INTAKE ASSESSMENT – Emergency Financial Services (EFS)

Client Name: _____
Client Record #: _____

Intake Date: _____/_____/_____
mm / dd / yyyy

Program Staff: Complete this form through a combination of client interview and chart review at intake.

All sections and questions are required unless stated otherwise.

I. Clinical Information — *Chart Review and/or Client Interview*

HIV Status: *(Check only one)* ❑ HIV+, Not AIDS ❑ HIV+, AIDS status unknown ❑ CDC-Defined AIDS

Optional **HIV Diagnosis Date:** _____/_____/_____ (mm/dd/yyyy)

Optional If AIDS, **AIDS Diagnosis Date:** _____/_____/_____ (mm/dd/yyyy)

Optional **HIV Risk Factor:** *(Check all that apply)*

❑ MSM
❑ IDU
❑ Heterosexual contact
❑ Blood transfusion/components
❑ Hemophilia/coagulation disorder
❑ Perinatal
❑ Risk factor not reported or not identified

Do you currently have a Primary Care Physician (PCP) / HIV primary care provider? ❑ Yes ❑ No

Last PCP visit *prior* to enrollment: _____/_____/_____ (mm/dd/yyyy) OR ❑ Unknown ❑ N/A

II. Client Information — *Chart Review and/or Client Interview*

Total number in household *(including the client)*: _____

Current employment status: *(Check only one)*

❑ Full-time ❑ Part-time ❑ Unemployed ❑ Unpaid volunteer/peer worker
❑ Out of workforce (e.g., retired, on disability) ❑ Other (**Specify:** _____) ❑ Declined

Highest level of education achieved: *(Check only one)*

❑ No schooling ❑ 8th grade or less ❑ Some high school ❑ High School/GED or equivalent
❑ Some college ❑ Bachelors/technical degree ❑ Postgraduate ❑ Declined

Primary Language Spoken (i.e., at home): *(Check only one)*

❑ English ❑ Spanish ❑ Other (**Specify:** _____) ❑ Declined

If Primary Language is not English: **Secondary Language Spoken:** *(Check only one)*
❑ English ❑ Spanish ❑ Other (**Specify:** _____) ❑ Declined

Country of Birth: *(Check only one)*

❑ USA ❑ US territory/dependency (❍ Puerto Rico ❍ Other - **Specify:** _____)
❑ Other country (**Specify:** _____) ❑ Declined

III. Insurance Information — *Chart Review and/or Client Interview*

Insurance Status: ❑ Uninsured ❑ Insured

If insured, complete the table on the next page to indicate insurance types that are in effect for client at assessment. Otherwise, SKIP to Section IV.

Client Name: _____

Insurance Type	Insurance details
❑ Private	*(Check only one)* ❍ Employer plan ❍ Individual plan
❑ ADAP/ADAP+	*(Check all that apply)* ❍ ADAP (Rx Coverage) ❍ ADAP Plus (Outpatient Medical Care)
❑ Medicaid or CHIP	*(Check only one plan type)* ❍ SNP (special needs plan) ❍ MCO (managed care organization) ❍ FFS (fee-for-service) ❍ Not sure which type
❑ Medicare	
❑ Military, VA, Tricare	
❑ IHS (Indian Health Service)	
❑ Other Public Insurance	

IV. Financial Information *Client Interview*

What is your annual household income? $_____ per year

V. Other Needs *Client Interview*

Are you deaf or do you have serious difficulty hearing? ❑ Yes ❑ No ❑ Not Asked

Are you blind or do you have serious difficulty seeing, even when wearing glasses (or contact lenses)? ❑ Yes ❑ No ❑ Not Asked

Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?
❑ Yes ❑ No ❑ Not Asked *OR* ❑ Client's age is less than 5 years old

Do you have serious difficulty walking or climbing stairs? ❑ Yes ❑ No ❑ Not Asked

Do you have difficulty dressing or bathing? ❑ Yes ❑ No ❑ Not Asked

Because of a physical, mental, or emotional condition, do you have serious difficulty doing errands alone such as visiting a doctor's office or shopping?
❑ Yes ❑ No ❑ Not Asked *OR* ❑ Client's age is less than 15 years old

Notes:

_____

_____

_____

_____

_____

_____

_____

Staff Member Completing Form:

Name: _____ **Signature:** _____ **Date:** _____/____/_____
mm / dd / yyyy