CAREWare MA Form

June 2020 v1.6

Use this form to record client information for data entry into CAREWare MA.

Patient Name/ ID _____ / _____

CONTACT INFORMATION

First: Middle: Last:

(Record the client's full legal name - do not use nicknames. Do not use punctuation (apostrophes or hyphens) in CAREWare.)

Client ID: Date of Birth: M M / D D / Y Y Y Y Est? ❑

(Optional: enter local site ID, if using.) *(If month and/or day are unknown, enter 01.)*

Street Address:

City: State: M A ZIP:

County: Phone Number: ( ) -

(Address and phone number are optional in CAREWare.)

DEMOGRAPHIC INFORMATION

Gender:

- ❑ Male
- ❑ Female
- ❑ Transgender Unknown
- ❑ Transgender Male-to-Female
- ❑ Transgender Female-to-Male
- ❑ Refused to report
- ❑ Unknown

Sex at Birth:

- ❑ Male
- ❑ Female

Ethnicity:

- ❑ Hispanic or Latino/a
- ❑ Not Hispanic or Latino/a

(If Hispanic) Hispanic Subgroup *(check all that apply):*

- ❑ Mexican, Mexican American, Chicano/a
- ❑ Puerto Rican
- ❑ Cuban
- ❑ Another Hispanic, Latino/a or Spanish origin

Race *(check all that apply):*

- ❑ White
- ❑ Black or African American
- ❑ Asian
- ❑ American Indian or Alaska Native
- ❑ Native Hawaiian or Other Pacific Islander

(If Asian) Asian Subgroup *(check all that apply):*

- ❑ Asian Indian
- ❑ Chinese
- ❑ Filipino
- ❑ Japanese
- ❑ Korean
- ❑ Vietnamese
- ❑ Other Asian

(If NH/PI): Pacific Subgroup *(check all that apply):*

- ❑ Native Hawaiian
- ❑ Guamanian or Chamorro
- ❑ Samoan
- ❑ Other Pacific Islander

ENROLLMENT INFORMATION

Enrollment Status:

- ❑ Active
- ❑ Referred or Discharged
- ❑ Removed
- ❑ Incarcerated
- ❑ Relocated

→ Case Closed Date: M M / D D / Y Y Y Y

Enrollment Date: M M / D D / Y Y Y Y

Date the client first received HIV services at your agency.

Vital Status:

- ❑ Alive
- ❑ Deceased
- ❑ Unknown

→ Date of Death: M

Ryan White HIV/AIDS Program Eligibility:

- ❑ Yes, eligible
- ❑ No, not eligible

Date updated: M M / D D / Y Y Y Y

Patient Name/ ID _____ / _____

HIV INFORMATION

HIV Status:

- ❑ HIV-positive (not AIDS)
- ❑ HIV-positive (AIDS status unknown)
- ❑ CDC defined AIDS
- ❑ HIV-negative (affected)
- ❑ HIV-indeterminate

HIV Positive Date: Est?❑ M M / D D / Y Y Y Y

AIDS Diagnosis Date: Est?❑ M M / D D / Y Y Y Y

HIV Risk Factors *(check all that apply):*
Select the risk factors at the time of diagnosis:

- ❑ Men who have sex with men (MSM)
- ❑ Injection drug use (IDU)
- ❑ Hemophilia/coagulation disorder
- ❑ Heterosexual contact
- ❑ Perinatal transmission
- ❑ Receipt of transfusion of blood, blood components, or tissue
- ❑ Not reported or identified

ANNUAL REVIEW INFORMATION (update this section every 6 mos.)

Primary Insurance *(select only one)*:

- ❑ Medicaid
- ❑ Medicare (unspecified)
- ❑ Medicare Part A/B
- ❑ Medicare Part D
- ❑ Private - Employer
- ❑ Private - Individual
- ❑ VA, Tricare and other military health care
- ❑ Indian Health Service (IHS)
- ❑ No Insurance
- ❑ Other

Date updated: M M / D D / Y Y Y Y

Other Insurance *(check all that apply):*

- ❑ Medicaid
- ❑ Medicare (Part unspecified)
- ❑ Medicare Part A/B
- ❑ Medicare Part D → ❑ Full Low Income Subsidy
- ❑ Private - Employer
- ❑ Private - Individual
- ❑ VA, Tricare and other military health care
- ❑ Indian Health Service (IHS)
- ❑ No Insurance
- ❑ Other, specify: _____

Individual Income (yearly): $_____

Household Income (yearly): $ _____

Household Size (including self): _____ people

Date updated: M M / D D / Y Y Y Y

Housing Arrangement:

- ❑ Stable/Permanent
- ❑ Temporary
- ❑ Unstable
- ❑ Other

Date updated: M M / D D / Y Y Y Y

HIV Risk Reduction Counseling *(MCM & MassCARE only (optional))*:

- ❑ Yes
- ❑ No

(If yes) Counseled By:

- ❑ Case manager/social worker
- ❑ Other trained counselor
- ❑ Primary care clinician
- ❑ Unknown

