# Section 3
# Assessing Clients' Needs

**FORMS IN THIS SECTION**

- **Intake-Assessment Packet**
  - **Case Management Intake-Assessment Form**
  - **Addictions Support Assessment**
  - **Mental Health Assessment Form (for mental health professionals)**
  - **Medical Diagnosis Form**
  - **HIV Benefits Screening Form (MA specific)**

**RELEVANT STANDARDS OF CARE**

- **Needs Assessment**
- **Residents' Records**
- **Medication Protocols and Adherence Support**

# Introduction to Section 3

## SECTION DESCRIPTION

This section contains an intake-assessment packet. The individual sample forms that make up the comprehensive packet and are intended to be viewed together feature the following topics: case management, addictions support, mental health assessment, medical diagnosis, and HIV benefits screening in Massachusetts.

These documents are typically used in gathering information about the specific needs of an individual AFTER s/he has been accepted into housing.

Emphasis is given to the word AFTER because the Standards of Care encourage programs to divide the steps of an application process into two distinct phases:

- **Tenant Selection** (limited to legally appropriate questions and investigations) and

- **Needs Assessment** (a more extensive exploration of significant issues, not appropriate for tenant selection, but necessary for the provider to understand in order to serve the new resident well).

This division of steps allows the provider to avoid inappropriately introducing information gleaned from the needs assessment process in making tenant selection. This also assures that decisions will be consistent with fair housing and discrimination laws. See Section I: Tenant Selection for more information about the considerations of tenant selection.

The needs assessment evaluates the client's service related needs with accuracy and sensitivity. It serves as the basis for developing an initial individual service plan for ensuring the quality of the overall care to be provided.

Ongoing reassessments are conducted on a regular and pre-scheduled basis. The intended outcome is for residents to receive supportive housing services from a provider who has sufficient current information to fully understand the residents' needs and preferences.

An additional assessment that providers are encouraged to perform is a Brief Behavioral Risk and Health Assessment for people living with HIV/AIDS. The purpose of this assessment, which can be performed at intake and on an on-going basis, is to incorporate positive prevention and harm reduction strategies into day to day case management. A Brief Behavioral Risk and Health Assessment for people living with HIV/AIDS tool will be available from the Massachusetts Department of Public Health AIDS Bureau web site in January 2005.

## MORE EXPLANATION ON SOME OF THE FORMS:

Most programs utilize a number of forms throughout the intake process. Therefore, the intake process can be lengthy. Some intake workers choose not to introduce paperwork until the latter part of this meeting to give the contact a less bureaucratic tone. Another strategy is to take notes pertaining to a resident's history on a notepad and later transfer it to the necessary forms.

However the intake worker chooses to collect background information on the client, it may be helpful to prepare the

client by explaining that the information being collected:

- is being asked of everyone entering into the program and not only of him/her
- can be personal in nature
- will be kept in strict confidence
- will not be used to terminate the client
- will be used to maximize the value of the services provided

Finally, some programs find that clients will more willingly and honestly answer questions of a personal nature after they have begun to develop a relationship with the program and program staff. Therefore, it may be helpful to evaluate the immediacy of the questions being asked on a case by case basis.

***Case Management Intake Form***
The actual intake meeting or meetings usually involve the completion of a significant portion, if not all, of this form.

***Addictions Support Assessment Form***
The intent of this form is to assess the client's need for and willingness to participate in addictions/recovery support services. This assessment is sometimes conducted by a specialist in the field and, at others times, is conducted by a general staff member with an appreciation for challenges associated with obtaining information about substance using habits.

***Mental Health Assessment Form***
This form may best be administered by a mental health professional, one who can make an assessment of the resident's current mental status.

***HIV Benefits Screening Form***
This form assists program staff persons in determining if residents are receiving all of the HIV-related benefits for which they are eligible. Benefits such as insurance and medication coverage vary greatly from state to state; the form included here covers current benefits available in Massachusetts. Programs should consult with experts in their state to develop a similar list of benefits for use in their programs.

## MORE INFORMATION ABOUT KEY ELEMENTS OF THE STANDARDS OF CARE:

The Standards of Care are recommended best practices that have been established in every area of the provision of housing and supportive services. Standards that are particularly relevant to the topics in this section are identified and explained below.

