

HOPWA PROGRAM REGISTRATION FORM

(Please Print)

Today's date (MM/DD/YYYY): / /	Agency ID:	eCOMPAS ID:		
GENERAL INFORMATION				
Last Name:		First:	Middle:	Date of birth (MM/DD/YYYY): / /
Last Name at Birth (if different from above):		Social Security number: - -	Gender at birth: <input type="checkbox"/> M <input type="checkbox"/> F	Transgender? <input type="checkbox"/> Yes <input type="checkbox"/> No
Current Address				
Street address:		City:	Zip Code:	
Permanent Mailing Address				
Street address:		City:	Zip Code:	
Primary phone number: ()		Alternate phone number: ()		
Emergency contact information				
Name:		Relationship to client:	Home phone no.: ()	Alternate phone no.: ()
Race/Ethnicity (select all that apply): <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other		Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employment Status: <input type="checkbox"/> Employed or self-employed <input type="checkbox"/> Homemaker / Student / Retired <input type="checkbox"/> Intermittently employed <input type="checkbox"/> Unemployed for > 1 year	Education: <input type="checkbox"/> Less than high school <input type="checkbox"/> Some high school <input type="checkbox"/> High school diploma or GED <input type="checkbox"/> Some college or technical school <input type="checkbox"/> College graduate
Native Language (select only one): <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> Haitian Creole <input type="checkbox"/> Other (specify): _____		Country of birth: <input type="checkbox"/> USA <input type="checkbox"/> Other (specify): _____		
Veteran of the armed forces?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Domestic violence survivor?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown or refused		
Institutionalized at present or more than 15 days in the past 3 months?				
<input type="checkbox"/> Not institutionalized at present or more than 15 days during the past 3 months				
<input type="checkbox"/> Prison, jail, or juvenile detention facility		<input type="checkbox"/> Substance Abuse Treatment Facility		
<input type="checkbox"/> Psychiatric Hospital		<input type="checkbox"/> Hospital (excluding psychiatric)		

HOUSING INFORMATION			
Number of persons in household:	Gross household monthly income (<i>Estimated</i>): \$	Adjusted monthly household income (<i>Verified</i>): \$	
Currently enrolled in the HIV/AIDS Services Administration (HASA) program? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown or refused			
Current housing status (<i>select one</i>): <input type="checkbox"/> Homeless – in shelter <input type="checkbox"/> Homeless – on street <input type="checkbox"/> In foster home <input type="checkbox"/> In jail or otherwise institutionalized at the time of intake <input type="checkbox"/> Lives with family/friends <input type="checkbox"/> Owns home <input type="checkbox"/> Rented room, apartment, or house <input type="checkbox"/> None of the above or refused		Housing type (<i>select one</i>): <input type="checkbox"/> Congregate housing <input type="checkbox"/> HIV subsidized housing <input type="checkbox"/> Hotel or motel (not Single Room Occupancy hotel) <input type="checkbox"/> Independent living <input type="checkbox"/> Other subsidized housing <input type="checkbox"/> Scattered site supportive <input type="checkbox"/> SRO (Commercial Single Room Occupancy hotel) <input type="checkbox"/> Transitional housing (other than Single Room Occupancy hotel) <input type="checkbox"/> None of these choices or refused	
Ever homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown or refused	Homeless in the past 3 years? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown or refused	Number of episodes (past 3 years):	Homeless for the entire past year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown or refused
Reason for seeking housing (<i>select one</i>): <input type="checkbox"/> Cost <input type="checkbox"/> Eviction or pending eviction <input type="checkbox"/> Health and safety concerns / Hazards <input type="checkbox"/> Irresolvable conflict with others in household			<input type="checkbox"/> Doubled-up in the unit <input type="checkbox"/> Expanding household (e.g. newborn) <input type="checkbox"/> Space / configuration (e.g. too small) <input type="checkbox"/> Other (<i>specify</i>): _____
			Housing plan in place and on file? <input type="checkbox"/> Yes <input type="checkbox"/> No

HOUSEHOLD INFORMATION			
Collateral Name	Phone number/contact information:	Intake completed?	eCOMPAS ID
1.		<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.		<input type="checkbox"/> Yes <input type="checkbox"/> No	
3.		<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.		<input type="checkbox"/> Yes <input type="checkbox"/> No	
5.		<input type="checkbox"/> Yes <input type="checkbox"/> No	
6.		<input type="checkbox"/> Yes <input type="checkbox"/> No	

To enter additional collaterals, use additional blank copies of this page and attach them to the file.

MEDICAL INFORMATION

Health Insurance Status (*check all that apply*):

- Medicaid Medicaid number: _____
 Medicare Medicare number: _____
 ADAP/ADAP+ ADAP/ADAP+ number: _____
 Private
 Uninsured
 Other (specify): _____

HIV Status: Unknown HIV Negative Date of last negative test (MM/YYYY): /

If HIV Negative or Unknown, skip to pregnancy status. HIV Positive Date of first positive HIV test (MM/YYYY): /

Are you: Asymptomatic Symptomatic

AIDS diagnosis: Yes No AIDS diagnosis date (MM/YYYY): /

Client has HIV primary care provider? Yes No

Hospital/Clinic/Office name:	HIV primary care provider last name:	Date of last visit: (MM/YYYY):
		/

Client has a case manager with an HIV/AIDS program? Yes No

Agency name:	Case manager last name:	Date of last visit (MM/YYYY):
		/

CD4 Count		
Most recent CD4 count:	Date (MM/YYYY):	<input type="checkbox"/> Unknown
	/	

Viral Load		
Most recent viral load:	Date (MM/YYYY):	<input type="checkbox"/> Undetectable <input type="checkbox"/> Unknown
	/	

Client on HIV antiretroviral therapy? Yes No

Hospitalizations in the past six months: None

Date (MM/YYYY):	Diagnosis:
1. /	
2. /	
3. /	

Emergency Department / Emergency Room visits in the past six months: None

Date (MM/YYYY):	Diagnosis:
1. /	
2. /	
3. /	

Client pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (Male)	In prenatal care? <input type="checkbox"/> Yes <input type="checkbox"/> No
Due date (MM/DD/YYYY): / /	Prenatal care provider aware of HIV status? <input type="checkbox"/> Yes <input type="checkbox"/> No

- | | |
|---|---|
| Ever diagnosed with mental illness? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/refused |
| Ever hospitalized for psychiatric reasons? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/refused |
| Ever prescribed psychotropic medication? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/refused |
| Ever abuse alcohol and/or drugs? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/refused |
| Ever injected drugs (recreationally/IDU)? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/refused |
| Ever admitted into an inpatient treatment program (e.g., detox, rehab, etc.) for alcohol or drug use? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/refused |
| Ever attended an outpatient alcohol or drug treatment program? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/refused |

