

# Comprehensive Case Management Reassessment

Reassessment Start Date: \_\_\_\_\_

② Reassessment Completion Date: \_\_\_\_\_

Date of previous Assessment/Reassessment: \_\_\_\_\_

Name: \_\_\_\_\_ Client ID # \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

If Reassessment is early or late explain: \_\_\_\_\_

Current HIV Status: Asymptomatic \_\_\_\_\_ Symptomatic \_\_\_\_\_ AIDS \_\_\_\_\_ At Risk \_\_\_\_\_

⑦ Date of most recent Viral Load: \_\_\_\_\_

⑧ Viral Load Test Results: \_\_\_\_\_

⑨ Date of most recent CD4 Count: \_\_\_\_\_

⑩ CD4 Count Results: \_\_\_\_\_

Method of Verification: \_\_\_\_\_

Describe client's current situation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone # \_\_\_\_\_

Relationship: \_\_\_\_\_ Aware of Status? \_\_\_\_\_ Y \_\_\_\_\_ N

Is there a Release of Information? \_\_\_\_\_ Y \_\_\_\_\_ N Date of Release: \_\_\_\_\_

Address: \_\_\_\_\_

**4** Does the client currently have an HIV medical care provider? \_\_\_\_\_ Yes \_\_\_\_\_ No

<b>5</b> HIV Medical Provider Name	Full Address	Phone #	<b>6</b> Date of most recent HIV medical visit	Release of Information Expiration Date

**List all Other Service Providers that were involved in the last 180 days:**

Agency/Type of Service	Provider Contact	Phone #	Date of last visit/service rendered	Release of Information Expiration Date

**Identify Client's Collaterals/Children:**

\*If any new children (under the age of 21) have moved into the household in the last 180 days, complete Child Assessment.

Name	Relationship	In Household Y/N	New to Household Y/N	Aware of Status Y/N	Children's Assessment Completed Y/N	Date of Assessment

## NEEDS REASSESSMENT

For each area, review client's current status, and comment on any changes in client's functioning, needs and resources. Where appropriate, include information about the family support system. Comment on all areas checked and identify progress on goal areas for the previous reassessment period. Provide a brief summary for each section.

\*Remaining Need = not previously addressed; client not ready; in process; or, other with detailed information.

<b>HEALTH CARE</b>	Remaining Need* Explain	New Need	Not Needed	Comments/Follow-up
Primary Health Care Provider				
Is client keeping appointments with primary care provider? ___Y ___N ___Inconsistent				
Explain:				
Means of Verification:				
Current Hospital Preference:				
Complementary/Alternative Therapies				
Clinical Trials				
TB Testing/Treatment				
OB/GYN				
Identify Provider:				
Date of most recent OB-GYN visit:				
<div style="border: 1px solid black; padding: 2px;"> <span style="border: 1px solid black; border-radius: 50%; padding: 2px;">11</span> Date of most Recent Pap Smear:         </div>				
Pap Smear Results:				

Is Client Pregnant? ___Yes ___No					Due Date:				
If yes, is client receiving prenatal care? ___Yes ___No									
If yes, has ARV Therapy been discussed? ___Yes ___No									
Family Planning									
STD Testing/Treatment									

<b>HEALTH CARE</b> continued	Remaining Need* Explain	New Need	Not Needed	Comments/Follow-up
<b>12</b> Hepatitis C Antibody Status: _____ Positive _____ Negative _____ Unknown <b>12</b> <b>a.</b> If antibody positive for Hepatitis C, does the client have chronic Hepatitis C? _____ Yes _____ No _____ Unknown				
Hepatitis Testing/Treatment/Vaccination				
Home Care				
Hospice				
Nutrition				
Dental				
Vision				
Other: (Fill in spaces below)				
Medications				
Identify current medication – See next page specifically for medication				
Does client have access to medication? _____ Y _____ N _____ Inconsistent				
If No or Inconsistent, Explain:				
Does client need education in this area? _____ Y _____ N				
Explain:				

