DOHMH FORM# THCC 05-11-09

STANDARDIZED NYC JAIL INTAKE /ASSESSMENT

Interview Date: __ __/__ __/__ __ __ __ Interviewer's Full Name: * Interviewer's Work Title:	Program Performing Intake: Current Facility: Housing Area:	**Notes:**

DEMOGRAPHICS

Last Name:	Gender: ☐ Male ☐ Female ☐ Transgender Female ☐ Transgender Male
First Name:	Date of Birth: __ __/__/__ __ __ __
Middle Name/Initial:	Age:
Alias/AKA:	Country of Birth:
Book and Case Number:	Citizenship Status: ☐ Citizen ☐ Permanent Resident ☐ Non-citizen ☐ Visa/Permit
NYSID:	Attorney: (name) ( ) -
Client Assigned to Site:	Social Security Number: __ __ __/ __ __/ __ __ __ __ If no SS# is provided indicate reason below: ☐ SS# not assigned ☐ # unknown
Date of Admission: __ __/__ __/__ __ __ __	
Date of Release: __ __/__ __/__ __ __ __	
Next Court Date: __ __/__ __/__ __ __ __	

Ethnicity: ☐ Hispanic/Spanish ☐ Latino(a) ☐ Non-Hispanic / Spanish ☐ Other Ethnicity _____

Race: ☐ African American/Black ☐ Hispanic ☐ Asian ☐ Caucasian ☐ Other Race _____

Language: ☐ English ☐ Spanish ☐ French ☐ Haitian ☐ American Sign Language ☐ Other (specify) _____

How can we reach you in the community?

Location: _____ Phone #: _____

Emergency Contact Person: _____
Contact Information: _____
_____

REFERRAL SOURCE

1. Sources: ☐ Physician ☐ Jail Event ☐ Other

INCOME

1. What was your annual income prior to incarceration? $__ __ __, __ __ __.__ __
2. Will you continue to receive this income when you are released from this City jail?
   ☐ Yes
   ☐ No → Why?

MARITAL STATUS/HOUSEHOLD SIZE

1. What is your marital status?
   - ☐ Single, Never married
   - ☐ Divorced
   - ☐ Widowed
   - ☐ Separated
   - ☐ Married. If married, is this your ☐ first marriage or are you ☐ remarried?
   - ☐ In a committed relationship but not living together
   - ☐ In a committed relationship and living together

2. What is your total household size?

_____

3. Do you have any children?
   - ☐ No
   - ☐ Yes → Where are they now?

PRIMARY CARE PROVIDER / DOCTOR

1. Do you have a primary care provider/doctor? ☐ Yes ☐ No

2. What was the date of your last visit to your primary care provider/doctor? __ __/__/__ __ __ __

3. If you were released tomorrow where would you follow up for medical care?
   - ☐ Hospital ☐ Emergency Room (ER)
   - ☐ Clinic ☐ Community Health Center
   - ☐ Private Doctor's Office ☐ Other, Specify:

4. If known, what is your doctor's address?

Address: _____ Apt. #/Floor #:_____

City:_____ State:_____ Zip Code_____

Phone #: (__ __ __) __ __ __-__ __ __ __

MEDICAL HISTORY

Part I: Review the client's medical chart and prepare aftercare letter.

ALERT: Obtain and review the inmate's/ client's pharmacy report prior to completing this section

Part II: After reviewing the client's medical chart and if the client is taking medication determine if the client has already picked it up.

Did you pick up your medication? ☐ Yes ☐ No

HIV STATUS/RISK ASSESSMENT

1. Do you know your HIV Status? ☐ Yes ☐ No

2. Where were you first diagnosed with HIV? Date:

3. What is your HIV Status?

Adults: ☐ HIV-Positive, Not AIDS ☐ HIV-Positive, AIDS Status Unknown
☐ HIV-Negative, At Risk, Not Affected ☐ HIV-Negative, Affected
☐ Unknown, Unreported AIDS Diagnosis

Pediatrics: ☐ HIV-Infected (Pediatric) ☐ HIV-Vertical (Perinatal) Exposure ☐ HIV-Negative, Affected

4. Is your current partner living with HIV/AIDS? ☐ Yes ☐ No ☐ Don't know ☐ Not Applicable (no partner)

5. How do you believe you contracted HIV?

Interviewer, please check off the appropriate box that best reflects the given explanation.

