Joint HIV/AIDS Client Information Form

Boston Public Health Commission HIV/AIDS Services Division
Massachusetts DPH Office of HIV/AIDS
Massachusetts DPH MassCARE Program

Date Completed

/ /

month / day / year

Completed By

☐ **New Client**
☐ **Update**
☐ **New UCI only**

Client Code

First 3 letters of client's Mother's first name (XXX if unknown) – 6 digit DOB – Last 4 digits SS# (9999 if unknown)

UCI

1st and 3rd letters of client's first name, 1st and 3rd letters of client's last name – DOB (mm,dd,yy) – gender code (1, 2, 3 or 9 only)

General Information

Birth Date

/ /

month / day / year

Gender (Choose one)

01 = Male
02 = Female
03 = Transgender - check if known

☐ *Male to Female (optional)*
☐ *Female to Male (optional)*

99 = Unknown / Unreported

City

State **Zip**

Contract Information

Vendor

Intake Date / /

month / day / year

Activity Status (Circle One)

01 = Active
02 = Deceased
03 = Other inactive status - check if known

☐ *Violation of rules (optional)*
☐ *Incarcerated (optional)*

04 = Moved
05 = Lost to follow-up
06 = Changed Provider
07 = Discharged

DPH		BPHC – Part A	
Client Services	☐	Part A	☐
Home Health	☐		
Medical Mgt	☐		
Housing	☐		
Corrections	☐		
MassCARE Part D	☐		

For MassCARE Part D use page 4

Case Manager (Optional)

Ethnicity / Race

Hispanic or Latino/a

You MUST circle one.

01 = Hispanic or Latino/a
02 = Not Hispanic or Latino/a
99 = Unknown / Unreported

Country of Birth (select one)

01 = United States
02 = United States Dependencies (including Puerto Rico)
03 = Other

Federal Race Categories

Choose as many as applicable but you MUST circle at least one.

01 = White
02 = Black or African American
03 = Asian
04 = Native Hawaiian / Pacific Islander
05 = American Indian / Alaskan Native
99 = Unknown / Unreported
("99" Includes Latinos who do not identify with any of the 5 Federal race categories.)

Other Racial or Ethnic Groups

In ADDITION to the categories on the left, you may choose one or more from the following. Write in any other groups below.

☐ African
☐ Cape Verdean
☐ Haitian
☐ Brazilian
☐ Portuguese

Primary Language

Choose One

01 = English
02 = Spanish
03 = Haitian Creole
04 = French
05 = Portuguese
06 = Crioulo (Cape Verdean)
07 = S.E. Asian Language
08 = American Sign Language
98 = Other (specify below)

Exposure Category

Choose as many as applicable

01 = Men who have sex with men (MSM)
02 = Women who have sex with women (WSW)
03 = Injection drug users (IDU)
04 = Heterosexual contact
05 = Perinatal transmission
06 = Hemophilia / Coagulation disorder
07 = Through blood, blood products, tissue
98 = Other risk
99 = Undetermined / Unknown

Diagnostic Information

Choose one

* 01 = HIV+, not AIDS
* 02 = HIV+, AIDS status unknown
* 03 = AIDS, CDC defined
If CDC defined AIDS, what is client's diagnosis year?
04 = HIV negative (affected clients)
05 = HIV indeterminate (under age 2 only)
99 = Unknown / Unreported

* **HIV verification is required**

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Updated 7/4/09

Client Code | | | | | | | | | | | | | |

UCI | | | | | | | | | | | | |

Referral Source **Choose one**

01 = Self
02 = Case Management
03 = Substance Abuse Trtmnt Prog.
04 = Adult/Juvenile Detention Facility
05 = Prevention/Education Program
06 = Detoxification Program
07 = Homeless Service
08 = Counseling/Testing Site
09 = Mental Health Program
10 = Health Center
11 = STD Clinic
12 = Emergency Room
98 = Other

Circle one in each category. Enter a date if different from the "Date Completed" on form.

Date / /

Income
01 = Equal to or below Federal poverty line
02 = 101 – 200% of Federal poverty line
03 = 201 – 300% of Federal poverty line
04 = Greater than 300% of Federal poverty line
99 = Unknown / Unreported

Date / /

Housing / Living Arrangement
01 = Permanently housed
02 = Non-permanently housed
03 = Institution
98 = Other
99 = Unknown / Unreported

Date / /

Source of Primary Medical Insurance
01 = Private
02 = Medicare
03 = Medicaid
04 = Other public insurance
05 = No insurance
98 = Other
99 = Unknown / Unreported

Date / /

Source of Other Medical Insurance (if applicable)
01 = Private
02 = Medicare
03 = Medicaid
04 = Other public insurance
05 = No insurance
98 = Other
99 = Unknown / Unreported

