Oregon Department of Human Services
Public Health Division
HIV/STD/TB Program
HIV Care and Treatment Program

Client Intake/Annual Update

Required form

"Confidential — this form must always be saved on a secure network accessible only by Ryan White funded staff."

☐ Intake ☐ Annual update Date:	Social Security number:	Age:	DOB:

Personal information

County:

Legal last name	Legal first name	Middle initial	Other names used

Street address	City	State	ZIP	O.K. to send mail
				☐ Yes ☐ No

Mailing address, if different	City	State	ZIP	O.K. to send mail
				☐ Yes ☐ No

Home phone number	O.K. to leave message
	☐ Yes ☐ No
Cell phone number	**O.K. to leave message**
	☐ Yes ☐ No
Message phone number	**O.K. to leave message**
	☐ Yes ☐ No
E-mail address	**O.K. to leave message**
	☐ Yes ☐ No

Gender ☐ Male ☐ Female ☐ Transgender (M → F) ☐ Transgender (F → M)

Ethinicity ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Race ☐ White/Caucasian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ American Indian/Alaska Native ☐ Other

Medical health insurance

☐ Private	☐ Medicare	☐ Medicaid	☐ Other public	☐ No insurance
Company: ______ ID #: ______ OMIP #: ______ COBRA *(end date)*: ______ Dental insurance *(name)*: ______	☐ Part A ☐ Part B ☐ Part D _____ ☐ Low income subsidy ☐ Qual. Medicare ben.	☐ OHP Standard ☐ OHP Plus ☐ OHP open card OHP# _____ ☐ Dual eligible MCO _____	☐ VA benefits # _____ ☐ Champus # _____	**Comments:**

CAREAssist ☐ Yes ☐ No If yes, number: ______

Key contacts

Other emergency contact	Relationship	Phone number	Aware of HIV status
			☐ Yes ☐ No
Primary care physician	**Phone number**	**Pharmacist**	**Phone number**
HIV specialist	**Phone number**	**Other agency**	**Phone number**

House/living arrangement

☐ Permanently housed *(describe)*: ______
☐ Not permanently housed *(describe)*: ______
☐ Institution ☐ Unknown ☐ Unstable ☐ Other

Client name: ______ Client #: ______ CM initial: ______ Date: ______

Transportation

☐ Not available *(describe):* ______
☐ Available *(describe):* ______
☐ Access to and funds for transportation *(gas, bus pass, etc …):* ______
☐ Needs help arranging transportation *(paratransit, volunteer, etc …):* ______
☐ Barriers to accessing transportation: ______

Availability of basic needs *(check if needed)*

☐ Clothing ☐ Shelter ☐ Food ☐ Utilities
Access to food programs ☐ No ☐ Yes, which ones: ______
Safe child care available ☐ No ☐ Yes
☐ Other household personal items *(toilet articles, cleaning or pet supplies, etc …):* ______
☐ Other basic needs: ______

Employment/education

☐ Not employed
☐ Currently seeking employment
☐ Employer location: ______

Highest grade completed in school ☐ High school ☐ Diploma ☐ GED ☐ College ☐ Post-graduate
Currently in school? ☐ No ☐ Yes, school name: ______
Do you have difficulty reading? ☐ No ☐ Yes Do you have difficulty writing? ☐ No ☐ Yes
Were you in special education classes in school? ☐ No ☐ Yes, what type: ______

Legal/criminal issues

Do you have ☐ Trust ☐ Will ☐ Physician's directive ☐ Healthcare power of attorney
☐ Durable power of attorney ☐ Guardian/conservator for self/dependents
If *power of attorney*, name: ______ Phone: ______
Are you a guardian/conservator for anyone? ☐ No ☐ Yes If yes, who: ______
Criminal history ☐ Arrest(s) ☐ Conviction(s) ☐ Restraining order(s) ☐ Parole/probation(s)
☐ Incarceration
Describe: ______

Family/dependent children

Do you have dependent children *(including children you are paying child support for)?* ☐ No ☐ Yes, number:
If yes, do they live with you? ☐ No ☐ Yes

Household members

Names	Relationship	Age	Aware of HIV status	Income
			☐ No ☐ Yes	
			☐ No ☐ Yes	
			☐ No ☐ Yes	
			☐ No ☐ Yes	
			☐ No ☐ Yes	

Financial information

Source *(gross)*	Amount	Itemization	Amount
Salary		Rent/mortgage	
Spouse's salary		Phone	
Disability *(short or long-term)*		Utilities	
SSI/SSDI		Food	
TANF/General Assistance		Non-food household expenses	
VA pension/retirement		Car payment	
Unemployment benefits		Insurance premiums	
Child support		Alimony/child support	
Savings/investments		Child care	
Rental income		Uncovered medical expenses	
Family support		Debts	
Other:		Other:	
Monthly total *(gross)*		**Monthly total**	
Annual total *(for CAREWare)*			
Household size *(for CAREWare)*		**Food stamps**	
% FPL *(Federal Poverty Level)*		☐ No ☐ Yes, amount/month	

Income verified by ☐ Pay stubs ☐ W-2 from employer ☐ Year-end 1099 form
☐ Copy of federal income tax return ☐ Bank statements *(showing deposits)*
☐ Accounting paperwork ☐ Copy of SS check ☐ SS award letter
☐ **No income documentation**

Do you have a payee? ☐ No ☐ Yes, name: ____________________ Phone: ____________________

Comments

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Signature and credentials: ______________________________ **Date:** ______________

Client name: ____________________ Client#: ____________ CM initial: ________ Date: ____________