## STANDARD: Needs Assessments

☑ The service provider develops a needs assessment tool to be used consistently with all residents.

☑ The nature of information explored in the needs assessment will vary from program to program but, may include: medical history and current health status; mental health and emotional health; substance abuse history and current status; functional and cognitive ability; emotional and spiritual needs; assessment of support systems; legal and financial needs.

☑ Needs assessments are conducted by staff members with an appreciation for the challenges associated with collecting this kind of information.

☑ According to the Standards, it is the responsibility of the housing provider to ensure that the initial assessment is updated as the status and needs of the resident change. At a minimum the assessment is updated every six months. Regardless, it is always done

prior to the development of a revised Service Plan.

## STANDARD: Residents' Records

- ☑ Standard program records are tailored to meet the precise need for information required by the provider and its funders, and are not excessively intrusive without programmatic necessity. The provider has a clear rationale for all information which is maintained in resident records.

- ☑ Programs have record keeping systems that are secure against inappropriate access.

- ☑ The provider has a policy for clients to review their records, upon request within a reasonable amount of time.

## Case Management Intake and Assessment Form

*This form is to be filled out with information gathered from both the client and collateral contacts. Some questions touch upon sensitive topics which the client may not be ready to discuss during a first meeting (custody issues, domestic violence, legal issues, etc.). If this occurs, consider waiting until a later meeting to ask these questions; when the client may feel more comfortable.*

## General Information

**Resident Name:** _____ **Preferred 1st Name:**_____

Phone: _____ Phone where message may be left:_____

Primary Address:_____

_____

City_____ State _____ Zip _____

Date of Birth: _____/_____/_____ Place of Birth (city/state/country):_____ Gender:_____

Racial or Ethnic Background: _____ Religion *(optional)*: _____

Social Security Number: _____-_____-_____

Date of Admission to Housing Program: _____/_____/_____

**Emergency Contacts:**

**#1**: Name: _____ Relationship: _____ Phone: _____

Is this person aware of client's HIV/AIDS status? ❑ yes ❑ No ❑ Don't know

**#2**: Name: _____ Relationship: _____ Phone: _____

Is this person aware of client's HIV/AIDS status? ❑ yes ❑ No ❑ Don't know

| | | |
|---|---|---|
| **Primary Care Physician Name:** | | **Phone Number:** |
| Address: | | |
| Hospital Affiliation: | | |
| **Additional Health Care Providers:** | | |
| Name: | Specialty: | Phone Number: |
| Name: | Specialty: | Phone Number: |

| **Source of Referral to HIV/AIDS Housing** | |
|---|---|
| ____ Self | ____ Housing Advocate |
| ____ Case Manager | ____ Detox Program |
| ____ Substance Abuse Treatment Facility | ____ Homeless Services/Shelter |
| ____ Adult/Juvenile Detention Facility | ____ Counseling and Testing Site |
| ____ Prevention Education Program | ____ Mental Health Program |
| ____ STD Clinic | ____ Health Center |
| ____ Emergency Room | ____ Hospital |
| ____ Street Outreach Worker | ____ Other |

## Medical Information

Date of HIV diagnosis:_____/_____/_____

Does client have AIDS diagnosis? ❑ yes ❑ no If yes, date of AIDS diagnosis: _____/_____/_____

Verification: Physician, Date: _____ _____/_____/_____

What were the results of the client's most recent CD4 count? _____ % Date: _____/_____/_____

Using table below, list current and recent HIV-related illnesses / symptoms / opportunistic infections.

| Illness / Infection / Symptoms | Present? ✓ |
|---|---|
| | ❑ |
| | ❑ |
| | ❑ |
| | ❑ |
| | ❑ |
| | ❑ |
| | ❑ |
| | ❑ |

Any Hospitalizations? List details:

TB Screening: ❑ PPD: Date: _____/_____/_____ Results:_____

Hepatitis Screening: ❑ A: Date: _____/_____/_____ Results: _____ Vaccinated? ❑ yes ❑ no

❑ B: Date: _____/_____/_____ Results: _____ Vaccinated? ❑ yes ❑ no

❑ C: Date: _____/_____/_____ Results: _____

Alternative Therapies: ❑ yes ❑ no If yes, please list:

**Current medications:**

| Name | Frequency | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Is client allergic to any medications? ❑ yes ❑ no

