

# Module Four

## Appendix

### **Client Needs Assessment Questionnaire Sample Cultural Competency Expectations**

**CLIENT SUPPLEMENTAL NEEDS ASSESSMENT**  
**Medical Case Management Services**  
**CONTRA COSTA HIV/AIDS**

Agency Name: \_\_\_\_\_ Medical Case Manager \_\_\_\_\_  
 Client CARE Act/ARIES ID: \_\_\_\_\_ or Name \_\_\_\_\_  
 Date \_\_\_\_\_

<p><b>MEDICAL/HEALTH/NUTRITION</b>  <i>This is an ARIES core element. See ARIES form in Appendix 3 or ARIES database for complete screening questions.</i>          Opportunistic Infections _____</p> <p>T-cells/Date _____</p> <p>Viral Load/Date _____</p> <p>Last MD/primary care visit _____</p> <p>Any long periods out of regular care? _____</p> <p>When? _____          Describe: _____</p>	<p><b>INCOME</b>  <i>This is an ARIES core element. See ARIES form in Appendix 3 or ARIES database for complete screening questions.</i>          Does Client have a Payee?  <input type="checkbox"/> <b>Yes</b> If yes, Please indicate name and contact information for payee.          Name _____          Address _____          _____          _____</p> <p><input type="checkbox"/> <b>No</b></p> <p><b>Comments:</b></p>
<p>How many MD/primary care visits in the last 12 months? _____</p> <p>How many medical visits has the client missed in the past year? _____</p> <p>Are there issues that prevent client from making medical appointments? _____          _____</p> <p>What Medications is client taking? (See pharmacy print-out) _____          Input list of all medications into ARIES whether or not related to non HIV condition:</p> <p>Are there any issues related to medication adherence? _____          _____</p> <p>Is the client taking all their medication regularly? _____          _____</p> <p>Nutritional status: _____</p>	<p><b>SOCIAL SUPPORT/NETWORK</b></p> <p>Significant Supports:</p> <p>Children?</p> <p>Which family/friends aware of dx?</p> <p>Sexually active?</p> <p>Practicing safe sex?</p> <p>Aware of safer sex practice?</p> <p>Support group:</p> <p>Volunteers:</p> <p>Recreational/Social activities:</p>

**TRANSPORTATION**

How does client get around?

Does client have a car?

DMV disabled placard/license?

Disabled public transit ID?

Paratransit?

**UTILITIES**

Yes No N/A

PG&E HEAP CARE

\_\_\_\_\_

Reach

\_\_\_\_\_

Medical Quan.

\_\_\_\_\_

Tele. Lifeline

\_\_\_\_\_

Water/San.

\_\_\_\_\_

Other:

**PRACTICAL SUPPORT** (as appropriate)

Yes No

Attendant care

\_\_\_\_\_

IHSS

\_\_\_\_\_

Home care/hospice(circle)

\_\_\_\_\_

Lifeline

\_\_\_\_\_

Child Care

\_\_\_\_\_

Caregiver at home(name)? \_\_\_\_\_

IHSS Provider (name)? \_\_\_\_\_

IHSS SW (name)? \_\_\_\_\_

Comments:

**SUBSTANCE ABUSE**

Addiction?

Treatment? \_\_\_\_\_

Currently in tx?

Where? \_\_\_\_\_

Drug of choice

Frequency/Amount

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Currently using?

\_\_\_\_\_

S/A referral necessary? \_\_\_\_\_

Comments:

