Minnesota Department of Human Services
& Hennepin County Ryan White Program
Medical Case Management Acuity Assessment

CLIENT NAME:	**DATE:**	**REVIEWED ON:**
TOTAL SCORE:	**TIER:**	**NAME OF MCM:**

CATEGORY	SCORE 1	SCORE 0	ASSESSMENT QUESTIONS (OPTIONAL)	POINTS
Cultural/Language Assistance				
Do you need translation services or sign language interpretation?	Yes - Client needs translations services or sign interpretation	No - Client has no language barriers	*Do you want assistance to address any barriers?	
Are there any cultural/ spiritual barriers impacting your access to healthcare services and medications?	Yes	No	*Do you want assistance to address any barriers?	

Health Insurance and Benefits-** If the client scores a 1 in this section, client will automatically be a tier A client				
Do you have health insurance?	No	If yes, what type(s)? ☐ Private ☐ Medicare A/B ☐ Medicare D ☐ Medicare Part D/ LIS (extra help) ☐Medicaid (MA) ☐Minnesota Care ☐VA Insurance/Tricare ☐Applied for/Pending ☐Other	*Are you currently accessing any public benefits or have private insurance? *Do you want assistance applying for benefits/insurance? *Do you have out-of-pocket medical costs? *Do you need assistance in meeting deductibles, premiums, co-payments and/or spend-down requirements? *Do you need assistance applying for outpatient ambulatory medical care grants to assist with out of pocket costs? *Do you want assistance to address any barriers?	

CATEGORY	SCORE 1	SCORE 0	ASSESSMENT QUESTIONS (OPTIONAL)	POINTS
HIV Diagnosis-** If the client scores a 1 in this section, client will automatically be a tier A client				
What is the approximate date you were diagnosed with HIV?	If less than 12 months ago, Date of Diagnosis _____	If more than 12 months ago, Date of Diagnosis _____	*Have you been diagnosed with AIDS? *Do you want assistance with partner notification? *Do you want assistance to address any barriers?	

Pregnancy-** If the client scores a 1 in this section, client will automatically be a tier A client				
Are you currently Pregnant?	Yes - pregnant and accessing Prenatal Care OR Yes - pregnant and not accessing Prenatal Care	No - not pregnant or not applicable.	*Have you been referred to Children's HIV perinatal program? *What is your estimated date of delivery? *Do you want assistance to address any barriers? *Are you receiving routine prenatal care?	

CATEGORY	SCORE 1	SCORE 0	ASSESSMENT QUESTIONS (OPTIONAL)	POINTS
HIV Medications and Medical Treatment Adherence-** If the client scores a 1 in this section, client will automatically be a tier A				
Are you currently taking all your prescribed HIV medications?	Yes - reports frequently missing medications in the past 30 days OR Yes – New to antiretrovirals OR Yes – Experiencing Negative Side Effects OR No - treatment not prescribed (i.e. newly diagnosed, client choosing not take medications)	Yes - reports taking medications daily	*Do you understand your medications and what they do? *What prevents you from taking your medications? *Do you need treatment adherence counseling? *What side effects are you experiencing? *What tools might help you take medications? *Do you want assistance to address any barriers?	
Have you seen an HIV medical provider in the last 12 months?	No; Date of last appointment _____	Yes; Date of last appointment _____	*What barriers prevent you from seeing your HIV provider? *Do you want assistance to address any barriers?	
Are you Virally Suppressed (under 200 copies) AND have you had labs drawn in the last 12 months?	No; Date of last labs and results _____	Yes; Date of last labs and results _____	*What barriers prevent you from having an undetectable viral load or getting your labs drawn *Do you want assistance to address any barriers?	

CATEGORY	SCORE 1	SCORE 0	ASSESSMENT QUESTIONS (OPTIONAL)	POINTS
Housing Stability and Access-** If the client scores a 1 in this section, client will automatically be a tier A				
Do you have stable housing?	No - Client is homeless or has unstable housing and unable to manage their health and medical care Client is in immediate danger of becoming homeless and needs housing placement Client is at-risk of eviction, having utilities shutoff and/or of losing housing due to financial strain. Client is unable to live independently and needs to be placed in assisted living facility.	Yes OR No – Client is Homeless but is able to manage their own health and medical care	*Do you have any past legal charges, convictions or evictions that could affect your housing? *Do you want assistance to address any barriers?	
Financial				
Does your income support your basic needs?	No	Yes	*Do you have any additional household income * Are you receiving financial assistance? *Do you want assistance to address any barriers?	

CATEGORY	SCORE 1	SCORE 0	ASSESSMENT QUESTIONS (OPTIONAL)	POINTS
Trauma / Mistreatment / Abuse -** If the client scores a 1 in this section, client will automatically be a tier A				
Are you currently experiencing physical, sexual, economic, and/or psychological abuse?	Yes (If yes, identify need to report.)	No	*Are any of these issues creating a barrier to your HIV medical care? *Do you have a safety plan in place? *Do you want assistance to address any barriers?	
Have you ever experienced physical, sexual, economic, and/or psychological abuse?	Yes – And client has not addressed these issues to the extent that they would like, they do not feel like they have healed from this (If yes, identify need to report.)	No – No history of abuse OR Yes – And client has addressed these issues and feel they have healed from it	*Are any of these issues creating a barrier to your HIV medical care? *Do you have a safety plan in place? *Do you want assistance to address any barriers?	