If yes, please describe:

_____

_____

_____

## Family Information

Does client have a partner or spouse? ❑ yes ❑ no If yes, does client live with partner or spouse? ❑ yes ❑ no

Does client have any children in family? ❑ yes ❑ no

If yes, fill in the chart below for all children. (When more space is needed, please use blank paper).

| NAME | AGE | GENDER (Circle One) | RELATIONSHIP TO CHILD | CURRENT WHEREABOUTS |
|---|---|---|---|---|
| | | Male / Female | | |
| | | Male / Female | | |
| | | Male / Female | | |
| | | Male / Female | | |
| | | Male / Female | | |
| | | Male / Female | | |

If client is separated from child, is there a plan for or interest in reunification with the child? ❑ yes ❑ no If yes, describe:

_____

_____

_____

Is a child protective services agency currently providing any assistance to the family? ❑ yes ❑ no If yes, describe:

_____

_____

_____

Has the client ever experienced ANY personal violence; being hit or abused physically, sexually, emotionally, or verbally? ❑ yes ❑ no

If yes, please describe. Please include whether the client has an Order of Protection and the current whereabouts of the abuser).

_____

_____

_____

Does the client have any other needs related to children, partners, or family members? ❑ yes ❑ no If yes, describe:

_____

_____

_____

## Practical Supports and Assistance

- ❑ Remembering appointments
- ❑ Transportation to appointments
- ❑ Making appointments
- ❑ Remembering medications
- ❑ Communicating needs to others
- ❑ Childcare
- ❑ Managing finances / budgeting
- ❑ Personal care (bathing, dressing etc.)
- ❑ Cleaning / housekeeping
- ❑ Supervision for safety
- ❑ Doing laundry
- ❑ Cooking / food preparation
- ❑ Nutrition
- ❑ Shopping (Grocery)
- ❑ Shopping (Pharmacy)

## Social Support Systems

**Identify social support system**, both informal (family, friends, caregivers) and other (other agencies, support groups, spirituality):

| Name | Relationship / Agency | Aware of HIV / AIDS Status? |
|---|---|---|
| | | ❑ Yes ❑ No ❑ Don't know |
| | | ❑ Yes ❑ No ❑ Don't know |
| | | ❑ Yes ❑ No ❑ Don't know |
| | | ❑ Yes ❑ No ❑ Don't know |

Comments on social support systems:

## Employment / Job Training / Education

Client

❑ Works full-time ❑ Works part-time ❑ Works in "temp" jobs ❑ Currently unemployed

If employed, indicate current occupation: _____

Employer name and address: _____

_____

Does HIV affect your ability to do your job in any way? ❑ yes ❑ no If yes, how? _____

_____

Contact name: _____ Phone: (_____)_____

Length of Employment: _____

If not currently employed, indicate most recent occupation: _____

Does the client need any assistance with: ❑ workforce training ❑ finding employment ❑ education

Other ❑ (explain) _____

_____

## Household Income

List all persons in the household with any form of income including live-in boyfriends/ girlfriends. List children live with client.

| *Names of individuals who will live with the client* | *Relationship to client* | *Age* | *Source(S) of income * (Wages, SSI, AFDC, etc.)* | ***Monthly Income**** | ***Annual Income**** |
|---|---|---|---|---|---|
| Client | Self | | | $ | $ |
| | | | | $ | $ |
| | | | | $ | $ |
| | | | | $ | $ |
| | | | | $ | $ |
| | | | Total Household Income: | $ | $ |

* Leave blank for official Personal Care Attendant for whom medical documentation can be supplied evidencing this role.

## Legal and Advocacy

Does the client need any assistance with:

❑ will ❑ guardianship ❑ immigration ❑ power of attorney ❑ health care proxy ❑ prior evictions ❑ credit problems

❑ Other _____

Probation: ❑ Yes ❑ No Probation officer: _____ Phone: _(_____)_____

Parole: ❑ Yes ❑ No Parole officer:_____ Phone: _(_____)_____

Pending court case: ❑ Yes ❑ No If yes, what issue: _____ Date due in court: _____/_____/_____

