Unique Client Identifier (UCI) Instructions

Instructions: The Unique Client Identifier (UCI) is generated by the first and third characters of the client's first name, followed by the first and third characters of the client's last name, the six digit date of birth, and the one digit gender code. These instructions provide guidance on how to create each part of the UCI.

First and third characters of the first and last name

Characters include letters, symbols (periods, hyphens, apostrophes) and spaces, so each of these should be "counted" when constructing the UCI. If the first or third character is a letter, that letter is entered into the UCI in the appropriate space; however, if it is not a letter, then the number 9 is entered into the UCI in the appropriate space. If the client declines to provide the first and third letters of the first or last name, please enter the number 9 in the appropriate spaces.
Additional guidelines include:

- The client's legal name should be used to develop the UCI. Do not use nicknames or abbreviations (i.e. do not use Bill if the client's full name is William).
- If the first or last name is an initial only and the initial is not an abbreviation of a longer name, count that as a character. Please also count the period as a character. For example, if a client's name was T. Walter Smith and "T" is not an abbreviation for a longer name, you would count the T as the first character, the period as the second character and the space as the third character. In this case, the client code is T9SI, assuming that T. Walter was the client's first name.
- When individuals have more than one first or last name (i.e. Pérez Rivera, Peters-Smith, De Leone), start with the first name in the sequence to determine the first and third characters for the UCI. Remember, if a symbol or space is the first or third character of the name, enter the number 9 in the appropriate space of the UCI.
- When a client only has two letters in the first or last name (i.e. Phuong Do, Yi Chen), enter a 9 in the appropriate space in the UCI.

Examples:

1: James Doe = JMDE
2: Lonnie D'Agostino = LNDA
3: Robert McCarthy = RBMC
4: Jane O'Brien = JNOB
5: Alvin Smith-Jones = AVSI
6: Anna Maria Lopez Sanchez = ANLP
7: Phuong Do = PUD9
8: Yi Chen = Y9CE

Clients with the same ID: If two clients have the same UCI, record each individually. These clients will be distinguishable through their old client code. Contact your program coordinator or contract manager if you have further questions.

Date of Birth (MMDDYY)
Please enter date of birth as the two digit month (MM), two digit day (DD) and two digit year(YY). For one-digit months and days, it is required to include a leading zero.

Gender
Gender coding for the UCI is slightly different than gender coding for data for the RSR. When creating the UCI, please enter gender as the following values:
Male=1
Female=2
Transgender=3
Unknown=9

If a client refused to provide their gender, please code gender as “unknown”.
Do not use leading zeros or the Male to Female/Female to Male subcategories for Transgender when creating the UCI.

Note: If you are using Genuwin, you will receive additional instructions about entering the UCI.

Joint Form Instructions

Updated 6/1/09

Instructions for completing the *Joint HIV/AIDS Client Information Form* for Part A services follow. BPHC will not process *Joint HIV/AIDS Client Information Forms* that are incomplete or incorrect. We will contact the agency for correction. *Client Utilization Forms* cannot be processed until the *Joint HIV/AIDS Client Information Forms* are submitted correctly.

All Fields Are Required Unless Otherwise Indicated	
CLIENT CODE	Enter the 13-character **Client Code using the required coding system:** First 3 letters of the client's mother's first name, the 6-digit client's date of birth (MMDDYY), and the last 4 digits of the client's social security number. If unknown, use XXX for the mother's name and 9999 for the SS#. The last box for Client Code should be left blank.
UNIQUE CLIENT IDENTIFIER	**Enter the 11-character *UCI* using the required coding system: First and third letters of client's first name, first and third letters of client's last name, 6 digit date of birth (MMDDYY), and the gender code (1=male, 2=female, 3=transgender, 9=unknown).**
GENERAL INFORMATION	Enter ***Date Completed***, ***Completed By***, and ***New Client/Update***. Be sure to place an X indicating whether the form is for a new client or is an update of an existing client. New clients are those for whom no *Joint HIV/AIDS Client Information Form* is on file at the BPHC. Updated Clients are those who have a *Joint HIV/AIDS Client Information Form* on file but whose information has changed. Updated *Joint Forms* must be submitted for all active clients with the new UCI with monthly and quarterly submissions.
	Enter the 6 digit ***Date of Birth*** (ex: 01/16/76); Enter ***Age.***
	Circle one choice for ***Gender***. For transgender clients, indicate if client's gender is Male to Female or Female to Male. Male to Female or Female to Male information does not need to be entered into Genuwin systems (only for applicable agencies).
	Enter ***City, State*** *and* ***Zip Code*** of current residence. If homeless, use "99999" for ***Zip Code***. List the City and State.
CONTRACT INFORMATION	***Vendor*** – Enter the name of agency contracting with BPHC. If you are a subcontractor, you **must** indicate the agency with which BPHC has the contract. Subcontracting agencies may enter their names in the Service Coordination section.
	Intake Date - Enter when the client intake process was started or when the first services were received.
	Activity Status – Circle the appropriate status. All new clients are assumed to be active. If client status changes, submit an updated *Joint Form*. For clients designated "Other inactive status," please indicate if status is a result of violation of rules or incarceration. "Other inactive status" information does not need to be entered into Genuwin systems (only for applicable agencies).
	Contract Check Boxes - Check all that apply. For Boston Public Health Commission contracts, the "Part A" box must be checked. Boxes checked as DPH will not be processed by BPHC.
	Case Manager is optional. You may enter initials or full name up to 12 characters. Be consistent for each case manager.
ETHNICITY & RACE *This section is based on Federally mandated ethnicity and race categories. Country of Birth has been added to this section. These responses should be based on client self-identification.*	***Hispanic or Latino/a*** – Must circle one.
	Country of Birth – Must circle one.
	Federal Race Categories – Client may choose as many as s/he likes but ***must*** choose at least one even if s/he has identified as Hispanic or Latino/a. Use "99" (unknown/unreported) if the other categories don't apply.
	Other Racial or Ethnic Groups – This is optional. Clients may choose as many as they like. Write in any not listed.
PRIMARY LANGUAGE	Circle only one. If primary language is not on the list, circle "98 = Other" ***and*** write the language in the space provided.