>>>> The section below is for Ryan White HIV/AIDS Program funded medical care providers. <<<<

**** Medical information must be updated each calendar year. ****

1. What was the date of the client's first ambulatory care visit at agency?	

2. Did client receive a CD-4 test in reporting period?	**Yes**	**No**

CD-4 Value	Test date

3. Did client receive a Viral Load test in reporting period?	**Yes**	**No**

Viral Load	Test date

4. Was HIV risk reduction screening/ counseling provided during the reporting period?	**Yes**	**No**	**Date**

5. Was the client prescribed PCP prophylaxis during the reporting period?	**Yes**	**No**	**Unknown**
	If no, choose one: 3 = Not medically indicated 4 = Client refused		

6. Was the client prescribed HAART at any time during the reporting period?	**Yes**	**No**	**Unknown**
	If no, choose one: 2 = Not medically indicated 3 = Not ready 4= Client refused 5 = Intolerance 6 = HAART payment assistance unavailable 7 = Other reason		

7. What other type of antiretroviral therapy was the client on during this reporting period?	Date Initiated:		
None		Other (mono or dual)	
Unknown / Unreported			

8. Was a Tuberculosis (TB) PPD skin test indicated during the reporting period?	**Yes**	**No**	**Date**

9. If medically indicated, did client receive a PPD skin test during reporting period?	**Yes**	**No**	**Date**

10. If client had a PPD skin test, check one.	**Yes**	**No**	**Date**
Negative (<5mm)			
Positive (>=5mm)			
Unknown / lost to follow-up			

11. If not medically indicated, has client been screened for TB since HIV diagnosis?	**Yes**	**No**	**Date**

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Client Code

UCI

12. If client tested positive for TB, did they receive:	Yes	No	Not medically indicated	Unknown	Date
Prophylaxis for latent TB infection					
Treatment for active TB disease					
Unknown / lost to follow-up					

13. If client started treatment, did they complete:	Yes	No	Not medically indicated	Unknown	Date
Prophylaxis for latent TB infection					
Treatment for active TB disease					
Unknown / lost to follow-up					

14. Did client receive any of these services during the reporting period?	Yes	No	Not medically indicated	Unknown	Date
Syphilis screening / testing					
Treatment for syphilis					
Screening / testing for other STI					
Treatment for other STI					

15. Did client receive any of these services during the reporting period?	Yes	No	Not medically indicated	Unknown	Date
Hepatitis B screening / testing					
If no or not medically indicated, has client been screened for Hep B since diagnosis?					
Vaccinated against Hepatitis B					
Hepatitis C screening / testing					
If no or not medically indicated, has client been screened for Hep C since diagnosis?					
Hepatitis C treatment					

16. Did client receive any of these services during the reporting period?	Yes	No	Not medically indicated	Unknown	Date
Screened for substance use (alcohol and drugs)?					
Screened for mental health?					

17. If female, did client receive a pelvic exam and pap smear during the reporting period?	Yes	No	Not medically indicated	Unknown	Date

18. Was client pregnant at any time during the reporting period?	Yes	No	Not applicable	Unknown	Date

19. If pregnant, when did client ENTER care (date)?			
First Trimester		Third Trimester	
Second Trimester		At Time of Delivery	

20. If pregnant, did client receive antiretroviral medications?	Yes	No	Not applicable	Unknown

21. What was the number of children client delivered during the reporting period?	Num	Date

22. Of the number of children born, what was their HIV status at the end of the calendar year?	Num
HIV Positive, confirmed	
HIV Indeterminate	
HIV Negative, confirmed	

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<<<This page is for Part D MDPH funded agencies ONLY>>>

MassCARE ID

UCI

Site ID

1. Is English the client's second language?	Yes	No

2. Are other family members enrolled in MassCARE?	Yes	No

3. Is the client a mother?	Yes	No

4. Is the client currently employed?

1 = Yes, full-time
2 = Yes, part-time
3 = No / Unemployed
4 = N/A, under 16 years of age
9 = Unknown

5. Primary caregiver (Choose one):

1 = Self
2 = Both parents
3 = Mother
4 = Father
5 = Adoptive / Step parent(s)
6 = Non-kinship foster parent
7 = Grandparent
8 = Spouse / Partner
9 = Sibling
10 = Adult relation (not foster)
11 = Adult friend (not foster)
12 = Professional caregiver
13 = Other _____
14 = Kinship foster parent
99 = Refused / unknown

6. Educational status

1 = in K-12
2 = in a vocational program
3 = in college
4 = dropped out of HS or less
5 = obtained HS diploma/GED
6 = completed vocational program
7 = graduated college
8 = N/A, infant
9 = unknown