Any other agency involvement? ❑ Yes ❑ No If yes, which? _____

_____

## Spiritual

Is the client connected to any spiritual or religious support? ❑ Yes ❑ No

If yes, please explain: _____

Does client express need for connection with spiritual or religious support? ❑ Yes ❑ No

If yes, please explain: _____

## Recreational / Social Community Activity:

Hobbies/Interests: _____

Exercise/Sports: _____

Other: _____

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**Person completing this form (Print):** _____

Date: _____/_____/_____ Signature: _____

Title: _____

Client Signature: _____ Date: _____/_____/_____

# Addictions Support Assessment Form

*Can be conducted in conjunction with intake or as a separate assessment*

**Interviewer Name:**

Dates of Assessment:

Location:

*It is important to begin your drug and alcohol assessment with a description of the agency's policy on this issue. You should indicate that drug and alcohol history does not disqualify a person for the program. To the contrary, the best way for the applicant to qualify is by providing as thorough a history as possible such that the agency can make an accurate assessment of the individual's needs.*

*Begin this interview with a general discussion about the climate of drug and alcohol use in which person was raised and has been living.*

| **Family history of drug / alcohol use** | |
|---|---|
| Father | |
| Mother | |
| Brother(s) | |
| Sister(s) | |
| Grandfather | |
| Grandmother | |
| Children | |
| Other Relative(s) | |
| Other comments | |
| **Spouse / partner history**<br>❑ Active User ❑ Clean ❑ Never used ❑ Dealer<br>Other comments: | |

*Indicate again to applicant that acceptance into the program is not predicated on their drug and alcohol history. The questions are designed to help the service providers understand the applicant's needs and coping mechanisms. Do not expect to get completely accurate answers to any or all of these questions. When asking questions about individual's personal use of drugs and alcohol, be extremely specific. You want to obtain a count of how many times a day a person is using, if applicable.*

**Personal history**

Age of first drink? Age of first drug use?

How would you describe your current use of drugs and/or alcohol?

❑ Non-existent ❑ Infrequent ❑ Casual ❑ Problematic ❑ Habitual ❑ Addictive

How would you describe your past use of drugs and/or alcohol?

❑ Non-existent ❑ Infrequent ❑ Casual ❑ Problematic ❑ Habitual ❑ Addictive

What has been your drug(s) of choice?

What was your most recent drug of choice?

Frequency of drug / alcohol use (per day, per week, etc.):

How did you usually get drugs?

How much did you usually spend on drugs per week?

What was your usual source of money for drugs?

Have you ever had a problem with prescription medications? ❑ Yes ❑ No

If yes, explain:

Have you ever overdosed on alcohol or drugs?

If yes, explain:

Number of attempts to reduce or stop drug / alcohol use:

What helped?

What did not help?

Current length of sobriety/clean time:

Who can verify your clean time?

❑ Applicant only ❑ Addiction Counselor ❑Physician ❑Nurse ❑Social Worker ❑Therapist

Name: _____ Phone: _____

Who is supportive of recovery (friends, family, associates)?

**Alcohol / drug treatment experience**

| | No. of times | 1st treatment date | Most recent treatment date | Longest sobriety |
|---|---|---|---|---|
| Detox | | | | |
| Rehab | | | | |
| Outpatient | | | | |
| Residential | | | | |
| Acupuncture | | | | |
| Other | | | | |

Is the applicant currently on methadone? ❑ Yes ❑ No

If no, has applicant been on methadone in the past? ❑ Yes ❑ No

If applicant is currently on methadone, complete the following:

Provider: _____

Dosage: _____

What are the applicant's feelings regarding prior and/or current experiences with methadone?

| *Substance* | *Age of First Use* | *Last Use* | *Frequency* | *Usual Route of Transmission* |
|---|---|---|---|---|
| Alcohol | | | | |
| Cocaine | | | | |
| Crack | | | | |
| Marijuana/Hashish | | | | |
| Heroin | | | | |
| Non Rx Methadone | | | | |
| Other Opiates | | | | |
| PCP | | | | |
| Other Hallucinogens | | | | |
| Methamphetamine | | | | |
| Other Methamphetamine | | | | |
| Other Stimulants | | | | |
| Benzodiazepines | | | | |
| Other Tranquilizers | | | | |
| Barbiturates | | | | |
| Sedatives/Hypnotics | | | | |
| Inhalants | | | | |
| Over-the-Counter | | | | |
| Other | | | | |

| Past and present participation in recovery / prevention strategies | Past ✓ | Present ✓ |
|---|---|---|
| Member of recovery group/ support group | | |
| Working with individual counselor, buddy, therapist | | |
| Attending meetings/12 step | | |
| Having a sponsor | | |
| Phone contacts/ networks | | |
| "Service" at meetings e.g. setting up chairs etc. | | |
| Contracting | | |
| Setting goals | | |
| On-going commitments | | |
| Other: | | |

