CASE MANAGEMENT: NPO CHECK LIST

Name of the Organisation: _____

Practitioner's name and surname: _____

Date: _____

Does the organization have the following documents, in their beneficiary files	Is there evidence Yes	Is there evidence No	Comments
1. Intake Forms			
- Co1			
- Co2			
- Co3			
- CW 05			
2. Family Care plans			
- Family Care Plan			
- Contracts between family and the organisation			
- Consent forms (from parents) for participating in organizational activities			
- Risk Assessment Form			
- Girl/Boy Index form			
3. Vital Document			
- Birth certificates			
- Clinic Card			
- Parents ID's			
- Death Certificates			
4. Process notes			
- Caregiver/ Child and youth care workers house visit forms			
- SAW Process note-CW 11			
- Termination report/ Exit forms			
5. School visit reports			
- Educational Plan			
- Teachers Feedback report/process notes			
6. Referral forms			
7. Success stories			
8. Monthly Reports			
-CO6			

Practitioners Signature: _____

Date: _____

Content Page:

(Household Number:)

_____ f a m i ly

1. Intake Forms
   - Col
   - Co2
   - Co3
   - CW 05
2. Family Care plans
   - Family Care Plan
   - Contracts between family and the organisation
   - Consent forms (from parents) for participating in organisational activities
   - Risk Assessment Form
   - Girl/Boy Index form
3. Vital Documents
   - Birth Certificates
   - Clinic Card
   - Parents ID's
   - Death Certificate
4. Process notes
   - Caregiver/ Child and youth care workers house visit forms
   - SAW Process note-CW 11
   - Termination report/ Exit forms
5. School visit reports
   - Educational Plan
   - Teachers Feedback report/process notes
6. Referral forms
7. Success stories
8. Monthly Reports
   - CO6

1. Intakes Forms

C01: Household Details — CCG Form

Add Household

1. Org Household Nr.
2. House Number
3. Street
4. Town
*5. Personnel

Province
District
Municipality
*Ward

Head of Household

1. Type of ID — SA ID Number ☐ Passport Number ☐ Permit ☐
*2. ID Number
3. Organisation beneficiary number
4. Headship — Parent Headed ☐ Grand Parent Headed ☐ Youth Headed ☐ Child Headed ☐ Relative Headed ☐ Other ☐
*5. Name
*6 Surname
*7 Known As
*8. Nationality — South African ☐ Other ☐ Describe
*9. Date of Birth
*10.Sex — Male ☐ Female ☐
*11. Race — African ☐ White ☐ Coloured ☐ Indian ☐
12. Marital Status : — Married ☐ Divorced ☐ Widowed ☐ Single ☐ Cohabiting ☐ Separate ☐
13. Disability — No ☐ Yes ☐ Describe
14. Cell
15. Home Language
*16. Date Joined
17. Relationship to : — Member 1 Member 2 Member 3 Member 4

Add Member 1

1. Type of ID — SA ID Number ☐ Passport Number ☐ Permit ☐
*2. ID Number
*3. Name :
*4. Surname
5.Known As
*6.Nationality
7. Date of Birth
*8. Sex : — Male ☐ Female ☐
*9. Race — African ☐ White ☐ Coloured ☐ Indian ☐
*10.Disability — No ☐ Yes ☐ Describe
11. Date Joined
12. Relationship to Head of Household

Add member 2

1. Type of ID SA ID Number ☐ Passport Number ☐ Permit ☐
*2. ID Number
*3. Name :
*4. Surname
5.Known As
*6.Nationality
7. Date of Birth
*8. Sex : Male ☐ Female ☐
*9. Race African ☐ White ☐ Coloured ☐ Indian ☐
*10.Disability No ☐ Yes ☐ Describe
11. Date Joined
12. Relationship

Add member 3

1. Type of ID SA ID Number ☐ Passport Number ☐ Permit ☐
*2. ID Number
*3. Name :
*4. Surname
5.Known As
*6.Nationality
7. Date of Birth
*8. Sex : Male ☐ Female ☐
*9. Race African ☐ White ☐ Coloured ☐ Indian ☐
*10.Disability No ☐ Yes ☐ Describe
11. Date Joined
12. Relationship