Date updated: M M / D D / Y Y Y Y

Mental Health Screening *(MCM & MassCARE only) (optional)*:

- ❑ Yes
- ❑ No
- ❑ Not medically indicated

Date updated: M M / D D / Y Y Y Y

Substance Use Screening *(MCM & MassCARE only) (optional)*:

- ❑ Yes
- ❑ No
- ❑ Not medically indicated

Date updated: M M / D D / Y Y Y Y

Patient Name/ ID _____ / _____

SCREENING LABS (HIV Positive clients only)

	Date (mm/dd/yyyy)	Result:	Titer:	Treatment
Chlamydia		❑Intermediate ❑Positive ❑Negative ❑Presumptive ❑NMI ❑Unknown		❑Yes ❑Unknown ❑No ❑N/A
Gonorrhea		❑Intermediate ❑Positive ❑Negative ❑Presumptive ❑NMI ❑Unknown		❑Yes ❑Unknown ❑No ❑N/A
Syphilis		❑Intermediate ❑Positive ❑Negative ❑Presumptive ❑NMI ❑Unknown		❑Yes ❑Unknown ❑No ❑N/A
HCV(RNA)		❑Intermediate ❑Positive ❑Negative ❑Presumptive ❑NMI ❑Unknown	n/a	❑Yes ❑Unknown ❑No ❑N/A
Hepatitis C antibody		❑Intermediate ❑Positive ❑Negative ❑Presumptive ❑NMI ❑Unknown	n/a	❑Yes ❑Unknown ❑No ❑N/A
IGRA		❑Intermediate ❑Positive ❑Negative ❑Presumptive ❑NMI ❑Unknown	n/a	❑Yes ❑Unknown ❑No ❑N/A
Rectal Pap Smear		❑Intermediate ❑Positive ❑Negative ❑Presumptive ❑NMI ❑Unknown		❑Yes ❑Unknown ❑No ❑N/A
TB Chest Radiograph		❑Intermediate ❑Positive ❑Negative ❑Presumptive ❑NMI ❑Unknown		❑Yes ❑Unknown ❑No ❑N/A
TST		❑Intermediate ❑Positive ❑Negative ❑Presumptive ❑NMI ❑Unknown		❑Yes ❑Unknown ❑No ❑N/A

Use extra pages as needed to document additional results

LAB DATA (MCM only)

	Date *(mm/dd/yyyy):*	**Result:**
CD4 Count		
Viral Load		

Patient Name/ ID _____ / _____

SCREENINGS

	Date *(mm/dd/yyyy)*	Current Result	Current Score
Pap Smear		❑ AGCUS ❑ Appointment not kept ❑ ASCUC ❑ HSIL/CIN-2 ❑ HSIL/Cin-3 ❑ HSIL/CIS	❑ Invasive ❑ LSIL/CIN-1 ❑ Normal ❑ Not medically indicated ❑ Other, abnormal ❑ Unknown
Pelvic Exam		❑ N/A ❑ NMI ❑ No ❑ Unknown/unreported ❑ Yes	

Use extra pages as needed to document additional results

CUSTOM FIELDS

Case Manager Name: _____

Next Acuity Assessment (optional):

M M / D D / Y Y Y Y

MASSCARE

Country of Birth
- ❑ United States
- ❑ United states Dependencies (including Puerto Rico)
- ❑ Other

Primary Language
- ❑ American Sign-Language
- ❑ Crioulo
- ❑ English
- ❑ French
- ❑ Haitian Creole
- ❑ Portuguese
- ❑ S.E. Asian Language
- ❑ Spanish
- ❑ Other (specify): _____

Are other family members enrolled in MASSCare?
- ❑ Yes
- ❑ No

Is the client a mother?
- ❑ Yes
- ❑ No

❑

Employment status
- ❑ Full time
- ❑ N/A, under age of 16
- ❑ No/Unemployed

Primary Caregiver
- ❑ Adoptive/Step parent(s)
- ❑ Adult friend (not foster)
- ❑ Adult relation (not foster)
- ❑ Both Parents
- ❑ Father
- ❑ Grandparent
- ❑ Kinship foster parent
- ❑ Mother
- ❑ Non-kinship foster parent
- ❑ Other (specify)
- ❑ Professional Caregiver
- ❑ Refused/Unknown
- ❑ Self
- ❑ Sibling
- ❑ Spouse/Partner

Patient Name/ ID _____ / _____

Educational Status

- ❑ Completed vocational program
- ❑ Dropped out of HS or less
- ❑ Graduated College
- ❑ In a vocational program
- ❑ In college
- ❑ In K-12
- ❑ N/A, Infant
- ❑ Obtained HS diploma/GED
- ❑ Unknown

PREGNANCY

Estimated Conception Date: M M / D D / Y Y Y Y

Prenatal Begin Date: M M / D D / Y Y Y Y

Number of Prenatal Visits: _____

Pregnancy Outcome *(select only one)*:

- ❑ Live Birth
- ❑ Therapeutic (induced) abortion
- ❑ Spontaneous abortion (miscarriage)
- ❑ Stillbirth
- ❑ Unknown

Delivery/Outcome Date: M M / D D / Y Y Y Y

HIV Status of Newborn *(if "Live Birth")*

- ❑ Negative
- ❑ Positive
- ❑ Indeterminate
- ❑ Unknown/Unreported

ART Counseling?