**What are "triggers" of relapse for the applicant or times when the applicant is more likely to use?**

**Are there specific places that the applicant identifies with using or where the applicant is prone to relapse?**

**What does the applicant do to not use when triggered to do so?**

**What areas of life have been most affected by substance use/ abuse (relationships, job, education, spirituality, self esteem etc.)?**

**Assessment (define obstacles, problem areas, and concerns regarding present recovery program):**

**Recommendations:**

**Assessment completed by:** Date:

Signature:

# Mental Health Assessment Form

**Psychiatric/ mental health treatment (inpatient and outpatient)**

| *Problem* | *Diagnosis* | *Dates* | *Where treated (indicate whether inpatient or outpatient)* | *Frequency of visits* |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Psychotherapist / Psychiatrist:** **Phone:**

**Current mental health issues** (in client's words)**:**

**History of these issues** (psychosocial data, developmental incidents, crises/traumas as related directly or indirectly to the problem)

**Is applicant's functioning impacted by mental illness? Describe.**

**Applicant's description of relationship with previous and/or current mental health provider(s):**

**Current Mental Status** *(check one)*

| | | | |
|---|---|---|---|
| *Memory:* | ❑ normal | ❑ short-term deficit | ❑ long term deficit |
| *Insight:* | ❑ good | ❑ fair | ❑ absent |
| *Judgment:* | ❑ good | ❑ fair | ❑ poor |
| *Thought progression:* | ❑ normal | ❑ fragmented | ❑ tangential |
| | ❑ loose | ❑ paranoid | ❑ delusional |
| | ❑ hallucinations | ❑ hear voices | |
| *Mood:* | ❑ relaxed | ❑ fearful | ❑ anxious |
| | ❑ sad | ❑ hostile | ❑ depressed |
| *Affect:* | ❑ appropriate | ❑ inappropriate | |
| *Ideation:* | ❑ suicidal | ❑ homicidal | |
| Appearance (describe): | | | |

Has the applicant ever had a significant period in which the applicant has experienced one of the following:
**NOTE**: Lasting a period of one or more weeks and that was NOT a direct of result of drug or alcohol use.

| | **In Past Two Years** | | **In Past 30 Days** | |
|---|---|---|---|---|
| Experienced serious depression | ❑ Yes | ❑ No | ❑ Yes | ❑ No |
| Experienced serious anxiety | ❑ Yes | ❑ No | ❑ Yes | ❑ No |
| Experienced trouble understanding, concentrating, or remembering | ❑ Yes | ❑ No | ❑ Yes | ❑ No |
| Experienced hallucinations | ❑ Yes | ❑ No | ❑ Yes | ❑ No |
| Had serious thoughts about suicide | ❑ Yes | ❑ No | ❑ Yes | ❑ No |
| Tried to commit suicide | ❑ Yes | ❑ No | ❑ Yes | ❑ No |

If yes, how many times? _____ Dates of Attempts _____

| | | | |
|---|---|---|---|
| Took prescription medication for any psychiatric problems | ❑ Yes | ❑ No | ❑ Yes | ❑ No |

If applicant currently takes psychiatric medications, complete chart below:

| *Medication* | *Dosage* | *Dates of Use* | *Reason for Medication* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Social Functioning Assessment Scale (SOFAS):
❑ Excellent ❑ Good ❑ Slight Impairment ❑ Moderate ❑Serious Inability to Function ❑ At Risk of Harming Self/Others

Does applicant have a DSM IV diagnosis? If yes, indicate type: _____

Describe the applicant's self-perception:

Discuss applicant's personal strengths, coping mechanisms, recent successes:

| |
|---|
| How does applicant respond to feelings of anger? |
| What is applicant's ability to perform daily living skills, maintain house chores, etc.? |
| How does applicant describe current defenses or coping styles? |
| Additional Comments: |
| **Signature of Person Completing Form:**<br>**Signature:** **Date:** |

# Medical Diagnosis Form

**Consent to Release Information**

I, _____, hereby authorize _____
to give information from my record with no limitations placed on the date of illness, history of illness, or the diagnosis or therapeutic information to the (name of program) for the purpose of verification of diagnosis and developing my treatment plan. I understand that this authorization may be revoked at any time, except to the extent that action has already occurred in reliance thereupon. This authorization shall be valid for one year unless otherwise specified.