Add member 4 (Complete an extra from 5 members an higher)

1. Type of ID SA ID Number ☐ Passport Number ☐ Permit ☐
*2. ID Number
*3. Name :
*4. Surname
*5.Known As
*6.Nationality
7. Date of Birth
*8. Sex : Male ☐ Female ☐
*9. Race African ☐ White ☐ Coloured ☐ Indian ☐
*10.Disability No ☐ Yes ☐ Describe
11. Date Joined
12. Relationship

Date Captured: ___/___/20___ Data Capturer: _____ Signature: _____
Date Validated: ___/___/20___ Quality Assurer: _____ Signature: _____

C02 ADULT Assessment Form

Completed by the CCG one form per adult beneficairy

CCG Form

NPO	
Organisation:	
Personnel:	

Adult	
Name:	
Surname:	
Org Household Number	
Nationality:	
ID number:	

Date :	
CCG signature	
Supervisor signature	
Date :	

Assessment

	Tick "yes"or "no" where applicable	Yes	No	Comments
Socio Economic Status	Employed ?			
	Primary Breadwinner?			
	Permanent Employement ?			
	Self employed ?			
	Old Age Grant			
Home visits	Household chores needed			
Grants received this month	Old Age Grant			
	Social Relief of Distres Grant			
	War vetaran Grant			
	Disabilty Grant			
	Other : Described			
Private pension	Received this month			
Other	Any other need identify ?			
Other	Any other need identify ?			
Other	Any other need identify ?			

	Tick "yes"or "no" where applicable	Yes	No	Comments
Psychosocial Support	Lay counselling support needed			
	Adult Support Group needed			
Nutrition	Foodparcels needed			
	Daily meals needed			
Vital Documents	ID document needed			
Succesful Referral to	Social Worker			
	SASSA			
	Home Affairs			
	SAPS			
	Clinic			
Poverty alleviation	Food garden established			
	Income generating project establsihed			
Health status	Healthy			
	Sick			
Other	Any other need identify ?			

Comments

Comments on service after this assessment:

C03 CHILD Beneficiary Assessment

Completed by the CCG one per child beneficairy

CCG Form

Organisation/ Project		Date :	
CYCW/CCG Name		CYCW/ CCG Signature	
Beneficiary ID			
Name:		Supervisor Name	
Surname:		Date :	
HH number		Supervisors Signature	

Assessment

	Tick "yes" or "no" where applicable ?	Yes	No	Comments
Orphan status	Mother deceased ?			
	Father deceased ?			
Health	Road to health card updated ?			
	HIV/AIDS status known?			
	TB Adherence support needed ?			
	ARV Adherence support needed ?			
Nutrition Support	Child eats 3 meals per day?			
	Child had meals in the last two days ?			
	Child malnourished (saw a doctor/nurse)?			
	Child not in need of food ?			
	Child is overweight ?			
	Feeding plan needed?			
Psychosocial Support	Individual development plan (IDP) developed?			
	Lay Counselling needed ?			
	Caregiver support needed?			
	Succesion planning needed ?			
	Memory box needed ?			
	Referral to support group needed ?			
	Stimulation needed ?			
Reproductive asssessment	Is the child beneficiary pregnant ?			
	Information unintended pregnancies needed ?			
	Child is on PMTCT medication?			
	Adherence support needed ?			

	Tick "yes" or "no" where applicable ?	Yes	No	Comments
Educational Support	Child attend school or creche?			
	Did child missed ten days from school or creche?			
	School uniform needed ?			
	Homework supervision needed ?			
Grants received	Child support grant received ?			
	Foster child grant received ?			
	Care dependency grant received ?			
Refferd for services to:	Social Worker			
	SASSA			
	Home Affairs			
	Police station			
	Clinic / Hospital			
	Home Affairs			
Action taken as a result of referral:	Child removed from parents / family ?			
	Court order?			
	Treatment provided ?			
	No further action necessary?			
	Other needed identify			
Child protection incidents, Identified	Child sucessfully placed ?			
	Sexual Abuse case open ?			
	Form 22 to be completed ?			
	Child using drugs?			
	Child drinking alcohol?			

