# MDHHS-6002, HIV CASE MANAGEMENT BIOPSYCHOSOCIAL ASSESSMENT

Michigan Department of Health and Human Services (MDHHS)
(New 6-22)

## SECTION 1 – CLIENT INFORMATION

Full Legal Name | Preferred Name | Date of Birth

Sex assigned at birth
☐ Male ☐ Female
☐ Other

Current Gender
☐ Male ☐ Female ☐ Transgender
☐ Male to Female ☐ Female to Male ☐ Other
☐ Refuse to Report ☐ Unknown

Preferred Gender Pronouns

Ethnicity
☐ Hispanic ☐ Non-Hispanic

Race
☐ Black or African American ☐ White ☐ Asian ☐ Other
☐ Indian or Alaskan Native ☐ Native Hawaiian ☐ Pacific Islander

Street Address | City | State | Zip Code

Send mail to this address?
☐ Yes ☐ No

Confidential mail required?
☐ Yes ☐ No

Mailing Address (if different from above) | City | State | Zip Code

Send mail to this address?
☐ Yes ☐ No

Confidential mail required?
☐ Yes ☐ No

Home Phone Number
Leave a message? ☐ Yes ☐ No
Send text? ☐ Yes ☐ No
Confidential message? ☐ Yes ☐ No

Cell Phone Number
Leave a message? ☐ Yes ☐ No
Send text? ☐ Yes ☐ No
Confidential message? ☐ Yes ☐ No

Alternative Phone Number
Leave a message? ☐ Yes ☐ No
Send text? ☐ Yes ☐ No
Confidential message? ☐ Yes ☐ No

Email Address
Send email to this address? ☐ Yes ☐ No
Confidential message? ☐ Yes ☐ No

Marital Status
☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

## SECTION 2 – EMERGENCY CONTACT INFORMATION

See Release of Information form to view emergency contact information.

## SECTION 3 - TRANSPORTATION

How do you get to your healthcare appointments?

What barriers are there with transportation?

Do you have disabilities that impact your access to transportation?
☐ Yes ☐ No

If yes, what disability?

Comments

Needs Referral ☐ Yes ☐ No

## SECTION 4 – HOUSING

Describe your housing situation.

Type of Housing

☐ Stable ☐ Temporary ☐ Unstable

Housing

☐ Rental ☐ Own home ☐ Transitional living facility ☐ Living on streets ☐ Shelter
☐ Hospital ☐ Nursing home ☐ Living with others ☐ Living in car ☐ Prison/jail
☐ Other

Comments

## SECTION 5 – FINANCES AND BENEFITS

**Income**

Describe your income.

☐ See Intake Form

| **Monthly Income** | **Yes or No** | **Comments** |
|---|---|---|
| Employment/wages | ☐ Yes ☐ No | |
| Unemployment | ☐ Yes ☐ No | |
| Alimony/child support | ☐ Yes ☐ No | |
| Pension or retirement income | ☐ Yes ☐ No | |
| Social Security Retirement | ☐ Yes ☐ No | |
| Worker's compensation | ☐ Yes ☐ No | |
| Social Security Disability Income | ☐ Yes ☐ No | |
| Supplemental Security Income | ☐ Yes ☐ No | |
| FIP/TANF | ☐ Yes ☐ No | |
| State Disability Assistance | ☐ Yes ☐ No | |

Comments

**Insurance**

Describe your insurance.

☐ See Intake Form

If no insurance, have you applied? ☐ Yes ☐ No

If yes, which insurance?

**Benefit Type**

☐ Indian Health Services

☐ Medicaid

☐ Medicare

☐ Unspecified ☐ Part A ☐ Part B ☐ Part C ☐ Part D

☐ VA, Military, TRICARE

☐ Private Health Plan

☐ Healthy MI Plan

ADDITIONAL COVERAGE

☐ AIDS Drug Assistance Program

☐ Insurance Assistance Program

☐ Michigan Dental Program

See Release of Records for Provider Information

Does the client need assistance with health insurance? ☐ Yes ☐ No

If yes, explain

Comments

## SECTION 6 – MDHHS OFFICE

MDHHS Worker Name

MDHHS Worker Phone Number

MDHHS Office Address

City

State

Zip Code

Outstanding MDHHS Needs

## SECTION 7 – LEGAL

Do you need any legal assistance? ☐ Yes ☐ No

If yes, need referral? ☐ Yes ☐ No

If yes, explain

Comments

## SECTION 8 – CULTURAL/LINGUISTICS

What is your preferred language?