Signed: X Date:

Date of Birth:

**Medical Information** *(please check or complete any that apply)*

Date of last TB test: Result:

Date of last chest x-ray: Result:

Date of last HIV antibody test: Result:

Adults:

- ❑ HIV+ Asymptomatic
- ❑ HIV+ Symptomatic
- ❑ AIDS Diagnosis

Pediatric:

- ❑ P0
- ❑ P1
- ❑ P2
- ❑ P3

Most recent CD4 Count: %: Date:

Opportunistic Infections:

Date:

Date:

Date:

Current medications and dosage:

Dosage:

Dosage:

Dosage:

**Other relevant medical information**

Is your patient's health compromised to the point that they require assistance with the tasks of daily living?

❑ Yes ❑ No

If they do, what type of support do you recommend?

Doctor's Name:

License #:

Address:

Telephone Number: Fax Number:

Contact Person:

**Physician's Signature:** **Date:**

**Boston Public Health Commission - AIDS Services**
**Massachusetts Department of Public Health - HIV/AIDS Bureau**

# HIV/AIDS CASE MANAGEMENT COLLABORATIVE
# CASE MANAGEMENT BENEFITS SCREENING FORM

**2004 Edition**

**Client Name or Code**_____ **Client Phone**_____
**Agency**_____ **Case Mgr Phone**_____
**Case Manager**_____ **Date**_____

## I. INCOME INFORMATION

| SOURCE | AMOUNT |
|---|---|
| ☐ **SSI (Supplemental Security Income)**<br>*SSI recipients automatically receive MassHealth, which includes full prescription coverage. CHII for MassHealth prescription copays*<br>(Check Arrives 1st of month)<br>$2000.00 asset limit (does not affect MassHealth eligibility)<br>http://www.ssa.gov | $_____ per month<br>Living Situation:<br>☐Alone-$678.39 monthly (pays 100% of household expenses)<br>☐Shared Living-$594.40 monthly (equitable share of household expenses)<br>☐Home of Another-$463.58 monthly (no set rent, contributes as can) |
| ☐ **SSDI (Social Security Disability Insurance)** (no asset limit)<br>(Check arrives 3rd of month or any day thereafter)<br>*Medicare A & B ☐YES ☐NO<br>*MassHealth Eligible? ☐YES ☐NO (yes, if monthly income ≤ $1032)<br>HDAP for MassHealth copays and/or premium<br>*Medex Gold/Medicare HMO/other Medicare Supplement ☐YES ☐NO<br>(*these cover prescriptions—MIC for premium HDAP for copay*)<br>☐ **SSA Dependent's or Survivor's Benefits**<br>http://www.ssa.gov | $_____ per month<br>Month and year received 1st check :_____<br>(*Recipients get Medicare A & B 24 months after 1st check—if awaiting Medicare and uninsured, assess for nongroup through CHII*)<br><br>$_____ per month |
| ☐ **EAEDC (Emergency Assistance to Elderly, Disabled and Children)**-includes MassHealth Basic with prescription coverage. | $_____ per month<br>*Assess client for Presumptive SSI eligibility **before** applying for EAEDC* |
| ☐ **TAFDC (Transitional Assistance to Families with Dependent Children)**-includes MassHealth Standard with prescription coverage. | $_____ per month |
| ☐ **UCB (Unemployment Compensation Benefits)**<br>How Long on UCB?_____<br>Health Ins.? ☐YES ☐NO | $_____per month<br>*Assess eligibility for Medical Security Plan, Massachusetts Insurance Connection (if applying for disability), CHII (if not applying for disability)* |
| ☐ **Short Term or Long Term Disability Benefits**<br>Health Ins.? ☐YES ☐NO | $_____ per month |
| ☐ **Veterans Benefits**<br>VA Medical Insurance ☐YES ☐NO | $_____ per month |
| ☐ **Other retirement benefits**<br>Health Ins.? ☐YES ☐NO | $_____ per month |
| ☐ **Wages**<br>Health Ins.? ☐YES ☐NO | $_____ gross (before tax) per month<br>Working *and* Disabled? ☐YES ☐NO *(assess for CommonHealth)*<br>Self Employed? ☐YES ☐NO *(not disabled and uninsured, contact CHII)*<br>Employed and Uninsured? ☐YES ☐NO (assess for non-group insurance eligibility, contact CHII) |

