DHAS-9
JUL 12

New Jersey Department of Health
Division of HIV, STD and TB Services - HIV Home Care Program

CLIENT INTAKE RECORD

Last Name	**First Name**	**Middle Initial**

1. Name of Agency	**2. Case Manager** ☐ **RN** ☐ **MSW**	**3. Intake Date** ____/____/____ *Month / Day / Year*

4. ID Number

____ - ____ ____ ____ ____

1st Letter of Last Name + *Last 4 Digits of Social Security Number*

5a. Name of Referring Hospital/Agency

5b. Agency Type:
☐Client ☐Clinic/Social Service Agency
☐Hospital ☐Social Worker
☐Physician ☐Friend/Family
☐Other, Specify: _____

5c. Referral Date
____/____/____ *Month / Day / Year*

6. Enrollment Date
____/____/____ *Month / Day / Year*

7. City	**8. County**	**9. Zip Code**

10. Is client being re-enrolled into the HIV Home Care Program?
☐Yes ☐No If Yes, specify reason for re-enrollment: _____

11. Race
☐American Indian or Alaskan Native
☐Asian
☐Black or African American
☐Native Hawaiian or Other Pacific Islander
☐More than one race
☐Unknown/Unreported
☐White

12. Hispanic or Latino/a Ethnicity
☐Hispanic or Latino/a
☐Non-Hispanic or Non-Latino/a
☐Unknown/Unreported

13. Gender
☐Male
☐Female
☐Transgender
☐Unknown/Unreported

14. Date of Birth
____/____/____ *Month / Day / Year*

15. Age

16. Living Arrangement
☐Homeless/Shelter
☐Living with Friend
☐Living in Group Facility
☐Other
☐Living Alone
☐Living with Relative(s)
☐Living with Parents/Guardian
☐Living with Spouse
☐Living with Children- (No. of Children Under 18: _____)

17. Current Employment Status *(Check ALL that apply)*
☐Employed Full Time (35 or More Hours/Week)
☐Employed Part Time (Less Than 35 Hours/Week)
☐Medically Disabled
☐Not Employed

18. Number of Persons Living in Household:

19. Gross Monthly Household Income from ALL Sources:
$_____

20. Does client have health insurance coverage?
☐Yes ☐No
If No, complete Question 21
If Yes, complete the following:
☐Private Insurance
Specify: _____
☐Medicare
☐Medicaid
☐Other
Specify: _____

21. Has health insurance coverage been applied for?
☐Yes ☐No
If Yes, complete the following:

	Date Application Sent (Month/Year)
☐SSI	____/____
☐SSD	____/____
☐ACCAP	____/____
☐Medicaid	____/____
☐Other: _____	____/____

If No, explain: _____
When will application be completed and mailed? ____/____

22. Has client tested positive for HIV?
☐Yes ☐No
If Yes, what is the date of the test? ____/____ *Month/Year*
☐Cannot recall date.

23. Has client been diagnosed with AIDS?
☐Yes ☐No
If Yes, what is the date of the test? ____/____ *Month/Year*
☐Cannot recall date.

24a. Medical Diagnoses RELATED to HIV/AIDS:
1. _____
2. _____
3. _____

24b. Medical Diagnoses UNRELATED to HIV/AIDS:
1. _____
2. _____
3. _____

25. Exposure Category *(Check ALL that apply)*
☐Men Who have Sex with Men (MSM)
☐Injection Drug User (IDU)
☐Men Who Have Sex with Men and IDU
☐Receipt of blood transfusion, blood components or tissue
☐Heterosexual Contact
☐Other
☐Undetermined/unknown/risk not reported or identified
☐HIV Positive Mother
☐Hemophilia/Coagulation Disorder

26a. Client Needs *(Check ALL that apply)*
☐Intravenous Therapy ☐Drug Education
☐Oxygen Therapy ☐Drug Monitoring
☐Other: _____

26b. Assistance With
☐Transferring ☐Dressing ☐Toileting ☐Shopping ☐Laundry
☐Walking ☐Bathing ☐Meal Preparation ☐Housekeeping
☐Other: _____

27a. Overall Condition
☐Good ☐Fair ☐Poor
☐Wasting ☐Terminally Ill

27b. Cognitive Impairment
☐Yes ☐No

28. Circle the Estimated Number of Months HIV HCP Services Will Be Required
1 2 3 4 5 6 7 8 9 10 11 12

29a. Supervisor	**29b. Date**