Services after this assessment : Comments

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CW 05: INTAKE FORM
CONFIDENTIAL
To be completed by Social Worker

Briefly explain at the start of the interview Your name, title, mandate of the organization and the purpose of the interview, as well as the client's rights in the process including participation, confidentiality and their right to services and information, dignity and respect. Note that in some cases there may be multiple clients in one case		**Intake Ref Number**
Primary Client Surname	**Primary Client First name**	**Primary Client ID Number / Date of Birth**
If client is a child, add details of caregiver(s) below		
Caregiver Surname	**Caregiver First name**	**Caregiver ID Number / Date of Birth**

Presenting problem(s) and expectations of the client
Ask the client to explain their main concerns, expectations and coping skills applied

Preliminary / Initial Assessment by the social worker *Provide your professional opinion of the matter that is presented to you*			
Primary Problem Code (see CW 06)		**Other Problem Codes**	
Risk Level (see CW 07)	☐ Emergency 24 hours – 48 hours	☐ High 1 week	☐ Mild 3 weeks

Intake Action *Select relevant intake action and describe below, can choose multiple*	☐ Emergency Action ☐ Referral for comprehensive Assessment Internally (refer to CW 08) ☐ Case consultation (with Supervisor) ☐ Internal referral to departmental programme (see section below and complete CW 4A) ☐ External referral (see section below and complete CW 4B & C) ☐ Issue resolved (complete CW 10 & CW 12), no follow-up required ☐ Comprehensive assessment not required	
If comprehensive assessment not required, provide reasons		
If Referred, indicate to whom and date for follow up *Attach copy of referral form (CW 4A / 4B) to this intake*	☐ Referral to other Service provider, please specify	**Date of follow-up**
If emergency action is required, complete section below *If emergency action is required, discuss options with the client and explain the reasons for an emergency action and take client's consent. If client does not consent, but social worker believes emergency action is required, consult with supervisor to determine action to be taken. Comprehensive assessment to be completed after emergency action.*		
Specify emergency		
Briefly describe action to be taken		**Date for emergency action**

Consent			
Do you consent to the recommended Intake Action above	☐ Yes ☐ No	**Do you consent to sharing your information with other service providers (if necessary) or specific requests**	☐ Not applicable ☐ Yes ☐ No
Specify reasons if no to any of above questions			
If social worker is required to take action / share information without the consent of the client, document reasons why			
Client / Caregiver consent: signature or thumbprint			

Details of key people to be interviewed for assessment purposes					
Name (s)		**Contact details**		**Relationship**	
Name (s)		**Contact details**		**Relationship**	
Name (s)		**Contact details**		**Relationship**	
Name (s)		**Contact details**		**Relationship**	

INTAKE COMPLETED BY			
SSP Name and Surname	**Signature**	**SACSSP Number**	**Date**

RECOMMENDATION BY SUPERVISOR			
Intake Action Supported	☐ Yes ☐ No	**Return Date for Intake Action**	
Comments from supervisor			
Supervisor Name and Surname	**Signature**	**SACSSP Number**	**Date**

CASE ALLOCATED TO / CASE MANAGER		
Instruction to Registry (if relevant)	☐ Open file	☐ Other, specify

2. Family care plans

Family Care Plan[1]

Family Name:		Family Registration number:		Date of Registration:	

					Progress Made				
No.	Family members name	Identified Needs (each member may have more than one need – plan for each individually)	Action to be taken	Action to be taken by whom (e.g. parent, caregiver, social worker)	Month	Month	Month	Month	Month .....

[1] After 5 months, each family member should be reassessed for need, this will include redoing the HIV risks assessment to indicate if testing is necessary

					Progress Made				
No.	**Family members name**	**Identified Needs** (each member may have more than one need – plan for each individually)	**Action to be taken**	**Action to be taken by whom** (e.g. parent, caregiver, social worker)	**Month**	**Month**	**Month**	**Month**	**Month** .....

