HIV Care Collaborative National Program Office Chart Review Tool

Verify
DOB
Gender
Race
Ethnicity
ZIP
HH Size
HH Income $
FPL %
Insurance
HIV Risk
HIV+ Date
HIV Stage
AIDS Date

1. **Review Date:** /____/____/201__/
2. **Review Site:**
   - ☐ 1. Fulton County Department of Health & Wellness
   - ☐ 2. City of Philadelphia Dept of Public Health Ambulatory Health Services
   - ☐ 3. City of Houston Department of Health and Human Services (DHHS)
   - ☐ 4. Harris Health
   - ☐ 5. Houston Area Community Services
   - ☐ 6. Legacy Community Health Services
   - ☐ 7. St. Hope Foundation
   - ☐ 8. Action AIDS
3. **Client UCI: _____**
4. **Client Case Status:** ☐ 1. Open/Active ☐ 2. Closed ☐ 9. Unknown
5. **Date of Referral From CTS to SL/PN:** /____/____/201___/

   5a. Referring Agency Name: _____
6. **Date of Referral From HIV Clinic or Other Organization to SL/PN**: /____/____/201___/

   6a. Referring Agency Name: _____
7. **HCC ACTIVITY DATES**

	MM/DD/YYYY	HCC Worker		MM/DD/YYYY	MCM Worker
HCC Assignment Date			**MCM Transfer 1**		
Initial Intake Date			**MCM Transfer 2**		
Consent for Services			**MCM Transfer 3**		
CAREWare/CPCDMS Consent			**Supervisor Note 1**		
Assessment Date 1			**Supervisor Note 2**		
Info Exchange Release			**Supervisor Note 3**		
Assessment Date 2			**Supervisor Note 4**		
Assessment Date 3			**Supervisor Note 5**		
ISP Date 1					
ISP Date 2			**Comments:**		
ISP Date 3					
Case Closure Date 1					
Case Closure Date 2					
Case Closure Date 3					

8. **HCC Enrollment Criteria:** ☐ 1.Client newly diagnosed HIV+ ☐ 2. Client previously lost to care ☐ Client loosely engaged ☐ 9. Unk
9. **Circumstances Regarding Previous Loss to Care:**

_____

_____

10. **Intake Verification:** ☐ Photo ID ☐ Residency ☐ HIV Seropositivity ☐ Household Size ☐ Household Income

11. HCC SERVICE ACTIVITIES IN REVIEW PERIOD (Include Intake, Assessment, and Reassessment Visits)

Date MM/DD/YYYY	Activity Type? F2F TC OC HV CC OT UN	Type of Service Delivered? INTAKE ASST REF CC HOME MEDVISIT MCMVISIT ED TRANS OAMCAPT COACH LOST CLOSE	Reason for Visit/Contact Documented? Y N U NA	Service Is Goal Related? Y N U NA	Follow-Up & Outcomes Noted? Y N U NA	Progress Notes Signed & Dated? Y N U NA

Activity Type: F2F= Face to Face Visit, TC= Telephone Call With Client, OC= Other Telephone Call, CC= Case Conference, OT=Other Activity

Type of Service Delivered: INTAKE= Intake to HCC, ASST= HCC Assessment, REF= Referral to Services, CC= Case Conference, HOME= Home Visit, MEDVISIT= Accompanied Client to OAMC Visit, MCMVISIT= Accompanied Client to MCM Visit, ED= Client Education, TRAN= Transport Client, COACH= ART Treatment Adherence Coaching, LOST= Re-linkage Activities to Find Client, CLOSE= Case Closure

12. ASSESSMENT DOMAINS EVALUATED, ADDRESSED IN THE ISP, AND ADDRESSED BY REFERRALS (Yes, No, or NA in each column for each domain)

Assessment Date:

Assessment Domain	Assessment		Service Plan				Referral		Follow-up to Achieve Goal Documented?
	Domain Evaluated?	Need Identified?	Goals?	Objec-tives?	Resources Identified?	Time-lines?	Referral Made?	Follow-up to Referral?	
ADAP									
AIDS Pharmacy Assistance									
Child Care									
Commercial Health Insurance									
Dental Care									
Emergency Financial Assistance									
Family Planning									
Family, Spiritual, Social Support									
Food, Pantry									
General Education, Vocation, and Literacy									
Health Insurance Premiums, Co-Pays, Deductibles									
Hearing Care									
HIV Education/Prevention									
Home Health Care									
Housing Services									
Intimate Violence									
Legal									
Medicaid, Medicare									
Medical Case Management									
Medical Nutrition Therapy									
Mental Health Treatment									
OAMC									
Post-Incarceration Reentry Services									
SNAP									
SSI, SSDI									
Substance Abuse Treatment									
Translation Services (Including ASL)									
Transportation									
Treatment Adherence									
Vision Care									
Other Domain 1:									
Other Domain 2:									
Other Domain 3:									
Other Domain 4:									

13. REFERRALS MADE FOLLOWING CARE PLAN COMPLETION

Date	Agency/Service	Services Requested

14. CASE CONFERENCES IN WHICH HCC STAFF PARTICIPATED IN OBSERVATION PERIOD

Date	Agency/Service	Staff Participating & Their Titles

CASE CLOSURE

15. Was case discharged/closed case during the review period? ☐ 1. Yes ☐ 2. No ☐ 8. NA

16. If YES, did the client meet the criteria for case closure/discharge as defined in the HCC protocol?
☐ 1. Yes ☐ 2. No ☐ 8. NA, case not closed

17. Reasons documented for closing case: (Check all that apply)
- ☐ 0, 1 All goals met / no needs as defined in HCC protocol
- ☐ 0, 1 Client continues no show, lack of follow-up with worker
- ☐ 0, 1 Client became self sufficient
- ☐ 0, 1 Death of the client
- ☐ 0, 1 At the client's or legal guardian request
- ☐ 0, 1 Client actions put the agency, case manager or other clients at risk
- ☐ 0, 1 Client moved out of service area
- ☐ 0, 1 Client incarcerated
- ☐ 0,1 Client could not be contacted using methods defined in HCC protocol
- ☐ 0, 1 Client is hospitalized
- ☐ 0, 1 Client refused service
- ☐ 0, 1 Unknown, unclear, contradictory documentation
- ☐ 0, 1 NA

Reviewer Comments
