HCH, INC. / CONNECT PROJECT

INITIAL/UPDATED ASSESSMENT FORM

Date: _____ Case Manager: _____

Current Client Residence: _____

_____

How Long? _____

Mailing Address: _____

_____

Telephone No.: _____

Soc. Sec. No: _____

Date of Birth: _____

BENEFITS			
	Current	Applied (Date)	Pending
☐ MC			
☐ FS			
☐ TEMHA			
☐ BUS PASS			
☐ PA/TAP			
☐ MA			
☐ SSI/SSDI			
OTHER: _____			

Referral Source: _____

Referral Address: _____ Phone/Fax: _____

Reason for Referral: _____

Patient Aware of Referral? ☐ Yes ☐ No Tier I _____

Program Eligibility: ☐ HIV+ ☐ S.A. ☐ M.H. Tier II _____

CD4 _____ VL _____

Additional Illness: _____ Referred: _____

Medications: _____

Current Needs:

☐ Housing ☐ Medical Care ☐ Transportation
☐ Mental Health ☐ Addictions ☐ Food
☐ Income ☐ Employment ☐ Support Group/Buddy
☐ Health Insurance ☐ Job Training/Education ☐ Other _____

Social Support (Family History): _____

Housing Status: _____

Education: _____

Employment History: _____

Are they receiving:	No	Yes	Contact	Provider	Phone #
-Medical Care?					
-Mental Health Services?					
-Addiction Treatment?					

CLIENT LAST NAME: _____ FIRST: _____ HCH#: _____

History of Substance Abuse? ☐ **No** ☐ **Yes**

Drug of Choice: _____ ☐ N/A

Treatment History _____

Presenting Medical Problems: _____

Psycho-Social Problems: _____

Medications: _____

Legal/Criminal History: _____

Religious Affiliation/Spiritual Beliefs: _____

Contact Person (Next of Kin:) _____ **Phone:** _____

INITIAL/UPDATED CARE PLAN

GOALS	OBJECTIVES	OUTCOME

_____
Client's Signature

_____
Signature of Case Manager

Provider Code

_____
Date of Plan