Name of parent/guardian:		Name of practitioner (caregiver/SAW/SW):	
Signature:		Signature:	

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HIV RISK ASSESSMENT FORM

Organisation/Service Point			Job Title		
Parent's/Legal Guardian/ Caregiver Full Name			Parent's/Legal Guardian Contact Details		
Child's Full Name			Child's Contact Details		
Child's ID Number/Date of Birth			Date of assessment		
Gender		Race		Disability?	Y/N

PART 1: HIV SCREENING

Is the child's HIV status known		**Yes**	**No**
What is the status	**Positive**	**Negative**	**Unknown**

POSITIVE STATUS	**If POSITIVE: STOP the risk assessment.** Ensure that the child is enrolled in a treatment and care programme and support them with adherence and retention in care.
NEGATIVE STATUS	**If NEGATIVE:** First determine when the test was conducted. If more than 6 months ago and child is over 13 years of age and sexually active, **proceed with risk assessment questions (Part B).** **NB:**If HIV test was conducted within the last 6 MONTHS: **HIV test NOT needed (as per HTS Policy).** **STOP** screening and refer to Social and Behaviour change programmes. If possible, **confirm** documentation of the test **results.**
UNKNOWN STATUS	Establish the reasons the HIV status is not known and whether the Risk Assessment was ever conducted? Determine whether was there any HIV test conducted in the past. **NB**: If there was no Risk Assessment and HIV Test conducted, **proceed to risk assessment questions(Part B).**

PART 2: RISK INDICATORS

CIRCUMSTANTIAL INDICATORS (PARENTAL/FAMILY)	**Yes**	**No**
Are either of the child's biological parents reported to be HIV positive		
Is one or both parents deceased due to a known HIV related illness?		
Does the child have one or more siblings that are deceased? (***If siblings of the child are deceased, ask probing questions on the cause of death, especially if the cause may HIV, TB related)***		
Is there any member of the household that is addicted to substances? ***(Probe to ask the nature of addiction and implications to child care).***		
Has there been incidents of domestic violence in the family? ***(Probe about the nature of the incidences, who is involved and how often).***		

If **YES** to any of the above the **CHILD IS AT RISK** of HIV and supportive referral for **TESTING IS ADVISED** *(consent for referral to local hospital, clinic or health partners should be obtained prior to making a referral).*

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HEALTH INDICATORS The SSP must use the following symptoms to enquire and to observe the client to determine the risk. NB: If the child is experiencing some of these symptoms, the child may be at risk of HIV		Yes	No
Does the child get sick often or has he/she been sick for more than three weeks at time?	**ANY of the following conditions should be checked:** • Fever- Frequent and long lasting fevers Fever, a cough, shortness of breath, rapid shallow breathing • Weight loss -Slow growth and weight loss • Runny stomach – continues for 3 – 5 days and happens often e.g., every month • Swollen lymph nodes(neck, armpits and groin that persists more than 3 months. • Yeast infections: Persistent or frequent oral or vaginal yeast infections • Diarrhoea that continues several times • Ear infection, pus (yellow substance) leaking from ear, may have been leaking for a long time and is not responding to treatment or stops when on treatment only to restart again • Skin problems (itchy, spotty skin) • Lung infections: Lung infections and difficulty in breathing • Bacterial infections : Repeated bacterial infections, such as middle ear infection, sinusitis or pneumonia. • Mouth ulcers : Mouth ulcers or persistent lesions and open blisters.		
Is the child small and/or underweight for his/her age?	If available - review the child's Road to Health card. Does the child not gain weight even if they are receiving regular nutritional meals?		
Has the child been diagnosed with TB?	Check Road to Health card if available		
Has the child been admitted to hospital in the past six months?	Check Road to Health card if available		
If YES to any of the above the **CHILD IS AT RISK** of HIV and supportive referral for **TESTING IS ADVISED** (refer to local hospital, clinic or health funded NPO for HIV testing)			

BEHAVIORAL INDICATORS		
FOR YOUNGER CHILD **(Ask the primary caregiver)**	Yes	No
Do you suspect that the child may have been exposed to sexual violence? ***Probe on the nature of the violence.*** If there is suspicion that the child may have been abused ***check if the suspicion was reported to the police or a social worker).*** ***Please note that all suspicion of abuse MUST be reported to a social worker or a police officer.***		
Do you know if the child has been sexually abused? **(If yes probe further and identify a need for a referral to appropriate services)**		