EXPOSURE CATEGORY	Circle the exposure category that the client indicates is the likely source of infection. You may select more than one category if necessary. **Definitions of categories:** ***Men who have sex with men*** cases include men who report sexual contact with other men (i.e. homosexual contact) and men who report sexual contact with both men and women (i.e. bisexual contact). ***Women who have sex with women*** cases include women for whom all other exposure categories can be excluded and whose only sexual contact is with women. ***Injection drug user*** (IDU) cases include individuals who report use of drugs intravenously or through skin-popping. ***Heterosexual contact*** cases include individuals who report specific heterosexual contact with an individual with HIV infection or with a person at increased risk for infection through MSM, IDU, receiving blood, etc. ***Perinatal transmission*** cases includes the transmission of disease from mother to child during pregnancy. This category is exclusively for infants and children infected by mothers who are HIV-positive or at risk. ***Hemophilia/Coagulation Disorder*** cases include individuals who receive clotting factor for hemophilia/coagulation disorder. ***Through blood, blood products, or tissue*** cases include transmission through receipt of infected blood, blood components or tissue products (other than clotting factor) given for medical care. ***Other risk*** indicates the individual's exposure is known, but not listed above. ***Unknown or undetermined*** indicates the individual's exposure is unknown or undetermined.
DIAGNOSTIC INFORMATION	Circle one. An HIV/AIDS diagnosis requires that you have verification on file. "HIV Indeterminate*" only refers to children under age 2.* If client status is "AIDS, CDC defined," please indicate diagnosis year.
REFERRAL SOURCE	Circle one. Indicates what type of agency originally referred the client to the vendor agency.
INCOME	This should be updated once each calendar year if status changes. Circle one response and fill in the ***Date*** field indicating the year for which the updated information applies. **Note:** Federal poverty levels change each year in the first quarter. Your agency should provide you with the latest guidelines.
HOUSING/LIVING ARRANGEMENT	This should be updated once each calendar year if status changes. Circle one response and fill in the ***Date*** field indicating the year for which the updated information applies. **Definitions of categories:** ***Permanently housed*** includes clients who reside in apartments, houses, foster homes, long-term residences, and boarding homes, as long as the situation is not time limited. ***Non-permanently housed*** includes clients who are homeless, as well as those living in transient or transitional housing. Homeless includes shelters, vehicles, the streets, or other places not intended as a regular living accommodation. Transitional housing includes any stable but temporary living arrangement, regardless of whether or not it is part of a formal program. ***Institution*** includes residential, health care, and correctional facilities. Residential facility includes supervised group homes, and extended treatment programs for alcohol and other drug abuse or for mental illness. Health care facility includes hospitals, nursing homes and hospices. Correctional facility includes jails, prisons, and correctional halfway houses. ***Other*** includes other housing/living arrangements not listed above. ***Unknown/unreported*** indicates that housing/living arrangements were not reported.