<p><b>COMMUNITY RESOURCES</b></p> <p>Case managers:</p> <p>Day program?</p> <p>Food services?</p> <p>Emergency funds?</p> <p>Other(s)?</p>	<p><b>EDUCATIONAL/VOCATIONAL</b></p> <hr/> <p><b>CULTURAL/LINGUISTIC/SPIRITUAL AFFILIATIONS</b></p>																																																						
<p><b>MENTAL HEALTH/PSYCHOLOGICAL</b></p> <p>Therapy?</p> <p>Psychiatrist?</p> <p>Meds?</p> <p>Therapist/Psychiatrist name/#:</p> <p>Psych. History?</p> <p>Physical/sexual abuse history?</p> <p>Coping strategies/current coping?</p> <p>Reactions to illness?</p> <p>Mental health/counseling referral needed?</p>	<p><b>MENTAL HEALTH CHECKLIST</b></p> <p>Do you notice or does client report changes/problems with any of the following?</p> <table border="0"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>1. Concentration:</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> </tr> <tr> <td>2. Safety/judgment:</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> </tr> <tr> <td>3. Motivation:</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> </tr> <tr> <td>4. Personal appearance:</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> </tr> <tr> <td>5. Affect:</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> </tr> <tr> <td>6. Appetite:</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> </tr> </tbody> </table> <p>Is there any evidence of the following?</p> <table border="0"> <tbody> <tr> <td>1. Sleep disturbance: (On sleep meds?)</td> <td></td> <td></td> </tr> <tr> <td>2. Anxiety:</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> </tr> <tr> <td>3. Depression:</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> </tr> <tr> <td>4. Delusions/hallucinations:</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> </tr> <tr> <td>5. Violent/abusive behavior:</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> </tr> <tr> <td>6. Suicide attempts:</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> </tr> <tr> <td>7. Current/Immediate Suicidal plans/thoughts</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> </tr> <tr> <td>8. Sexual issues:</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> </tr> <tr> <td>9. Dementia:</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> </tr> <tr> <td>10. Problems with memory:</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> </tr> <tr> <td>11. Developmental delay:</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> </tr> </tbody> </table>		Yes	No	1. Concentration:	___	___	2. Safety/judgment:	___	___	3. Motivation:	___	___	4. Personal appearance:	___	___	5. Affect:	___	___	6. Appetite:	___	___	1. Sleep disturbance: (On sleep meds?)			2. Anxiety:	___	___	3. Depression:	___	___	4. Delusions/hallucinations:	___	___	5. Violent/abusive behavior:	___	___	6. Suicide attempts:	___	___	7. Current/Immediate Suicidal plans/thoughts	___	___	8. Sexual issues:	___	___	9. Dementia:	___	___	10. Problems with memory:	___	___	11. Developmental delay:	___	___
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<b>LEGAL</b>	Yes	No	N/A	<b>END OF LIFE PLANS</b>
Durable Power of Attorney (DPOA)	—	—	—	Burial or cremation?
Durable Power of Attorney Health Care (DPOAHC)	—	—	—	Plot?
Custody Arrangements	—	—	—	Pre-Payment?
Guardianship	—	—	—	Funeral plans?
Other plans for children	—	—	—	Responsible party?
Will	—	—	—	
Name of DPOA/DPOAHC:				
Legal referral needed?				

**HIV/SAFER SEX KNOWLEDGE**

Needs additional education? \_\_\_\_\_

Topics \_\_\_\_\_

Case Manager/STA Provider: \_\_\_\_\_ Date: \_\_\_\_\_

**CLIENT SUPPLEMENTAL NEEDS ASSESSMENT  
Medical Case Management Services  
CONTRA COSTA HIV/AIDS**

**EXAMPLE**

Agency: Star Provider  
Client CARE Act/ARIES ID: **ANCI4828**  
Date: **4/30/2007**

Medical Case Manager Betty Jones  
or Name \_\_\_\_\_

<p><b>MEDICAL/HEALTH/NUTRITION</b> <i>This is an ARIES core element. See ARIES form in Appendix 2 or ARIES database for complete screening questions.</i> OIs: <b><u>candidiasis, non-PCP cervical cancer/dysplasia, herpes</u></b> T-cells/Date <b><u>&lt;200 3-07</u></b></p> <p>Viral Load/Date <b><u>1 million/3-07</u></b></p> <p>Last MD/primary care visit <b><u>April 2007</u></b></p> <p>Any long periods out of regular care? <b><u>Yes</u></b></p> <p>When? <b><u>3 years ago</u></b> Describe: <b><u>No regular health care before, only ER</u></b></p> <p>How many MD/primary care visits in the last 12 months? <b><u>3</u></b></p> <p>How many medical visits has the client missed in the past year? Are there issues that prevent the client from making medical appointments? <b><u>Currently adheres</u></b></p> <p>What medications is client taking? (See <u>pharmacy print</u> out) In put list of all medications into ARIES whether or not related to non-HIV condition. <b><u>viramune, virasept, trazodne, acyclovir, klonopin</u></b></p> <p>Nutritional status: <b><u>weight gain, poor diet, poor appetite, junk food</u></b></p>	<p><b>INCOME</b> <i>This is an ARIES core element. See ARIES form in Appendix 2 or ARIES database for complete screening questions.</i> Does Client have a Payee? <input checked="" type="checkbox"/> <b>Yes</b> If yes, Please indicate name and contact information for payee. Name <b><u>Bob Green - Rubicon</u></b> Address _____ <u>101 Broadway St</u> <u>Richmond, CA</u> <u>510-888-1234</u></p> <p><input type="checkbox"/> <b>No</b></p> <p><b>Comments:</b></p>
	<p><b>SOCIAL SUPPORT/NETWORK</b></p> <p>Significant Supports: <b><u>IHSS worker (Paul)</u></b></p> <p>Children? <b><u>1) Bonnie (13) lives in Texas; Wally (18) &amp; other two kids live with relatives</u></b></p> <p>Which family/friends aware of dx? <b><u>Entire family aware of dx</u></b></p> <p>Sexually active? <b><u>Yes</u></b></p> <p>Practicing safe sex? <b><u>Yes</u></b></p> <p>Aware of safer sex practices? <b><u>Yes; knows about condoms will discuss other methods.</u></b></p> <p>Support group: <b><u>EIP</u></b></p> <p>Volunteers: <b><u>No</u></b></p> <p>Recreational/ Social activities: <b><u>video movies, EIP support group</u></b></p> <p><b>UTILITIES</b></p>

