Client Concerns for People Living with HIV (PLWH): 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:** _____
☐ **Newly diagnosed PLWH (Date___/_____/_____)**
☐ **Previously diagnosed PLWH (Date/Time-frame___/___/_____)**

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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☐ **Enrolling in HIV Care and Treatment**	_____	☐ Literature provided for HIV transmission, diagnosis, risk reduction, treatment and care **Other Resources:** • _____ • _____ • _____ • _____	Notes:
☐ **Childcare**	_____	Childcare Arrangements: Agency or Person: _____ Address: _____ _____ Phone#: _____ Email: _____	Notes:

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☐ **Disclosure**	_____	Healthcare Agency: _____ Appointment Date: ___/___/_____ Address: _____ _____ Counselor Name: _____ Phone #: _____ Email: _____	Notes:

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☐ **Prevention**	_____	☐ Conduct educational session. Date: _____ ☐ Refer for Counseling and Education. Healthcare Agency: _____ Appointment Date: ___/___/_____ Address: _____ _____ Prevention Counselor Name: _____ Phone #: _____ Email: _____	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: _____ _____ STI/Viral Hepatitis Testing Referral Healthcare Agency: _____

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			Appointment Date: ___/___/_____ Address: _____ _____ Counselor Name: _____ Phone #: _____ Email: _____ PrEP Referral Healthcare Agency: _____ Appointment Date: ___/___/_____ Address: _____ _____ Counselor Name: _____ Phone #: _____ Email: _____

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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: _____ Phone #: _____ Email: _____

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☐ **Medication Adherence**	_____	Healthcare Agency: _____ Appointment Date: ___/____/____ Address: _____ _____ Adherence Counselor Name: _____ Phone #: _____ Email: _____	**Medication Adherence Tips for Providers:** https://effectiveinterventions.cdc.gov
☐ **Finding a Provider**	_____	List of hospitals, clinics, FQHC, or infectious disease doctors: • _____ • _____ • _____ • _____	Notes:

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		Name of preferred or available provider: _____ Appointment Date: ___/___/_____ Address: _____ _____ Contact Name: _____ Phone #: _____ Email: _____	
☐ **Housing Assistance**	_____	Housing Agency: _____ Appointment Date: ___/___/_____ Address: _____ _____ Housing Counselor Name: _____ Phone #: _____	Notes:

Client Concerns for People Living with HIV (PLWH): Checklist

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

Client Concerns for People Living with HIV (PLWH): Checklist

☐ **Employment Assistance**	_____	Employment Agency: _____ Appointment Date: ___/___/_____ Address: _____ _____ Contact Name: _____ Phone #: _____ Email: _____	Notes:
☐ **Substance Use/Treatment**	_____	Type of substance(s) used: _____ Frequency used: _____ Local alcohol or drug treatment program: _____ Appointment Date: ___/___/____ Address: _____	Notes:

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

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		Email: _____	
☐ **Intimate Partner Violence Assistance**	_____	Local Counseling Agency: _____ Appointment Date: ___/____/____ Address: _____ _____ Counselor Name: _____ Phone #: _____ Email: _____	Notes:
☐ **Transportation**	_____	☐ Agency bus/ transportation service: _____ ☐ Available bus/train passes (given to client): _____	Notes:

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		☐ Public transportation options: _____ Other: _____	
☐ **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.