- ❑ No
- ❑ Yes
- ❑ Unknown

ART Offered?

- ❑ No
- ❑ Yes
- ❑ Unknown

ART Taken

- ❑ No
- ❑ Yes
- ❑ Unknown

ART Date: M M / D D / Y Y Y Y

Patient Name/ ID _____ / _____

SERVICE INFORMATION

See Subservice Definitions document for details: http://carewarema.jsi.com/materials/ Continue on another page or capture separately, if needed

Service	Date	Units	Date	Unit	Date	Unit
MEDICAL CASE MANAGEMENT						
Intake/initial assessment						
Initial acuity assessment						
MCM acuity reassessment						
ISP/Care Plan						
In-person session						
Telehealth session						
Client communication (not in person)						
Linkage to medical care						
Linkage to health insurance						
Communication with medical provider						
Transition to adult care planning						
Transition to adult care						

Service Date: ___ / ___ / _____ *Print new pages for each new date.*

SERVICE INFORMATION –LINKAGE TO MEDICAL CARE

For "Linkage to medical care" subservice:

Linkage type:

- ❑ Substance HIV
- ❑ HCV
- ❑ STI screening
- ❑ Non-HIV related

Confirmation of linkage date: M M / D D / Y Y Y Y

Linkage status:

- ❑ Open
- ❑ Closed
- ❑ Lost to Follow-Up (60 Days)

MASSACHUSETTS careware

Patient Name/ ID _____ / _____

Service	Date	Units	Date	Unit	Date	Unit
MEDICAL TRANSPORTATION SERVICES						
Taxi/Transportation						
Mileage reimbursement						
Public transportation ride						
Public transportation pass						
PSYCHOSOCIAL SUPPORT						
Individual-Level peer support session						
Group-Level peer support session						
Group-Level peer support session-Part D						
Communication on behalf of client						
Medical accompaniments						
Non-medical accompaniments						
Individual Level peer support communication (not-in person)						
Assistance navigating system						
Care retention						
Sexual health promotion						
Substance use/risk reduction						
Support HIV treatment adherence						
Youth transition-counseling support						
Emotional support						
HIV health & treatment literacy						
Disclosure support						
Support around community resources						
Support around housing resources						
Other support						

Patient Name/ ID _____ / _____

Service	Date	Units	Date	Unit	Date	Unit
CASE MANAGEMENT (NON-MEDICAL)						
NMCM intake/assessment						
NMCM acuity assessment						
NMCM acuity reassessment						
NMCM ISP/Care Plan						
NMCM in person session						
NMCM Telehealth session						
NMCM client communication (not in person)						
Family assessment/reassessment						
Referrals to social services						
Linkage to social services						
Communication with non-medical provider						
Other NMCM support						

Patient Name/ ID _____ / _____

Service Date: __ / __ / _____
Print new pages for each new date.

SERVICE INFORMATION - ACUITY

For acuity assessments and re-assessments for MassCARE Non-Medical Case Management:

	Score
Other Non-HIV Related Medical Issues	
Health Insurance	
Sexual and Reproductive Health Status	
Current Mental Health Status	
Current Substance Use	
Current Housing Status	
Current Legal Status	
Support System and Relationships	
Current Income/Personal Finance Management Status	
Current Transportation/Mobility Status	
Current Nutritional Status	
Total	

Level of acuity:

- ❑ Basic (1-11)
- ❑ Moderate (12-22)
- ❑ High (23-33)

SERVICE INFORMATION –REFERRALS (NON-MEDICAL)

For "Referrals (non-medical)" subservice:

Referral type:

- ❑ Substance abuse
- ❑ Mental health
- ❑ Housing
- ❑ Financial/benefits
- ❑ Legal
- ❑ Transportation
- ❑ Peer support services
- ❑ Food/nutrition support services
- ❑ Other

Confirmation of referral date: M M / D D / Y Y Y Y

Referral status:

- ❑ Open
- ❑ Closed

Lost to Follow-Up (60 Days)

MASSACHUSETTS careware

Patient Name/ ID _____ / _____

Service	Date	Units	Date	Unit	Date	Unit
EMERGENCY FINANCIAL ASSISTANCE						
Rental assistance						
Utility assistance						
Food						
Other						
HEALTH EDUCATION/ RISK REDUCTION						
Health education/risk reduction						
HIV, the Viral Cycle & Medications at Work						
Communication with Health Care Provider						
Understanding Basic Lab Tests						
Stigma and Disclosure						
HIV and Substance Use						
HIV and Mental Health						
Adherence						
Other						