Client Concerns & Essential Support Services for Persons Who Are High-Risk HIV-Negative (PWHRN): Checklist

Please complete this checklist during the client interview. *Ask the client to rate each concern on a scale from 1-4. 1=no concern, 2=somewhat concerned, 3= concerned and 4=very concerned.*

The checklist contains sensitive and confidential information and ***should not be given to the client****. It is meant for use by the Provider only to facilitate HIV treatment and other essential health and support services.*

Give the client a copy of the ***Health and Support Services Referral Form****. Make sure that all key information is included on the referral form and that the client knows how to use and access the referrals.*

Refer to this checklist during the next scheduled client meeting to assess progress and determine next steps.

Sections

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Client ID#: _____ **Date:** _____ **Agency:** _____
Staff Name: _____ **Phone:** _____ **Email:** _____

LANGUAGE NEEDS

_☐_ *Check if client's preferred language is English*
_☐_ *Check if translation services are needed*
Preferred Language: _____
Check appropriate box
☐ Internal translation services used
☐ External translation services accessed
☐ Translation service company: _____ Telephone_____
☐ Client-designated (and HIPAA cleared) family or friend

HIPAA:

_☐_ *Check if HIPAA discussed with client*
_☐_ *Check if HIPAA Form Completed*

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Concerns	Rating # (1-4)	Referrals /Information	Other Resources/Notes
EXAMPLE: **Housing Assistance**	------4------	Service Agency: HOPWA of Alphabet County Appointment Date: __11__/__4__/__15__ Address: 96 County Highway Alphabet, AZ 00000 Counselor Name: Mrs. Campbell Phone #: 000-000-0000 Email: campbell@alphabet.org	Notes: Client currently resides with sister in unstable living situation. Sister will lose housing in 3 months.
☐ **Language Access/Translation Services**	_____	Language Preference: _____ Service/Agency Contact: _____ Phone #: _____ Email: _____	Notes:

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☐ **Prevention**	_____	EBI Main Website: https://effectiveinterventions.cdc.gov/ EBI Name: _____ EBI Info: _____ _____ EBI Service Agency: _____	Basic HIV information: transmission, diagnosis, risk reduction ☐ Fact sheet(s) ☐ Resources www.cdc.gov/hiv/ www.hivplusmag.com www.positivelyaware.com www.thebody.com Free Condoms Locations: _____ _____ Syringe Exchange Programs: _____ _____

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☐ **Pre-Exposure Prophylaxis (PrEP)**	_____	Healthcare Agency: _____ Appointment Date: ___/___/_____ Address: _____ _____ PrEP Counselor Name: _____ Phone #: _____ Email: _____	Notes:

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☐ **Non-occupational Post-Exposure Prophylaxis (nPEP)**	_____	Healthcare Agency: _____ Appointment Date: ___/___/_____ Address: _____ _____ nPEP Counselor Name: _____ Phone #: _____ Email: _____	Notes:

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☐ **Sexually Transmitted Infections (STIs)/Viral Hepatitis (VH) Services**	_____	Healthcare Agency: _____ Appointment Date: ___/___/_____ Address: _____ _____ Counselor Name: _____ Phone #: _____ Email: _____	STI Resources: Viral Hepatitis (HCV) Resources:

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☐ **Paying for Healthcare**	_____	**Current Insurance Type** ☐ Private ☐ ADAP/ADAP+ ☐ Medicaid or CHIP ☐ Medicare ☐ Military, VA, Tricare ☐ IHS (Indian Health Service) ☐ Other Public Insurance ☐ None Services Covered: _____ _____ _____ Phone #: _____ Email: _____	**Suggested insurance, if uninsured** Name: _____ Coverage details: Insurance Assistance Agency: _____ Appointment Date: ___/____/_____ Address: _____ _____ Counselor Name: _____

Client Concerns & Essential Support Services for Persons Who Are High-Risk HIV-Negative (PWHRN): Checklist

			Phone #: _____ Email: _____

☐ Finding a Provider	_____	List of hospitals, clinics, FQHC, or infectious disease doctors: • _____ • _____ • _____ • _____ Name of preferred or available provider: _____	Notes:

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		Appointment Date: ___/___/_____ Address: _____ _____ Contact Name: _____ Phone #: _____ Email: _____	
☐ **Housing Assistance**	_____	Housing Agency: _____ Appointment Date: ___/___/_____ Address: _____ _____ Housing Counselor Name: _____ Phone #: _____ Email: _____	Notes:

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☐ **Food Assistance**	_____	Food Resource Agency: _____ Appointment Date: ___/___/_____ Days Open: _____ Hours: _____ Address: _____ _____ Contact Name: _____ Phone #: _____ Email: _____	Notes:
☐ **Employment Assistance**	_____	Employment Agency: _____ Appointment Date: ___/___/_____	Notes:

Client Concerns & Essential Support Services for Persons Who Are High-Risk HIV-Negative (PWHRN): Checklist

		Address: _____ _____ Contact Name: _____ Phone #: _____ Email: _____	
☐ **Childcare**	_____	Childcare Arrangements: Agency or Person: _____ Address: _____ _____ Phone#: _____ Email: _____	Notes:

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☐ **Transportation**	_____	☐ Agency bus/transportation service: _____ ☐ Available bus/train passes (given to client): _____ ☐ Public transportation options: _____ Other: _____ _____	Notes:
☐ **Substance Use/Treatment**	_____	Type of substance(s) used: _____ Frequency used: _____ Local alcohol or drug treatment program: _____ Appointment Date: ___/___/____	Notes:

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		Address: _____ _____ Counselor Name: _____ Phone #: _____ Email: _____	
☐ **Mental Health Services**	_____	Main symptom: _____ Local Mental Health Service Agency: _____ Appointment Date: ___/___/_____ Address: _____ _____	Notes:

Client Concerns & Essential Support Services for Persons Who Are High-Risk HIV-Negative (PWHRN): Checklist

		Counselor Name: _____ Phone #: _____ Email: _____	
☐ **Intimate Partner Violence (IPV) Assistance**	_____	Local Counseling Agency: _____ Appointment Date: ___/____/____ Address: _____ _____ Counselor Name: _____ Phone #: _____ Email: _____	Notes:

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☐ **Other Concerns (Please write: _____)**	_____	Local Service Agency: _____ Appointment Date: ___/___/_____ Address: _____ _____ Counselor/Contact Name: _____ Phone #: _____ Email: _____	Notes:

Next Client Meeting Date: _____/_____/_____

☐ Provided client with relevant health information resources

☐ Provided client with completed referral form(s)

A sample *Health and Support Services Referral Form* can be accessed here.