<p><b>TRANSPORTATION</b></p> <p>How does client get around? <b>Public Transportation</b></p> <p>Does client have a car? <b>No</b></p> <p>DMV disabled placard/license? <b>No</b></p> <p>Disabled public transit ID? <b>Yes (Tri-Delta)</b></p> <p>Paratransit?</p>	<table border="0"> <tr> <td></td> <td>Yes</td> <td>No</td> <td>N/A</td> </tr> <tr> <td>PG&amp;E HEAP</td> <td><u>  X  </u></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> CARE</td> <td><u>  X  </u></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Reach</td> <td><u>  X  </u></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Medical Quan.</td> <td><u>  X  </u></td> <td></td> <td></td> </tr> <tr> <td>Tele. Lifeline</td> <td></td> <td><u>  X  </u></td> <td></td> </tr> <tr> <td>Water/San.</td> <td></td> <td></td> <td><u>  X  </u></td> </tr> </table>		Yes	No	N/A	PG&E HEAP	<u>  X  </u>			<input type="checkbox"/> CARE	<u>  X  </u>			<input type="checkbox"/> Reach	<u>  X  </u>			<input type="checkbox"/> Medical Quan.	<u>  X  </u>			Tele. Lifeline		<u>  X  </u>		Water/San.			<u>  X  </u>
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<p><b>COMMUNITY RESOURCES</b></p> <p>Medical Case managers: <b>Jane F.</b> <b>Barbara N.</b></p> <p>Day program? <b>No</b></p> <p>Food services? <b>Food Bank of Contra Costa/Solano</b> <b>Meals on Wheels</b></p> <p>Emergency funds? <b>Access them intermittently (food, utilities, transportation)</b></p> <p>Other(s)? <b>Substance Abuse Coordinator/Jean Johnson</b></p>	<p><b>EDUCATIONAL/VOCATIONAL</b> <b>10th grade completed - no other plans</b></p> <p><b>CULTURAL/LINGUISTIC/SPIRITUAL AFFILIATIONS</b> <b>Native American, Latina, Caucasian: Raised Jehova's Witness. Speaks Spanish but English is primary language.</b></p>																																																						
<p><b>MENTAL HEALTH/PSYCHOLOGICAL</b></p> <p>Therapy? <b>Mary Brady from AFC</b></p> <p>Psychiatrist? <b>Dr. Carter</b></p> <p>Meds? <b>Prozac</b></p> <p>Therapist/Psychiatrist name/#: <b>M. Brady (510) 883-2562</b> <b>Dr. Carter prescribes psychiatric medications</b></p> <p>Psych. History? <b>Major depression (recurrent), poly substance dependence in remission, tourettes syndrome, dementia</b></p> <p>Physical/sexual abuse history? <b>Client reports husband was abusive and has been sexually abused (raped).</b></p> <p>Coping strategies/current coping? <b>Client states that children are primary strength. Client has shown increased adherence to program/medications.</b></p> <p>Reactions to illness? <b>Fearful, anxious, wants to connect with someone to discuss illness.</b></p> <p>Mental health/counseling referral needed?</p>	<p><b>MENTAL HEALTH CHECKLIST</b></p> <p>Do you notice or does client report changes/problems with any of the following?</p> <table border="0"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>1. Concentration:</td> <td style="text-align: center;"><u>  X  </u></td> <td></td> </tr> <tr> <td>2. Safety/judgment: <b>poor</b></td> <td style="text-align: center;"><u>  X  </u></td> <td></td> </tr> <tr> <td>3. Motivation: <b>improved</b></td> <td style="text-align: center;"><u>  X  </u></td> <td></td> </tr> <tr> <td>4. Personal appearance: <b>improved</b></td> <td style="text-align: center;"><u>  X  </u></td> <td></td> </tr> <tr> <td>5. Affect: <b>fair/calm, sadness</b></td> <td style="text-align: center;">_____</td> <td style="text-align: center;"><u>  X  </u></td> </tr> <tr> <td>6. Appetite: <b>fair</b></td> <td style="text-align: center;">_____</td> <td style="text-align: center;"><u>  X  </u></td> </tr> </tbody> </table> <p>Is there any evidence of the following?</p> <table border="0"> <tbody> <tr> <td>1. Sleep disturbance: (On sleep meds?)</td> <td style="text-align: center;"><u>  X  </u></td> <td style="text-align: center;">_____ <u>  X  </u></td> </tr> <tr> <td>2. Anxiety:</td> <td style="text-align: center;"><u>  X  </u></td> <td></td> </tr> <tr> <td>3. Depression:</td> <td style="text-align: center;"><u>  X  </u></td> <td></td> </tr> <tr> <td>4. Delusions/hallucinations:</td> <td style="text-align: center;">_____</td> <td style="text-align: center;"><u>  X  </u></td> </tr> <tr> <td>5. Violent/abusive behavior:</td> <td style="text-align: center;">_____</td> <td style="text-align: center;"><u>  X  </u></td> </tr> <tr> <td>6. Suicide attempts: <b>not for 5 yrs.</b></td> <td style="text-align: center;"><u>  X  </u></td> <td></td> </tr> <tr> <td>7. Current/Immediate Suicidal plans/thoughts:</td> <td style="text-align: center;">_____</td> <td style="text-align: center;"><u>  X  </u></td> </tr> <tr> <td>8. Sexual issues:</td> <td style="text-align: center;">_____</td> <td style="text-align: center;"><u>  X  </u></td> </tr> <tr> <td>9. Dementia: <b>? Not ruled out</b></td> <td></td> <td></td> </tr> <tr> <td>10. Problems with memory:</td> <td style="text-align: center;"><u>  X  </u></td> <td></td> </tr> <tr> <td>11. Developmental delay:</td> <td style="text-align: center;">_____</td> <td style="text-align: center;"><u>  X  </u></td> </tr> </tbody> </table>		Yes	No	1. Concentration:	<u>  X  </u>		2. Safety/judgment: <b>poor</b>	<u>  X  </u>		3. Motivation: <b>improved</b>	<u>  X  </u>		4. Personal appearance: <b>improved</b>	<u>  X  </u>		5. Affect: <b>fair/calm, sadness</b>	_____	<u>  X  </u>	6. Appetite: <b>fair</b>	_____	<u>  X  </u>	1. Sleep disturbance: (On sleep meds?)	<u>  X  </u>	_____ <u>  X  </u>	2. Anxiety:	<u>  X  </u>		3. Depression:	<u>  X  </u>		4. Delusions/hallucinations:	_____	<u>  X  </u>	5. Violent/abusive behavior:	_____	<u>  X  </u>	6. Suicide attempts: <b>not for 5 yrs.</b>	<u>  X  </u>		7. Current/Immediate Suicidal plans/thoughts:	_____	<u>  X  </u>	8. Sexual issues:	_____	<u>  X  </u>	9. Dementia: <b>? Not ruled out</b>			10. Problems with memory:	<u>  X  </u>		11. Developmental delay:	_____	<u>  X  </u>
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9. Dementia: <b>? Not ruled out</b>																																																							
10. Problems with memory:	<u>  X  </u>																																																						
11. Developmental delay:	_____	<u>  X  </u>																																																					