**The AIDS Institute updates the following Medications Page for use in Comprehensive Assessments and Reassessments on a quarterly basis. Replace the following page with the most recent updated copy found on the COBRA website (cobracm.org) under Resource Center.**

## ANTIRETROVIRAL MEDICATIONS

**13** Based on the previous medications list, is the client currently prescribed ARV therapy? \_\_\_\_\_ Y \_\_\_\_\_ N

**CLIENT ADHERENCE QUESTIONNAIRE**

**Please ask each question and each possible response, and circle the corresponding number next to the client’s answer. Then add up the circled numbers to calculate the score.**

1) How often do you feel that you have difficulty taking your HIV medications on time? By “on time” I mean no more than two hours before or two hours after the time your doctor told you to take it.

- 4 Never
- 3 Rarely
- 2 Most of the time
- 1 All of the time

2) On average, how many days PER WEEK would you say that you missed at least one dose of your HIV medications?

- 1 Everyday
- 2 4-6 days a week
- 3 2-3 days a week
- 4 Once a week
- 5 Less than once a week
- 6 Never

3) When was the last time you missed at least one dose of your HIV medications?

- 1 Within the past week
- 2 1 – 2 weeks ago
- 3 3 – 4 weeks ago
- 4 Between 1 and 3 months ago
- 5 More than 3 months ago
- 6 Never

**14** **SCORE:** \_\_\_\_\_ Good adherence (greater than 10) \_\_\_\_\_ Poor adherence (less than or equal to 10)

Discuss side effects, difficulties following regimen, and other barriers to taking medications <i>as prescribed</i> :

Is assistance needed? _____ Y _____ N Identify:

**Collateral (especially children) Healthcare Status/Needs:**


**Current Overall Healthcare Status/Barriers:**


<b>FINANCIAL/ ENTITLEMENTS</b>	<b>Remaining Need* Explain</b>	<b>New Need</b>	<b>Not Needed</b>	<b>Comments/Follow-up (Include \$ Amounts)</b>
Food Stamps				
Medicaid				
ADAP				
SSI/SSD/VA Benefits				
Unemployment Benefits				
Home Relief/Safety Net				
TANF				
HASA (LDSS)				
Rent Enhancement				
Financial Management				
<b>Other: (Fill in Section Below)</b>				
If on MA spend down, Identify amount:				
Indicate methods of spend down:				
<b>Current Overall Status/Needs:</b>				

<b>INDEPENDENT LIVING</b>	Remaining Need* Explain	New Need	Not Needed	Comments/Follow-up
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Date of most recent home visit:

Describe (permanent, transitional, etc):

Appropriate/Affordable				
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Eviction Notice				
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Owes Back Rent				
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Housing Repairs Needed				
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Advocacy with Landlord				
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Out of Pocket Rent Expense				
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Utilities				
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Phone				
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Transportation				
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Other:

22 Current housing status:  
 \_\_\_\_\_ Homeless or in Temporary Shelter \_\_\_\_\_ Inadequate and/or Unstable \_\_\_\_\_ Adequate and Stable

**Comments on Current Status/Barriers:**

SUBSTANCE USE	Remaining Need* Explain	New Need	Not Needed	Comments/Follow-up
<b>15</b> Does the client have a history of problem alcohol or drug use? _____ Yes _____ No				
Is client currently using substances? _____ Yes _____ No				
Explain (What/How Much/How Often):				
<b>16</b> <b>17</b> & <b>17</b> a. Is the client currently receiving or need:				
Out Patient Treatment				
Residential Treatment				
MMTP (Dosage _____ )				
AA/NA Meetings				
DETOX				
Needle Exchange/ Harm Reduction Program				
Other: (Fill in section below)				
If yes to any of the above, indicate frequency:				
<b>17</b> a.1. If client has been receiving outpatient drug or alcohol treatment, attendance over the past six months has been:				
_____ Inconsistent _____ Consistent (missed less than 10% of appointments)				
<b>Current Overall Status/Barriers:</b>				

