

Application Month _____

INTAKE

- Services received:
- ADAP
 - Case Management
 - Both

Ryan White Part B Primary Care Services & AIDS Drug Assistance Program (ADAP)

Intake Date: _____

Update Date: _____

Client ID: _____

CLIENT INFORMATION

Last Name _____ First Name _____ M.I. _____
 Street Address _____ City _____ Zip _____
 Telephone _____ Message @ Home Yes No Message @ contact Yes No
 SSN# _____ - _____ - _____ Birthdate _____ - _____ - _____ Male _____ Female _____ Transgender _____
 ER Contact _____ Relationship _____ Phone _____
 Case Manager _____ Physician _____

Race

- White
- Black or African American
- Asian
- American Indian or Alaska Native
- Native Hawaiian or Other Pacific Islander
- Other
- Unknown

Ethnicity

- Non-Hispanic
- Hispanic
- Unknown

Living Arrangements

- Homeless
- Owns
- Rents
- Other _____

Insurance

- Private Insurance
- Currently on Medicaid
- Applied for Medicaid Date: _____
- Medicare Part A/AB
- Medicare Part D
- VA
- Uninsured
- Other _____

Risk Factors

- MSM
- IDU
- Heterosexual Contact
- Hemophilia/coagulation disorder
- Perinatal Transmission
- Undetermined/unknown
- Receipt of transfusion of blood, or tissue
- Other specify _____

HIV/AIDS Status

- HIV – positive (not AIDS)
- HIV – positive (AIDS status unk.)
- CDC defined AIDS
- HIV – negative (affected)
- HIV – indeterminate
- Unknown

Incarcerated last 90 days

HIV + date _____
 State where diagnosed _____
 AIDs date _____
 Year first accessed care _____
 If taking medications, year started _____

Original CD4 _____ Date _____
 Current CD4 _____ Date _____
 Current VL _____ Date _____

Income Source/Financial Status

Family Size _____
 Gross Monthly Income _____
 Employment
 Compensation
 SSI/SSDI
 TAFI
 None
 Other _____

Eligibility

RW Part B CM Eligible Yes No
 ADAP Eligible Yes No
 Direct Care Yes No
 HOPWA Yes No
 Notified of Idaho Code Yes No
 Notified of Available Services Yes No

Service Need		Comments	Service Need		Comments
Shelter	<input type="radio"/> Y <input type="radio"/> N		Dental	<input type="radio"/> Y <input type="radio"/> N	
Food	<input type="radio"/> Y <input type="radio"/> N		Pharmaceutical	<input type="radio"/> Y <input type="radio"/> N	
Clothing	<input type="radio"/> Y <input type="radio"/> N		Vocation/Employ	<input type="radio"/> Y <input type="radio"/> N	
Mental Health	<input type="radio"/> Y <input type="radio"/> N		Entitlements	<input type="radio"/> Y <input type="radio"/> N	
Substance Abuse	<input type="radio"/> Y <input type="radio"/> N		Family Issues	<input type="radio"/> Y <input type="radio"/> N	
Transportation	<input type="radio"/> Y <input type="radio"/> N		Legal	<input type="radio"/> Y <input type="radio"/> N	
Medical	<input type="radio"/> Y <input type="radio"/> N		Other	<input type="radio"/> Y <input type="radio"/> N	

If you are eligible for the Ryan White/ADAP programs, your demographic information will be shared with the STD/AIDS Program with the Idaho Department of Health & Welfare. Shared information will be limited to that which is required for funding.

Client Signature and Date _____

Witness Signature and Date _____