Mental Health -** If the client scores a 1 in this section, client will automatically be a tier A				
Have you ever been diagnosed with a mental health diagnosis?	Yes - Client expresses or exhibits behavior that indicates the Client is a danger to self or others (If yes, complete mental health screening tool. Consult with supervisor) OR Client has been diagnosed with a mental illness and is not in treatment.	No - Client does not report a mental health diagnosis OR Client self-reports mental illness or history of mental illness and receives treatment and/or is evaluated consistently; and condition is stable.	*Do you want assistance to address any barriers? * Do you have a plan for or are thinking of taking any steps to harm yourself?	

CATEGORY	SCORE 1	SCORE 0	ASSESSMENT QUESTIONS (OPTIONAL)	POINTS
Chemical Health -** If the client scores a 1 in this section, client will automatically be a tier A				
Do you use any substances (drugs or alcohol)?	Yes - Client self-reports or exhibits behavior of current addiction or substance abuse	No - Client self-reports no current addiction or substance abuse OR Reports infrequent, legal use of substances	*Do you want assistance to address any barriers? *Have you ever struggled with addiction or substance abuse in the past?	

Incarceration -** If the client scores a 1 in this section, client will automatically be a tier A				
Have you been involved in the criminal justice system in the last 12 months?	Yes	No	*Do you have a Probation Officer? *Was there any lapse in your treatment/HIV medications? *Do you want assistance to address any barriers?	
Have you been incarcerated in the last 30 days?	Yes	No	*Do you have a Probation Officer? *Was there any lapse in your treatment/HIV medications? *Do you want assistance to address any barriers?	

CATEGORY	SCORE 1	SCORE 0	ASSESSMENT QUESTIONS (OPTIONAL)	POINTS
Knowledge of HIV				
What is your knowledge of HIV?	*Client has little understanding of the disease *Client doesn't demonstrate positive health seeking behaviors *Client has a religious/spiritual/other belief(s) that inhibit them from accepting traditional medical treatment options	Client has a clear understanding of the disease (transmission, prevention and progression) and translates knowledge into positive health behaviors	*Do you feel that additional HIV education is needed? *Do you want assistance to address any barriers? *What is your understanding of 'risk of HIV transmission'?	

Risk Assessment				
Have you been diagnosed with an STI or injected drugs in the past 12 months?	Yes (If yes, complete Sexual risk assessment tool. Consult with supervisor)	No	*If yes, have you been treated for the STI? *Have you accessed new syringes? *Do you want assistance to address any barriers?	

Psychosocial Support				
Is there a personal support system you can identify that is aware of your HIV status?	No	Yes	*Do you need assistance disclosing your HIV status to others? *Do you want assistance to address any barriers?	

CATEGORY	SCORE 1	SCORE 0	**ASSESSMENT QUESTIONS** (OPTIONAL)	POINTS
Physical Health				
Are your ADL needs being met?	No	Yes	*What type of ADL's do you need support with? *Do you want assistance to address any barriers?	
Do you have any medical issues other than HIV?	Yes	No	*If yes, what are your medical concerns or co-morbidities (i.e. diabetes, hypertension, Hepatitis C)? *Have you had routine vision care? *Do you want assistance to address any barriers?	
Have you seen a dentist in the last 12 months?	No; Last date reported_____	Yes; Last date reported_____	*Do you want assistance to address any barriers?	
Do you have a Primary Care Provider?	No	Yes	*Do you want assistance to address any barriers?	

Health Literacy				
Do you feel you have a good understanding of your health and medical care?	No OR Yes – And client needs support completing application material not related to medical care such as application and documents	Yes	*Does your understanding or lack of understanding provide a barrier to your care? *What is your ability to read and write? *What is your ability to understand what you read? *Do you want assistance to address any barriers?	

CATEGORY	SCORE 1	SCORE 0	ASSESSMENT QUESTIONS (OPTIONAL)	POINTS
Transportation Assistance				
Is transportation a barrier to getting to your medical appointments?	Yes	If no, what is primary mode of transportation? ☐ Personal car ☐ Public transportation ☐ Transportation services through insurance ☐ Ryan White funded transportation programs	*Does your clinic or insurance offer transportation assistance? *Do you want assistance to address any barriers?	

Food and Nutritional Assistance				
Do you have enough food/nutritional items to meet your needs?	No	Yes	*Do you want assistance to address any barriers?	

Legal Assistance				
Do you currently have any legal needs that need to be addressed?	Yes ☐ Benefits (SSDI) ☐ Immigration ☐ Guardianship/ POA/Living Will/Health Care Directive / Estate Planning ☐ Debt ☐ Discrimination /Confidentiality Issues ☐ Other	No	*Do you want assistance to address any barriers?	

CATEGORY	SCORE 1	SCORE 0	ASSESSMENT QUESTIONS (OPTIONAL)	POINTS
Dependent				
Do you have someone that relies on you for financial support (child, aging parent, partner, etc)	Yes	No	*Do you want assistance to address any barriers?	

NOTES:_____

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	Contact Frequency	Assessment and Planning Frequency			Total Points for Tier
	Phone or Face-to-Face	Complete Acuity Assessment	ISP	Reassessment	
Tier A	A minimum phone or face-to-face every 3 months unless the ISP requires a greater frequency; however a face to face should occur at least every 6 months.	Initial assessment should be started within 5 days of initial client contact and completed within 30 days of intake	Within 45 days of intake	Every 6 months	Score of 7 or more or A Score of 1 on any * asterisk category
Tier B	A minimum phone or face-to-face every 6 months; a face-to-face should occur yearly.	Initial assessment should be started within 5 days of initial client contact and completed within 30 days of intake	Within 45 days of intake	Annually	A score of 6 or below And A score of 0 on any asterisk category