## Cultural Competency Expectations

Promoting cultural competency among all providers may help break down some of the barriers that contribute to health disparities. As a step in trying to address poor health outcomes, the AIDS Program is requesting that providers tell us what steps they are taking toward implementing culturally based assessments and treatment plans.

Please use whatever resources you feel most appropriate to ensure that needs assessments, care plans and other assessment oriented activities have a visible demonstration of cultural competence. One resource you might consider is a series prepared by the National Minority AIDS Education and Training Center: "Be Safe: A Cultural Competency Model for African Americans" and "Be Safe: A Cultural Competency Model for Latinos". These documents are available in PDF format on their website: [www.nmaetc.org](http://www.nmaetc.org). They suggest using the following questions as a guide to developing a culturally appropriate treatment plan.

1. What do you think has caused your problem?
2. Why do you think it started when it did?
3. What do you think your sickness does to you?
4. How severe is your sickness?
5. What kind of treatment do you think you should receive?
6. What are the most important results you hope to achieve from this treatment?
7. What are the chief problems your sickness has caused?
8. What do you fear most about your sickness?

**Using these (or other) questions without context is not sufficient.** Please review these or other preferred materials you may wish to use before identifying your methods. Once you have determined what you will be doing, please provide the AIDS Program with a brief written description of the process, questions, and steps you will be using toward implementing culturally based assessments and treatment plans. The timeframe is specified in your workplan.