☐ Unprotected sex with a female ☐ Unprotected sex with a male ☐ Injection Drug Use ☐ Unknown
☐ Sex work (prostitution) ☐ Exchanged sex for drugs or money ☐ Needle sharing ☐ Other/Not determined
☐ Transfusion / Blood products ☐ Perinatal / Vertical ☐ Sexual Abuse/Assault ☐ Occupational Exposure

HIV Status/Risk Assessment (continued)

6. If you have one main sex partner, who you are committed to above anyone else, think about when you have had vaginal or anal sex with this person. Do you and this partner use a condom:

(when having vaginal sex):
□ every time □ most of the time □ none of the time
□ Don't know/Don't remember

(when having anal sex):
□ every time □ most of the time □ none of the time
□ Don't know/Don't remember

7. If you have more than one sex partner, think about when you have had vaginal or anal sex with these partners. Do you and these partners use a condom:

(when having vaginal sex):
□ every time □ most of the time □ none of the time
□ Don't know/Don't remember

(when having anal sex):
□ every time □ most of the time □ none of the time
□ Don't know/Don't remember

TREATMENT ADHERENCE

Inmates/Clients on Medication ONLY

If you are currently on medication for HIV infection/AIDS do you:

1. Take your medication exactly as prescribed?	□ Yes □ No
2. Rarely or never take medication as prescribed?	□ Yes □ No
3. Take medication as prescribed most of the time?	□ Yes □ No
4. Sometimes take medication as prescribed?	□ Yes □ No
5. Refuse to take medication?	□ Yes □ No
6. Feel sicker after taking the medication?	□ Yes □ No

SUBSTANCE ABUSE HISTORY

1. Have you ever used drugs?
□ No □ Yes: If yes, when was the last time used? □ Refused to answer

2. Have you ever received any alcohol or drug treatment including support groups? □ Yes □ No
If Yes, how many times in your life have you been treated for… Drug Abuse _____ Alcohol Abuse_____
How many of these were detox only… Drugs _____ Alcohol _____

3. Have you ever injected any drugs or hormones, even once?
□ No □ Yes: If yes, when was the last time used?_____ □ If yes, how often do you use?_____

4. Have you ever shared the same needles, syringes or works, including cotton, cooker or rinse water?
□ No □ Yes: If yes, when was the last time used? How many people? _____

PARTNER ELICITATION FOR HIV-POSITIVE INMATES/CLIENTS

1. What is Partner Notification? Partner Notification is a process for letting sexual and needle-sharing partners of HIV infected persons know they may have been exposed to HIV.

2. How is Partner Notification different from HIV reporting?
Doctors and laboratories are required to report to the State Dept. of Health all cases of HIV infection and illness.

3. Why is Partner notification important?
It helps people who have been exposed to HIV learn about their risk so they can get tested. If they test positive, they can learn about treatment that may help them live longer, healthier lives and learn about ways to prevent transmission of the virus. If they test negative, they can learn how to stay that way.

4. What are my Partner notification Options?
• You can tell your partners yourself.
• We can contact the CNAP office and they can notify your partners for you.
• You can contact CNAP directly and they can help you notify your partners or do it for you.
The second two options can be completely anonymous. Your partners do not need to know that you were the person who may have exposed them to the virus.

HOUSING STATUS

1. What was your address immediately before coming to this City jail?
   Address: _____ Apt. #: _____
   City: _____ State: _____ Zip Code: __ __ __ __ __
   Telephone Number: (__ __ __) __ __ __ - __ __ __ __ ☐ N/A, Client hasn't been living at any one location

2. What kind of place was this?
   ☐ The streets (homeless)
   ☐ Family/friends' place (homeless)
   ☐ Homeless shelter
   ☐ Residential treatment program
   ☐ Emergency housing
   ☐ Transitional housing
   ☐ Temporarily staying with family/friend (not homeless)
   ☐ Nursing home/hospice
   ☐ Permanent supportive housing
   ☐ Client's own permanent housing (rent)
   ☐ Client's own permanent housing (own)
   ☐ Other (specify):_____

3. Are you planning to return to this address after leaving City jail?
   ☐ Yes ☐ No → If not, where will you be ☐ Refuse to answer/ Do not know