☐ Speak ☐ Read ☐ Write

☐ See Intake Form

Do you need a translator or interpreter? ☐ Yes ☐ No

Are you deaf or hard of hearing? ☐ Yes ☐ No

Do you need a sign interpreter? ☐ Yes ☐ No

Are you able to complete forms independently? ☐ Yes ☐ No

Do you prefer a medical provider of a particular gender? ☐ Yes ☐ No

Comments

## SECTION 9 – HEALTH AND MEDICAL CARE

**Medical Appointments**

Are you in medical care? ☐ Yes ☐ No If yes, complete the chart below.

If no, needs referral? ☐ Yes ☐ No

| Type of Provider | Name | Clinic Name/Address/ Phone Number | Last Appointment |
|---|---|---|---|
| Primary Care | | | |
| Infectious Disease | | | |
| Other: | | | |

Do you schedule your own appointments? ☐ Yes ☐ No

What are some reasons for missed appointments?

How do you keep track of medical visits, discussions about health, labs, etc.?

How is your relationship with your medical provider? (Identify barriers related to provider-client relationship, clinic practices and services, etc.)

Describe what you feel uncomfortable discussing with your medical provider.

Comments

**Health Status**

Date of HIV diagnosis

Mode of transmission/Risk Factors

- [ ] Male who has sex with male
- [ ] Injection drug use
- [ ] Hemophilia/Coagulation Disorder
- [ ] Heterosexual contact
- [ ] Perinatal
- [ ] Receipt of blood products, blood components or tissue
- [ ] Not Reported
- [ ] Not Identified

HIV Status

- [ ] HIV Positive, not AIDS
- [ ] HIV Positive, AIDS Status Unknown
- [ ] CDC Defined AIDS
- [ ] HIV Negative (Affected)
- [ ] HIV Indeterminate

Describe your health. (Discuss if health has improved/stayed same/declined; any significant changes in lab work; any concerns with health; if medications are working.)

| Viral Load | Date | CD4 count | Date |
|---|---|---|---|
| | | | |

**Women's Health**

| Are you pregnant? | Are you receiving prenatal care? | Are you currently breastfeeding? |
|---|---|---|
| ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

Comments

**Transgender Health**

Do you have any transgender health needs? ☐ Yes ☐ No

Comments

**Oral Health**

Describe your dental healthcare needs.

Needs Referral ☐ Yes ☐ No

Identified Barriers

Comments

**Vision Health**

Describe your vision healthcare needs.

Needs Referral ☐ Yes ☐ No

Identified Barriers

Comments

**Medication Adherence**

Describe how you take your medications.

Have you missed any doses in the last month and if so, why?

What will make it easier for you to take your medications when missing doses?

What side effects are you experiencing with your HIV medications?

If you are having side effects, what did your provider tell you about the side effects you're having?

How do you receive your medications?
☐ Pick up at pharmacy ☐ Delivery ☐ Other

Do you have difficulty filling/refilling your medications? ☐ Yes ☐ No

Where do you store your medications?

Do you believe your medications are stored safely? ☐ Yes ☐ No

Do you hide your medications from others? ☐ Yes ☐ No

How do you take your medications?
☐ Given by another person ☐ Self-administered ☐ Other

Name of Primary Pharmacy

Name of Secondary Pharmacy

Are you having trouble with any of the following?
☐ Understanding instructions for medications
☐ Not taking proper number of medications
☐ Taking medications prescribed for others
☐ Not taking medications on time

Comments

**HIV Medications**

| Name of Medication | Dose | Prescriber (if applicable) |
|---|---|---|
| | | |

| Name of Medication | Dose | Prescriber (if applicable) |
| --- | --- | --- |
| | | |
| | | |
| | | |

**Food and Nutrition**

Do you have access to food? ☐ Yes ☐ No

Needs Referral ☐ Yes ☐ No

Comments

**Activities of Daily Living**

Do you need assistance with daily living activities? ☐ Yes ☐ No

Needs Referral ☐ Yes ☐ No

Comments

**Mental Health/Substance Use**

Describe your current or history of mental health diagnoses or needs (depression, anxiety, bi-polar, etc.).