SOURCE OF MEDICAL INSURANCE	Circle the source of primary medical insurance and indicate the date for which the information applies. Indicate other types of medical insurance that client may have. **Definitions of categories:** ***Private*** includes health insurance plans such as Blue Cross/Blue Shield, Harvard Pilgrim, etc. ***Medicare*** is a health insurance program for people ages 65 years and older, people with disabilities under age 65, and people with End-Stage Renal Disease. ***Medicaid*** is a jointly funded, Federal-State health insurance program for people with low incomes. ***Other public*** includes other Federal, State, and/or local government programs providing a broad array of benefits for eligible individuals. Examples include Commonwealth Care Health Insurance Program, HDAP/CHII, etc. ***No insurance*** indicates the client has no insurance to cover the cost of services (i.e. self-pays or free care pool). ***Other*** indicates that the client has an insurance type other than those listed above. ***Unknown/unreported*** indicates that the source of medical insurance is unknown and not documented. ***Source of Other insurance*** may be selected for clients that have multiple insurance coverages. This section is optional and does not need to be entered into Genuwin database systems.

MEDICAL INFORMATION: This is only required from funded medical care providers. The information must be completed once each calendar year and can be submitted as obtained or at the end of the year. Non medical providers are welcome to record any of this data for their own use.	
1. What was the date of the client's first ambulatory care visit at agency?	Indicate the date of the client's first visit at your agency. This date does not necessarily have to be for an HIV related service. This visit may have occurred before the start of the reporting period. If the full date is not available, report the month and year of the first visit and the day as "01". Dates for additional visits are required for new RSR reporting and should be captured in utilization data reported to BPHC.
2. Did client receive a CD-4 test in the calendar year?	Check yes and list all dates and results if the client received a CD-4 testing the calendar year.
3. Did client receive a Viral Load test in the calendar year?	Check yes and list all dates and results if the client received a Viral Load test in the calendar year.
4. Was HIV risk reduction screening/counseling testing provided…	Check yes or no if HIV risk reduction screening/counseling testing provided for the client in the calendar year, recording the test date.
5. Was the client prescribed PCP prophylaxis during the calendar year?	Check yes, no, or unknown if client was prescribed PCP prophylaxis during the calendar year. If "no," select either "Not medically indicated" or "Client refused."
6. Was the client prescribed HAART at any time during the calendar year?	Check yes, no, or unknown if client was prescribed HAART during the calendar year. If "no," select one of the additional categories.
7. What other type of antiretroviral therapy was the client on during the calendar year?	Check what additional type of antiretroviral therapy other than HAART the client was on during the calendar year, noting the date therapy was initiated.
8. Was a Tuberculosis (TB) PPD skin test indicated...	Check yes or no if a Tuberculosis (TB) PPD skin test was indicated for the client in the calendar year, recording the test date.

9. If medically indicated, did client receive a PPD skin test...	If client answered "yes" to question 9, check yes or no to indicate if the client did or did not receive a PPD skin test during the calendar year, recording the test date.

10. If client had a PPD skin test…	Check whether the PPD skin test was Negative, Positive, or Unknown. Also record the test date.
11. If not medically indicated, has client been screened for TB since diagnosis?	If client answered "no" to question 9, check yes or no to indicate if the client did or did not receive a TB screening since HIV diagnosis.
12. If client tested positive, did they…	If PPD skin test was Positive, check whether the client received Prophylaxis for latent TB infection, Treatment for Active TB disease, if treatment was not medically indicated, or if Unknown. Also record the treatment date.
13. If client started treatment, did they...	If client started treatment, check whether the client completed Prophylaxis for latent TB infection, Treatment for active TB disease, if treatment was not medically indicated, or if Unknown. Also record the end of treatment date.
14. Did the client receive any of these services...	Check yes, no, or not medically indicated if the client received any of the listed tests or treatments during the calendar year, noting the date they were administered.
15. Did the client receive any of these services...	Check yes, no, or not medically indicated if the client received any of the listed tests or treatments during the calendar year, noting the date they were administered.
16. Did the client receive any of these services...	Check yes, no, or not medically indicated if the client received any of the listed tests or treatments during the calendar year, noting the date they were administered.
17. If female, did client receive a pelvic exam and Pap smear...	Check yes, no, or not medically indicated to indicate if a female client received a pelvic exam and Pap smear during the calendar year, noting the date they were administered.
18. Was the client pregnant at any time...	Check yes, no or not medically indicated if the client was pregnant at any time during the calendar year, regardless of the outcome of the pregnancy.
19. If pregnant, when did the client ENTER care?	Check which trimester of pregnancy the client entered care.
20. If pregnant, did the client receive antiretroviral…	Check yes if the client received antiretroviral medications.
21. What was the number of children the client delivered...	Fill in the number of children delivered (live births) during the calendar year.
22. Of the number of children born, what was their HIV status…	Fill in whether the HIV status at the end of the calendar year is HIV Positive, HIV Indeterminate, or HIV Negative for each of the children born this year.