4. What is your permanent mailing address? ☐ Same as above address ☐ Different (Specify Below)
   Address: _____ Apt. #: _____
   City: _____ State: _____ Zip Code: __ __ __ __ __
   Telephone Number: (__ __ __) __ __ __ - __ __ __ __

Support Services/ Entitlements

1. Of the benefits I will mention to you, what have you received in the past?

Indicate when you last received (circle one):	(a) 30 days or less	(b) 30+ days	(c) Don't Know	(d)Refused
☐ Cash assistance $_____	a	b	c	d
☐ S.S.I. Disability $_____	a	b	c	d
☐ Veteran's Benefits $_____	a	b	c	d
☐ Food stamps $_____	a	b	c	d
☐ Unemployment $_____	a	b	c	d
☐ Other (specify)_____$_____	a	b	c	d
☐ None of the Above				

2. Do you have any of the following health insurance?
   ☐Medicaid ID#_____ Exp. Date: _ _ /_ _ / _ _ _ _
   ☐ADAP ID#_____ Exp. Date: _ _ /_ _ / _ _ _ _
   ☐Private Insurance _____ Exp. Date: _ _ /_ _ / _ _ _ _
   ☐Other, Specify: _____ ☐None

3. Were you receiving HASA (HIV/AIDS Services Administration) benefits prior to coming to this city jail?
   ☐No ☐ Refused to answer/ Do not know
   ☐ Yes → Where? (Borough/Center) _____
   If known, what is your HASA number? _____
   What HASA Services did you receive? ☐ Cash Assistance ☐ Food Stamps ☐ Housing ☐
   Other:_____

Court Advocacy

Did the client receive Court Advocacy? ☐ Yes ☐ No

If yes, check all that apply:

- ☐ DOHMH Court Advocacy (CAP)
- ☐ The Fortune Society Court Advocacy – Alternatives to Incarceration Program (ATI)
- ☐ TASC
- ☐ Compassionate Release Letter Provided by CHS Medical
- ☐ Other, please specify _____

NYSID _____

CONSENT FORM TO INITIATE INTERVIEW

1. I agree to take part in this intake interview process.
2. I agree to have my interviewer obtain my medical chart for prior review.

Date: __ __/__ __/__ __ __ __
Client's Printed Name:
Client's Signature:

CONSENT FORM TO PROCEED AFTER INTERVIEW

1. I certify that all the information I have provided is complete and accurate to the best of my knowledge.

2. I grant my interviewer permission to review any medical and non-medical documentation needed to determine the appropriate intervention plan for me.

3. I authorize the individual who interviewed me to proceed with making the appropriate referrals to assist me.

Date: __ __/__ __/__ __ __ __
Client's Printed Name:

Client's Signature:

☐ I have been provided with a copy of the grievance policy and procedures upon intake/admission to jail.

NYSID _____	Did the client receive Court Advocacy? ☐ Yes ☐ No

ACTION PLAN

Instructions to Interviewer: Check the appropriate boxes below based on above assessment. List all presenting problems, indicate each intervention and make the appropriate referrals, following up to report outcome of each. Check all that apply:

☐ **Primary Care** ☐ **HIV (+) Medical Care/Treatment** ☐ **Treatment Adherence** ☐ **Court Advocacy (ie SPNS)**
☐ **Alternative to Incarceration (ATI) Program (ie Fortune, WPA)** ☐ **Court Mandated Program**
☐ **Alcohol/Substance Abuse Tx** ☐ **Mental Health Treatment** ☐ **HIV+ Health Education**
☐ **Housing Assistance** ☐ **Social Services/Entitlements** ☐ **Partner Notification** ☐ **Health Insurance**

Presenting Problem: **Date: __ __/ __ __/ __ __ __ __**

Intervention: **Date: __ __/ __ __/ __ __ __ __**

Outcome: **Date: __ __/ __ __/ __ __ __ __**

Presenting Problem: **Date: __ __/ __ __/ __ __ __ __**

Intervention: **Date: __ __/ __ __/ __ __ __ __**

Outcome: **Date: __ __/ __ __/ __ __ __ __**

Copy this sheet as needed to complete assessment / service plan summary

TRACKING SHEET

Initial Assessment Completed by:

Interviewer's Name: _____

Signature: _____

Title: _____

Telephone: (__ __ __) __ __ __- __ __ __ __

Email: _____@_____

Date: _____

Supervisor Name: _____

Supervisor Signature: _____

Date: _____

Transitional Service Plan Completed by:

Interviewer's Name: _____

Signature: _____

Title: _____

Telephone: (__ __ __) __ __ __- __ __ __ __

Email: _____@_____

Date: _____

Supervisor Name: _____

Supervisor Signature: _____

Date: _____

Post-release Follow-up Completed by:

Interviewer's Name: _____

Signature: _____

Title: _____

Telephone: (__ __ __) __ __ __- __ __ __ __

Email: _____@_____

Date: _____

Supervisor Name: _____

Supervisor Signature: _____

Date: _____

Final Outcome Recorded by:

Interviewer's Name: _____

Signature: _____

Title: _____

Telephone: (__ __ __) __ __ __- __ __ __ __

Email: _____@_____

Date: _____

Supervisor Name: _____

Supervisor Signature: _____

Date: _____

SERVICES DOCUMENTATION / ACTIVITY RECORD

Instructions to Interviewer: Check all services provided and record all activities. Attach additional sheets as needed.

Worker Name: ______________________________

Client Name: ______________________________

Office of Health Education
☐ Patient Care Coordination
☐ Chronic Care Transitions
☐ Community Action for Prenatal Care

Correction-Community Linkage
☐ Bronx/Manhattan
☐ Brooklyn/Queens/Staten Island
☐ Home Visit Team

Services Provided (Check all that apply)

☐ Registration

☐ Initial Assessment completed __/__/____
☐ Consent form signed __/__/____
☐ After Care letter prepared __/__/____
☐ M11Q prepared __/__/____
☐ Walking medications / prescriptions ordered
☐ PRI requested __/__/____
☐ HASA application started __/__/____ Date sent
☐ ADAP application started __/__/____ Date sent
☐ Medicaid application started __/__/____ Date sent
☐ Birth Certificate requested __/__/____ Date sent

☐ SPNS Enhance Link Survey

☐ Baseline Interview completed __/__/____
☐ 6-Month Follow Up Interview completed __/__/____

☐ Care Coordination

☐ Court Advocacy ☐ Alternative To Incarceration program ☐ Reduced sentence

☐ Referred to RITC partner for Discharge Planning __/__/____ ☐ SPNS 6 mo. Follow-up Survey
☐ Palladia ☐ The Fortune Society ☐ Exponents ☐ WPA ☐ Other ____________

☐ Collateral contact(s) with other than RITC Partner to coordinate care /services

____________________ ____________________ __/__/____
Organization (Legal Aid, Attorney, Doctor, etc) Person contacted Date

____________________ ____________________ __/__/____
Organization (Legal Aid, Attorney, Doctor, etc) Person contacted Date

☐ Discharge Plan

☐ Resource(s) identified __/__/____
☐ Post-release referral(s) provided / appointment(s) made (list below) ☐ SPNS Baseline Survey

____________________ : __/__/____ __/__/____
Organization Name Person contacted Contact info Appointment date Date kept
Service Type : ☐ Primary Care ☐ Treatment ☐ Housing ☐ Social Services ☐ Other_________

____________________ : __/__/____ __/__/____
Organization Name Person contacted Contact info Appointment date Date kept
Service Type : ☐ Primary Care ☐ Treatment ☐ Housing ☐ Social Services ☐ Other_________

____________________ : __/__/____ __/__/____
Organization Name Person contacted Contact info Appointment date Date kept
Service Type : ☐ Primary Care ☐ Treatment ☐ Housing ☐ Social Services ☐ Other_________

____________________ : __/__/____ __/__/____
Organization Name Person contacted Contact info Appointment date Date kept
Service Type : ☐ Primary Care ☐ Treatment ☐ Housing ☐ Social Services ☐ Other_________

____________________ : __/__/____ __/__/____
Organization Name Person contacted Contact info Appointment date Date kept
Service Type : ☐ Primary Care ☐ Treatment ☐ Housing ☐ Social Services ☐ Other_________

☐ Escort / Transport

From __________ To __________ By: ☐ DOC escort ☐ The Fortune Society
Date: __/__/____ ☐ Case Manager ☐ CCLP ☐ Other __________

☐ Post-release connection to primary care confirmed/ documented __/__/____