days after release.

Level Total: _____ Asssigned Acuity Level: _____

Client Name: _____ Date: _____

Case Manager Signature: _____ Date: _____

Nurse Signature (if different than Case Manager): _____ Date: _____

# Oregon Client Acuity Scale Summary Worksheet

**Optional Form**

Oregon Department of Human Services

Date of Assessment _____ Client Name_____

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 | Line Totals (Points) |
|---|---|---|---|---|---|---|
| | Psychosocial Assessment | Basic Needs | Living Situation | Mental Health | Health Ins/Medical Care Coverage | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | Addictions | Transportation | Culture & Language | Dependents | Intimate Partner Violence | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | Risk Reduction | Developmental Disability/Cognitive Impairment | Legal | Financial Planning/ Counseling | Support System | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | Nurse Assessment | Knowledge of HIV Disease | Adherence | Medical Needs | Nutrition | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Stage 1: 18-30 Points
Stage 2: 31-59 Points
Stage 3: 60-86 Points
Stage 4: 87-113 Points

Date _____ Assigned Acuity Level _____
Date _____ Assigned Acuity Level _____
Date _____ Assigned Acuity Level _____
Date _____ Assigned Acuity Level _____

DHS
Oregon Department of Human Services

**Optional Form**

# CARE PLAN

| Client Name | | Date Opened | / / |
|---|---|---|---|
| Client ID# | | Case Manager | |

| Problem (circle all that apply) | | Primary Barriers (circle all that apply) | | |
|---|---|---|---|---|
| Access to end of life services<br>Childcare<br>Child Welfare<br>Dental Care<br>Disability Determ<br>Drug and Alcohol Education<br>Financial<br>Food<br>Health<br>High Risk Behaviors<br>Home Support/Placement | Household/Personal Needs<br>Housing<br>Insurance<br>Legal<br>Medication Adherence<br>Mental health<br>Social/Emotional Support<br>Transportation<br>Work Related Issues<br>Other: | A & D Use<br>Burned Bridges<br>Caregiving Responsibilities<br>Child Care<br>Communication<br>Complex Medication Regimen<br>Cultural<br>Depression/Mental Health<br>Difficulty w/Follow-through<br>Discrimination<br>Doubts Medication Effectiveness | Financial<br>Health<br>Inadequate Community Resources<br>Insurance<br>Lack of Documentation<br>Lack of Info.<br>Lack of Social Support<br>Lacks a Regular Schedule | Language<br>Legal Issues<br>Mental Status Changes<br>Side Effects<br>Transportation<br>Undisclosed HIV status<br>Works Outside the Home<br>Other: |

| Prioritized Issues/Problem Descriptions |
|---|
| |
| |
| |
| |
| |
| |
| |

| Tasks/Description | Owner | Target Date | Resolution Date/Outcome |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Client's Statement and 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. The case manager has explained to me what portions of the plan I am solely responsible for and those that my case manager will assist me with. I agree to follow all aspects of this plan and advise my case manager if there are significant changes in my life that makes it necessary to change my plan. I agree to stay in contact my case manager as planned.

Client Signature/Date _____ Case Mgr. Signature/Date _____

Client Review/Date _____ Case Mgr. Review/Date _____

DHS Oregon Department of Human Services

**Optional Form**

# PROBLEM INDEX

| PROBLEM LIST SHOULD BE REVIEWED ON EACH VISIT AND UPDATED WITH CURRENT VISIT PROBLEM | | | | |
|---|---|---|---|---|
| PROBLEM NUMBER # | ACTIVE PROBLEMS CURRENT OR POTENTIAL | BARRIERS | DATE IDENTIFIED | DATE RESOLVED |
| **1** | | | | |
| **2** | | | | |
| **3** | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |


# PROBLEM INDEX


Client Name: _____ Client ID#: _____

Optional Form

DHS Oregon Department of Human Services

# PROGRESS/CLINICAL NOTES

| DATE/ TIME | PROBLEM NUMBER | S O A P | FORMAT: PROBLEM NUMBER and TITLE:<br>S=Subjective O=Objective A=Assessment P=Plans<br>ALL ENTRIES MUST BE SIGNED WITH NAME AND TITLE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

PROGRESS/CLINICAL NOTES

Client Name: _____ Client ID#: _____