## II. PRIVATE HEALTH INSURANCE

**PREMIUM PAID BY**: ☐Employer (use CHII for employee contribution) ☐Self through Individual Policy ☐Self through COBRA
☐Medical Security Plan for UCB Recipients ☐MIC (Massachusetts Insurance Connection) ☐ COBRA or Individual Policy through CHII

**PRESCRIPTION COVERAGE**: ☐YES ☐NO Co Pays: $_____(name brand) $_____ (generic)—CONTACT HDAP TO COVER COPAYS THROUGH HDAP IF ANNUAL INCOME ≤ $50,000

**CAPS ON COVERAGE**: $_____annually $_____lifetime

***TO OBTAIN MORE INFORMATION ABOUT APPLYING FOR BENEFITS & PROGRAMS***
***SEE THE BACK OF THIS FORM, also www.masslegalservices.org for fact sheets***

REV 5/04—Income guidelines and benefit amounts subject to change annually

## III. PRIVATE & PUBLICLY FUNDED HEALTH INSURANCE & PRESCRIPTION OPTIONS

***A) MASSHEALTH** (Medicaid):* Apply through DMA. **DMA not required to report immigrants to the Immigration and Naturalization Service (INS). SEE THE MEMBER BOOKLET FOR MORE DETAILED INFORMATION,** http://www.state.ma.us/dma/hivservices/memberbklt.pdf (**includes income limits for each program and charts of Federal Poverty Level-FPL adjusted April 1 each year** ),

**1. MassHealth HIV Expansion:** MassHealth Family Assistance for HIV+ individuals and their families ***up to 133% of FPL***, covers children but not non-infected spouse. Full range of health care benefits including prescription coverage. Medicare deductibles and Part B premiums covered.

**2. MassHealth Standard:** Offers a full health-care benefits to pregnant women, children and disabled people aged 64 and under. (133% FPL limit)

**3. MassHealth Prenatal:** Immediate health benefits to pregnant women for up to 60 days. No proof of income needed. ***May not cover prescription drugs.***

**4. MassHealth CommonHealth:** Offers full health benefits to disabled adults and children. There is no income limit. Non-working HIV+ disabled adults with income over 133% of FPL must meet a one-time deductible and may pay a monthly premium (ASSESS FOR MEDEX GOLD). Disabled adults working over 40 hours per month do not need to meet the deductible but may have to pay a monthly premium.

**5. MassHealth Basic:** Offers health benefits to people who receive EAEDC benefits. (133%FPL limit).

**6. MassHealth Essential**: For individuals under age 65, unemployed for 1 year or more, income < 100% FPL, cannot collect unemployment benefits. PLHIV IN THESE CIRCUMSTANCES SHOULD BE IN HIV EXPANSION

**7. MassHealth Buy In:** Pays for all or part of a person's private health-insurance premium. For people out of work or certain immigrants who have health insurance and meet specific income standards.

**8. MassHealth Limited:** Emergency health services for people with an immigration status that prevents access to other services. Must meet the income standards for MassHealth Standard. ***Prescription drug coverage limited to drugs used to treat an emergency medical condition.*** Social Security Number not necessary. (Eligible individuals likely to receive Free Care or should assess for nongroup through CHII)

**9. MassHealth Family Assistance:** Offers coverage to children by paying for part of a family's health insurance premium or allows children to enroll in a MassHealth plan. Family income must be between 150% and 200% of the Federal Poverty Level (FPL).

