UIC – Center for Literacy
FAST Social Service Department
Case Management Intake Assessment Questionnaire (CMIAQ)

Confidentiality Statement:
All information shared with UIC – Center for Literary Adult Education Program will be held in the strictest confidence.
The following information will identify and address FAST Adult Education student's needs.

Client PED ID#: _____ **Intake Date**: _____

Referral Date: _____ **Referred by**: _____
(Date Referred to Case Management Program)

Last Name: _____ First Name: _____

Does the client prefer to be referred to by another name? _____

Address: _____ City: _____

State: _____ Zip Code: _____

County: _____

Phone: _____

Cellphone: _____

Email: _____

Client can be contacted at: (check all that apply)	_____	**Home**	_____	**By Mail**
	_____	**By Phone**	_____	**Do Not Contact**
Is discretion required?	_____	**Yes**	_____	**No**
If necessary, please provide additional details.	_____			
	_____			

Client's Date of Birth: _____ **Client's Current Age**: _____

Gender:

☐ Female
☐ Male
☐ Transgender-ID as Female
☐ Transgender-ID as Male
☐ Non-binary
☐ Prefer not to disclose

Ethnicity:

Hispanic?
☐ Yes, specify: _____
☐ No

Race:

☐ Asian
☐ Black or African American
☐ Native Hawaiian/Pacific Islander
☐ White
☐ American Indian or Alaska Native
☐ Other:
_____
_____

Relationship Status:

☐ Single
☐ Single-living w/partner
☐ Married
☐ Divorced
☐ Separated
☐ Widowed

Primary Language Spoken:

English:

Read? ☐ Yes ☐ No
Write? ☐ Yes ☐ No

Other Language: _____

Read? ☐ Yes ☐ No
Write? ☐ Yes ☐ No

Client PED ID#: _____ **Intake Date**: _____

Referral Date: _____ **Referred by**: _____

1. Presenting Problem(s)/Immediate Needs (Do you or your family members need help with any urgent or pressing problem right now?)

_____
_____
_____
_____
_____
_____

2. Other Case Management Providers (What other agencies are you working with? What services do they provide you? Are you working with a case manager or receiving case management anywhere else? Where, and with whom? Are these services meeting your needs?)

_____
_____
_____
_____
_____
_____

3. Fluency in English and Ease in Navigating Care Systems (Do you have any difficulty understanding English? Filling out forms in English? Do you find it easier to talk to your doctor with someone translating for you? Do you have any trouble making your own appointments, understanding medical instructions, getting what you need from a medical or social service agency?)

_____
_____
_____
_____
_____
_____

4. Housing (Do you have any problems with your current housing? Is your housing safe and stable? Is your housing in good repair, with adequate furniture and working appliances? Do you have a working phone? Do you already have or need assistance paying rent?)

_____
_____
_____
_____
_____
_____

Client PED ID#: _____ **Intake Date**: _____

Referral Date: _____ **Referred by**: _____

5. Collateral Needs/Disclosure Issues (Do your children, partner(s), or other close supports have needs that affect your ability to get healthcare and stay healthy? Do you have a steady source of emotional support from family and friends?)

6. Medical Insurance/Medicaid (Are you covered for medical costs by Medicaid, Medicare, private medical insurance? Do you need help getting your medical care or medications paid for? Any problems, limitations, or restrictions with your current coverage?)

7. Medical Needs (How is your health right now? Are you currently experiencing any symptoms or disabilities? Do you have any illnesses other than HIV? How recently have you seen your medical providers? Are you able to make and get to your appointments easily? Do you need any help getting your prescriptions filled and taking your medications?)

8. Income and Benefits (Do you have a steady source of income right now? Does your income meet your basic expenses? Any serious outstanding bills? Do you need any help applying for or keeping your benefits?)

9. Incarceration (Are you on parole or probation? Serving any type of sentence currently [i.e., community service hours]? Any outstanding warrants, summonses, cases pending?)

_____
_____
_____
_____
_____
_____

10. Mental Health (Have you ever seen a mental health counselor? Received psychiatric care? Are you currently seeing a mental health counselor? Are you currently prescribed medications for depression or other mental health concerns? Who do you speak to when you feel down?)

_____
_____
_____
_____
_____
_____

11. Domestic Violence (Do you ever feel unsafe in your current living situation? Do you ever feel you or a family member/partner would resort to force when interacting? In the past have you ever been involved in a violent relationship?)

_____
_____
_____
_____
_____
_____

12. Substance Use (Have you used drugs or alcohol in the past? Are you currently using? If so, are you currently enrolled in treatment? Do you consider yourself in recovery? If currently using, are you using harm reduction methods? Do you need a referral for substance use treatment, a harm reduction program, or other support?)

_____
_____
_____
_____
_____
_____

13. Basic HIV Education/Harm Reduction (Do you have questions about HIV infection and AIDS? Do you need information about how to keep yourself healthy? What works for you and what doesn't when it comes to safer sex [safer drug use]? Do want to work with someone to help you learn techniques to reduce the risk of transmitting the virus to others or getting exposed to other infections?)

_____
_____
_____
_____
_____
_____

14. Supportive Service Needs (How is your diet lately? Do you have a regular source of healthy food? Are you maintaining your weight? Do you need help obtaining groceries or meals? Do you have enough clothing to keep you comfortable and protected? Can you get transportation from your home to your appointments, grocery store, easily? Do you need a referral for legal help?)

_____
_____
_____
_____
_____
_____

DISPOSITION

Is Case Management Recommended?

☐ Yes

☐ No *(inform client access to CM is available if future need arises)*

Comments:

_____
_____
_____
_____

Was Case Management accepted?

☐ Yes - Advocacy

☐ Yes – Services

☐ Declined *(If accepted Client should be asked to sign Consent for Case Management Services)*

Comments:

_____
_____
_____
_____

Location of Case Management Services:

☐ FAST South

☐ FAST West

☐ FAST Southwest

☐ Other _____

Agency Name: _____
Contact Name: _____
Contact Phone: _____
Contact Email: _____

Client PED ID#: _____ **Intake Date**: _____

Referral Date: _____ **Referred by**: _____

OTHER IMMEDIATE REFERRALS MADE: (include contact name)

Agency:_____For: _____

Agency:_____For: _____

Agency:_____For: _____

Internal:_____For: _____

Internal:_____For: _____

Internal:_____For: _____

If other agencies or individuals are to be contacted, has a Release of Information form been signed?

☐ Yes

☐ No

Documents Requested of Clients:

Document Type: _____
Request Date: _____
Return Date: _____

Document Type: _____
Request Date: _____
Return Date: _____

Document Type: _____
Request Date: _____
Return Date: _____

I understand that by signing below, I am consenting to allow the UIC's Center for Literacy FAmily STart (FAST) Social Service Department staff (including but not limited to the Student Interns) to communicate with the referral source for the purpose of sharing information related to my care.

Client's Signature: _____ Date: _____

Client PED ID#: _____ Intake Date: _____

Referral Date: _____ Referred by: _____