HEALTH CARE FOR THE HOMELESS, INC.

PSYCHOSOCIAL CASE MANAGEMENT ASSESSMENT

SOCIAL SECURITY #	AGE	DATE OF BIRTH	☐ MALE ☐ FEMALE	☐ AFRICAN-AMERICAN ☐ CAUCASIAN	☐ HISPANIC ☐ OTHER _____

☞CONFIDENTIALITY FORM SIGNED? ☐ YES ☐ NO

1

PRESENTING PROBLEM:

WHERE STAYED LAST NIGHT:

HOW LONG HOMELESS?

HOMELESS HISTORY:

FAMILY COMPOSITION:

NEXT OF KIN:

CONTACT INFORMATION:

WHERE DO YOU GET YOUR FOOD?

2

EMPLOYED? ☐ YES ☐ NO.. . IF NOT, LAST FULL-TIME JOB:

USUAL OCCUPATION:

EDUCATIONAL LEVEL: | JOB SKILL TRAINING:

MILITARY SERVICES? ☐ NO ☐ YES.. . IF YES, EXPLAIN:

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INSURANCE? ☐ NO ☐ YES: | BENEFITS? ☐ NO ☐ YES:

INCOME? ☐ NO ☐ YES: | IS INCOME ADEQUATE TO MEET YOUR NEEDS? ☐ NO ☐ YES

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HIV TEST IN THE PAST 6 MONTHS? ☐ NO ☐ YES.. IF YES, WHERE:

WHAT WERE THE RESULTS? | TEST CONFIRMED IN CHART? ☐ YES ☐ NO

HOW IMPORTANT IS YOUR SEXUALITY TO YOU?:

ANY CONCERNS ABOUT SEXUALITY THAT YOU WANT TO DISCUSS? ☐ NO ☐ YES:

CONDOM USAGE? ☐ NO ☐ YES: | HOW MANY PARTNERS IN PAST SIX MONTHS:

TOBACCO USE? ☐ NO ☐ YES: | IV DRUG USE? ☐ NO ☐ YES:

COCAINE USE? ☐ NO ☐ YES.. .LAST USE: | HEROIN USE? ☐ NO ☐ YES. .LAST USE:

ETOH USE? ☐ NO ☐ YES.. .LAST USE: | OTHER: LAST USE:

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CURRENT MEDICAL PROBLEMS:

CURRENT MEDS:

IF HIV+, CD4 COUNT: | VIRAL LOAD:

OPPORTUNISTIC INFECTIONS:

CURRENT MH PROBLEMS:

EVER TRAUMATIZED? ☐ NO ☐ YES

6

TB TEST? ☐ NO ☐ YES | DATE:

WHERE: | RESULTS:

CLIENT LAST NAME: **FIRST:** **HCH#:**

HEP C TEST? ☐ NO ☐ YES | DATE:

WHERE: | RESULTS:

7 MEDICAL *CARE/ADHERENCE ASSESSMENT*

WHERE DID YOU RECEIVE CARE IN THE PAST?

WHY DID YOU CHANGE TO HCH?

HAVE YOU EVER BEEN ON HAART THERAPY? ☐ N/A ☐ NO ❑ YES.. . GIVE SPECIFICS:

WHAT HEALTH CARE CONCERNS DO YOU HAVE?	YES	NO
UNDERSTANDING AND TAKING MEDICINES		
KEEPING REGULAR APPOINTMENTS		
FEELING GOOD ABOUT MY TREATMENT OPTIONS		
HAVING ALL MY QUESTIONS ANSWERED		
SEXUALITY ISSUES		

OTHER:

WHAT GETS IN THE WAY OF MEETING YOUR HEALTH CARE GOALS?

8 *LEGAL HISTORY*

NUMBER OF ARRESTS IN PAST 2 YEARS: CURRENTLY ON PAROLE OR PROBATION? ☐ NO ☐ YES:

CHARGES PENDING? ☐ NO ☐ YES:

OTHER SIGNIFICANT HISTORY:

9

RELIGIOUS PREFERENCE: CHURCH HOME? ❑ NO ☐ YES:

DO YOU CONSIDER YOURSELF SPIRITUAL OR RELIGIOUS? ❑ NO ☐ YES

ANYTHING ABOUT YOUR BELIEFS YOU WANT ME TO KNOW IN TERMS OF YOUR TREATMENT? ☐ NO ❑ YES:

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PERSONAL GOALS:

RECREATION GOALS:

11 *SOCIAL/COMMUNITY SUPPORTS:*

WHAT OTHER AGENCIES PROVIDE SERVICES TO YOU?

NAME: SERVICES PROVIDED:

AGENCY ADDRESS: CITY: STATE: ZIP:

ARE THERE FAMILY & FRIENDS THAT HELP YOU? ☐ NO ☐ YES

DO YOU WANT THEM INVOLVED IN WHAT WE ARE WORKING ON? ☐ NO ❑ YES IF YES, DESCRIBE:

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REFERRAL DIAGNOSIS

HE/SHE NEEDS: ❑ HOUSING ☐ MENTAL HEALTH ☐ ADDICTION SERVICES ☐ INCOME
☐ JOB TRAINING ☐ EMPLOYMENT ☐ HEALTH INSURANCE ❑ MEDICAL CARE
☐ OTHER:

CASE MANAGER SIGNATURE DATE NEXT APPT. DATE: →

COMMENTS SECTION: