Name:	(Last) (First)	HCH ID#
. Site	(Must Circle One) 1. HCH 2. Other	
1. M 4. P 7. P 5. M 6. U 9. o	Ance/Benefit Status (Circle Only One) PA # I MA#	III. Where Did The Client Spend Last Night (Must Circle One)  1. Shelter 2. Transitional Shelter 3. Doubling-Up 4. Street 5. Other 6. Hospital 7. Unknown 6. Housed 9. Jail/Prison
	Signature Of Staff Completing Items	
ontact In	fo_	C/O(If Applicable)
	Street City State	zip Telephone #
	Yes         NoAssess           1         99         2. Heterosexual Risk           1         99         7. Men Having Sex With Men           1         99         3. Injection Drug Use           1         99         4. Non-injections Drug Use           1         99         5. Alcohol Use           1         99         6. Tobacco Use           1         99         8 Commercial Sex Worker	vi. Assessments  I >6 months □ <6months □ 1. ASI
eriously an To E 	Considering Entering Treatment In 6 Months?"No(Precontemplation) Inter Treabnent In The Next Month?"No (Contemplation)Yes (Ready For Assessed Section 2015)	Action) If Yes, Refer To Addictions Team For Assessment  If Yes, why?  Clinic Closed  Services CutOff Sent by HCH  Other Locali  If Yes why?  iclinic Closed  Setvices CutOff Sent by HCH  Other  Locali
	Codes (Circle All That Apply)	X. Reportable Interventions (Circle All That Apply)
5703	HIV Testing	5. Eligibility Assistance 6. Relationship Building
9401	Preventive Medicine Counseling And/Or Risk Factor Reduction Intervention (15 Minutes)	7. Crisis intervention 9. Case Management 10. Health Education 11. Individual Counseling 12. Group Counseling 16. Food
9402	Preventive Medicine Counseling And/Or Risk Factor Reduction Intervention (30 Minutes)	14. Other
9403	Preventive Medicine Counseling And/Or Risk Factor Reduction Intervention (45 Minutes)	15. Transportation #Tokens #Cab Voucher(s)_ Client Signature
9404	Preventive Medicine Counseling And/Or Risk Factor Reduction Intervention (60 Minutes)	1si Provider
9412	Preventive Medicine Counseling And/Or Risk Factor Reduction Intervention Provided To Individual In Group Setting (60 Minutes)	Signature & Title Of Provider Completing Encounter  Signature & Title Of Provider Completing Encounter  2nd Provider

Progress Notes:
Is Client eligible for PA YES NO Has Pharmacy Assistance application been completed? YES CI NO Does Client have regular Health Care Provider YES NO (circle only one)
Baseline Info (Please Complete On <u>First Encounter</u> Or If Information Changes)
Sex: (Check One):