Needs Referral ☐ Yes ☐ No If needed, see assessment tool in the attachments (Stress questionnaire)

Describe your current or history of substance use (street drugs, prescription drugs, alcohol, etc.).

Needs Referral ☐ Yes ☐ No

Comments

**Tobacco Use**

Describe any current or history of tobacco product use (cigarettes, chewing tobacco, e-cigs, etc.).

Needs Referral ☐ Yes ☐ No

Comments

## SECTION 10 – HIV KNOWLEDGE AND HEALTH LITERACY

How much education have you received about HIV and transmission of HIV?

Based on the above information, rate the client's level of HIV knowledge.
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Do you need help with the following:

| | | |
|---|---|---|
| Figuring out the time to take medications? | ☐ Yes | ☐ No |
| Figuring out if you need to eat with medications? | ☐ Yes | ☐ No |
| Understanding your medical provider when he/she talks about your health? | ☐ Yes | ☐ No |
| Being able to effectively communicate your needs to your medical provider? | ☐ Yes | ☐ No |
| Being able to effectively negotiate your health? | ☐ Yes | ☐ No |
| Discussing your insurance with your clinic's billing office? | ☐ Yes | ☐ No |
| Discussing your benefits with your insurance plan? | ☐ Yes | ☐ No |
| Filling out your medical forms by yourself? | ☐ Yes | ☐ No |

Comments

## SECTION 11 – HIV PREVENTION AND RISK REDUCTION

Are you sexually active? ☐ Yes ☐ No

Describe how you practice safer sex.
☐ Condom ☐ Dental dam ☐ Saran Wrap ☐ Latex gloves ☐ Withdrawal ☐ U=U
☐ Other:

Do you have access to safe sex supplies? ☐ Yes ☐ No

Needs Referral ☐ Yes ☐ No

Are there times when you do not practice safe sex?

| | | |
|---|---|---|
| ☐ When I am sexually excited | ☐ When I feel angry or upset | ☐ When I am with a new partner |
| ☐ When I am the top | ☐ When I am the bottom | ☐ When I am drinking and/or high |
| ☐ When I feel bad about myself | ☐ Condoms don't feel good | ☐ When I am seeking drugs/money |
| ☐ When there's not much risk | ☐ When I am undetectable | ☐ When I am not expecting sex |
| ☐ When my partner pressures me not to use condoms | ☐ When my partner(s) are HIV-positive | ☐ Other: |

Comments

Describe what you know about the Michigan HIV disclosure law.

☐ is aware ☐ needs more information/information provided
☐ Other

Describe what you have heard about Undetectable equals Un-transmittable (U=U).

☐ is aware ☐ needs more information/information provided
☐ Other

Describe what you know about Pre-exposure Prophylaxis (PrEP).

☐ is aware ☐ needs more information/information provided
☐ Other

Are there any topics around sexual health or risk reduction you want to discuss or talk about?

Comments

## SECTION 12 – SOCIAL SUPPORT AND SPIRITUALITY

Select who or what in your life is your support system

☐ None ☐ Family ☐ Friends ☐ Religious group
☐ Support group ☐ Neighbors ☐ Social Media ☐ Other:

Needs Referral ☐ Yes ☐ No

Do you want to disclose your HIV status to any one and you are having difficulty?

☐ Yes ☐ No If yes, describe

Needs Referral ☐ Yes ☐ No

Do you feel unsafe in any current relationship or place of residence?

☐ Yes ☐ No If yes, describe

Needs Referral ☐ Yes ☐ No

Describe any cultural beliefs you think need to be shared.

Comments

## SECTION 13 – SUMMARIES

Summary of Client Needs (per client)

Summary of Client Needs (per case manager)

## SECTION 14 – SIGNATURES

| Case Manager Name | Case Manager Signature | Date |
|---|---|---|
| | | |

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person’s eligibility.