***B) MEDICARE:*** Medical coverage for the disabled on SSDI and/or elderly. ***Part A -*** covers most inpatient costs, but there may be out-of-pocket expenses. ***Part B -*** Optional, costs $66.60 per month, and covers most non-inpatient costs but not prescription drugs. DMA may cover the costs of Part B premiums and/or other out-of-pocket expenses for qualified individuals. www.medicare.gov

***C) MEDIGAP:*** FOR INDIVIDUALS OVER INCOME FOR MAHEALTH, DISABLED AND NOT WORKING 40+ HOURS PER MONTH Medex Gold pays the costs not covered by Medicare A & B, including most prescription drugs. Medex Gold - monthly premium of $379.95 (2002 figure) plus a $35 quarterly deductible for the pharmacy program. **Medicare HMOs cap prescription coverage and are not recommended**.
http://www.state.ma.us/doi/Consumer/css_health_medsupproducts.html

***D) MASSACHUSETTS INSURANCE CONNECTION** (MIC):* For people with AIDS who left their jobs and cannot afford to COBRA their benefits. Pays health insurance premiums under COBRA guidelines and after 29 month COBRA limit *may reimburse Medigap (e.g. MEDEX GOLD) premiums* for Medicare qualified persons. Annual income less than $27,936 (add $9552 for each additional family member).

***E) MEDICAL SECURITY PLAN:*** For persons receiving unemployment benefits and are income-qualified. $100 assistance with monthly COBRA payment or direct medical coverage (with 20% co-payment). Prescription drug coverage available with a 5$ and $10 co-payment for generic and brand name drugs, respectively. http://www.detma.org/workers/msp.htm

***F) FREE CARE:*** **Full** Free Care available to MA residents *(no US residency status or citizenship required*) with annual income below $18,624 at acute care hospitals. May have prescription coverage. Check with individual hospitals for further details. No disability requirement. CONTACT CHII TO OBTAIN NONGROUP HEALTH INSURANCE. Free care resources should only be utilized as a final resort.

***G) HIV DRUG ASSISTANCE PLAN*** (HDAP)***: A program of last resort for the uninsured or underinsured.*** Provides HIV treatment medications to, or pays private insurance drug copays for persons with an annual income of $50,000 or less (add $2900 for each additional dependent).
http://www.crine.org/info/drugcontent1.html

*COMPREHENSIVE HEALTH INSURANCE INITIATIVE (CHII)* At HDAP, assists in obtaining and pays premiums for private nongroup or small group health insurance for uninsured individuals not on disability benefits (private or SSDI), and for disabled individuals over income for MIC. Pays employee contributions for work-related health insurance. Pays COBRA premiums for PLHIV not applying for disability benefits.
http://www.crine.org/info/drugcontent2.html

***H) NON-GROUP HEALTH INSURANCE:*** Comprehensive health insurance plans offered to MA residents who are neither disabled nor self-employed and who have no access to other insurance. May have pre-existing condition exclusions or waiting periods if individual has not had insurance in past 63 days. Contact CHII and/or major private insurers for more information. http://www.state.ma.us/doi/Consumer/css_health_plans01-12.html , http://www.state.ma.us/doi/Consumer/css_health_NonGroup.html

### Important Phone Numbers

**MassHealth Enrollment Centers (for applications):** 1-888-665-9993
**MassHealth Customer Service:** 1-800-841-2900(TTY:1-800-497-4648).
**Medical Security Plan:** 1-800-914-4455
**Massachusetts Office of Elder Affairs:** 1-800-882-2003

**Free Care** appeals and questions: **Division of Health Care Finance and Policy**: (617) 988-3100

**HIV Drug Assistance Program (HDAP) and Comprehensive Health Insurance Initiative (CHII):** 1-800-228-2714

**Massachusetts Insurance Consumer Help Line:** (617) 521-7777
**Blue Cross & Blue Shield Medex :** 1-800-678-2265
**Massachusetts Insurance Connection** (MIC) (617) 210-5320
**Social Security Administration:** 1-800-772-1213
**Department of Transitional Assistance** (DTA) **:** 1-800-445-6604
Apply for TAFDC or EAEDC at nearest DTA office.

**JRI Health Law Institute**: (for legal advice and benefits assessment):
(617) 988-8700 http://www.jri.org/hli.html

**AIDS Action Committee Financial & Legal Services**: (617) 450-1250
**http://www.aac.org/hivservices_clientservices_finandlegal.htm**