<b>MENTAL HEALTH</b>	<b>18</b> Remaining Need* Explain	<b>18</b> New Need	Not Needed	Comments/Follow-up
Mental health evaluation				
Individual counseling/therapy				
Family or group counseling				
Outpatient psychiatric services (Private PhD/MD)				
Inpatient psychiatric care				
Medication evaluation/monitoring				

**19** If client has been receiving outpatient mental health care services, over the past six months client attendance has been:  
 \_\_\_\_\_ Inconsistent \_\_\_\_\_ Consistent (attended over half of scheduled appointments)

Is client involved in or need a Support Group? \_\_\_\_\_ Yes \_\_\_\_\_ No Explain:

Is client involved in any Recreational/Social activity: \_\_\_\_\_ Yes \_\_\_\_\_ No Explain:

Ever prescribed medication for a psychiatric/emotional condition?

\_\_\_\_\_ Yes \_\_\_\_\_ No

**20** Currently prescribed medication for a psychiatric/emotional condition?

\_\_\_\_\_ Yes \_\_\_\_\_ No

Prescribed Medication	Purpose	Dosage/Frequency	Last Use (approximately if in the past year)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**21** Does client report adherence to this medication regimen?

\_\_\_\_\_ Yes \_\_\_\_\_ No

Does client need referral to physician/psychiatrist regarding psychotropic medication?

\_\_\_\_\_ Yes \_\_\_\_\_ No

**Current Overall Status/Barriers:**


<b>FAMILY STABILITY</b>	Remaining Need* Explain	New Need	Not Needed	Comments/Follow-up
<b>Children's Service Needs:</b>				
Medical				
Educational				
Developmental				
Emotional				
Social				
<b>Client/Collateral Service Needs:</b>				
Guardianship/ Permanency Planning				
Child Abuse/Neglect				
Parenting Skills				
Child Care				
Respite				
Disclosure				
Domestic Violence				
Partner/Spousal Notification				
Is client linked with support systems? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Inconsistent				
Identify:				
Other:				
<b>Current Overall Status/Barriers:</b>				





**PREVENTION EDUCATION REVIEW**

Date:

*\* Discussion in all areas is required unless referral is made.*

Topic	Referral Needed Y/N	New Need	Comments/Follow-up
HIV			
TB			
Hepatitis – (A, B,C)/Vaccines			
STD			
Safer Sex			
Condoms			
Spermicide			
Dental Dam			
Drug Use			
Needle Sharing			
Use of Bleach			
Other Harm Reduction Techniques			
Universal Precautions			
Does client report consistent adherence to safer sex/harm reduction guidelines? _____ Yes _____ No _____ Inconsistent			
Other:			
<b>Current Overall Status/Barriers:</b>			

Ability to Perform Activities of Daily Living:

If Assistance is Required,  
Who Currently Assists?

Feeding	0	1	2	_____
Ambulating	0	1	2	_____
Transferring	0	1	2	_____
Grooming	0	1	2	_____
Dressing	0	1	2	_____
Bathing	0	1	2	_____
Toileting	0	1	2	_____
Homemaking	0	1	2	_____
Financial Management	0	1	2	_____
Preparing Meals	0	1	2	_____
Nursing Home	0	1	2	_____
Taking Medicine	0	1	2	_____
Supportive Housing	0	1	2	_____
Grocery Shopping	0	1	2	_____
Traveling	0	1	2	_____
Using Telephone	0	1	2	_____
Decision Making	0	1	2	_____

- 0 = By Self
- 1 = Some Assistance
- 2 = Total Assistance

Recommended Care Environment:

_____ Home	_____ Home with Support	_____ Other
_____ Alone	_____ Homemaking	_____
_____ Family	_____ Personal Care	_____
_____ Other	_____ Skilled Nursing	_____
	_____ Hospital	_____
	_____ Nursing Home	_____
	_____ Supportive Housing	_____
	_____ Hospice	
	_____ ADHC	