ADOLESCENT/YOUTH INTERVIEW (Ask adolescents only)	Yes	No
Do you have an intimate partner?		
What is the age difference between you and your intimate partner?		
Are you sexually active?		
Have you ever engaged in sexual activities with anyone other than your intimate partner		
Have you been sexually and/or physically abused and or violated ? ***(If there is a suspicion that the adolescent may have been abused, the matter should be reported to the police or a social worker)***		
Have you been drunk or high on substance and had sex,or do you suspect that you may have been sexually abused whilst intoxicated?.		
If **YES** to any of the above the **CHILD IS AT RISK of HIV** and supportive referral for **TESTING IS ADVISED** (refer to local hospital, clinic or health funded NPO for HIV testing)		

PART 3: ASSESSMENT RESULT AND ACTION	
Outcome	**Comment**
Test Required	
Test Not Required	
Routine testing every six months required	
Child Referred for HIV Testing (indicate health facility where OVCAY is referred to)	
Date for Follow- up:	
Confirmation of HIV testing received	
Ensure that all Referrals are Entered on the Referral Log and the Referral is noted on the individual child's file	
Social Service Practitioners Overall Comments and concerns :	

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Primary Caregiver Consent to Supportive Referral for HIV Testing Form

I, _____ Parent/Guardian/Caregiver of,

Child 1 ..... Date of Birth .....

Child 2.....Date of Birth .....

Child 3.....Date of Birth.....

from (Residential Area):.....

Grant permission for my child/children to be referred for HIV testing.

Please write your initials or put a fingerprint to indicate your response on each of the following sentences below:

	YES	NO
I, hereby confirm that I have been informed by _____ _____ (Name of Social Service Practitioner) about the nature, conduct, benefits, risks and implications involved in undertaking an HIV Test.		
I, therefore freely and voluntarily agree that my child/ren is/are referred for an HIV test which will be performed by a Health Practitioner.		
I agree that the Health Practitioner will inform me of the results of the test in person and refer me or my child/ren back to the organisation/facility for further follow ups on prevention, treatment, adherence, care and support.		
I have also been provided with an option to consent to disclose results in a safe and confidential manner		
I have also been provided with an option to withhold my right not to disclose the results.		
I know that I am at any stage, free to withdraw my consent for referral for HIV test not to be performed.		

Parent/Guardian/Caregiver:(Identity number)	Social Service Practitioner (SACSSP No)
Address:	Name of Service Point/Organisation:
(Place) Signed at:	(Place) Signed at:
Date On the _____ (20_____)	Date On the _____ (20_____)
Signature:	Signature:
Print Name:	Print Name:
Mobile Number:	Mobile Number:

NB: Date Stamp Required

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Child Assent Form for referral for HIV Testing

I, _____grant permission for my social worker/social auxiliary worker/child and youth care worker/ community caregiver to refer me for HIV Testing Services, at a local hospital, clinic or health focused community based organisation

Date of Birth (Child) _____

From (Residential Area): _____

Please write your initials or put a fingerprint to indicate your response on each of the following sentences below:

	YES	NO
I, hereby confirm that I have been informed by _____ _____ (Name of Social Service Practitioner) about the nature, conduct, benefits, risks and implications involved in undertaking an HIV Test.		
I, therefore freely and voluntarily agree to be referred for an HIV test which will be performed by a Health Practitioner.		
I agree that the Health Practitioner will inform me of the results of the test in person and refer me for further follow ups on prevention, treatment, adherence, care and support.		
I have also been provided with an option to consent to disclose results in a safe and confidential manner		
I have also been provided with an option to withhold my right not to disclose the results.		
I know that I am at any stage, free to withdraw my consent for referral for HIV test not to be performed.		

Child/Adolescent/Youth (Identity Number)	Social Service Practitioner (SACSSP number)
Address:	Name of Organisation:
(Place) Signed at:	(Place) Signed at:
Date On the _____ (20_____)	Date On the _____ (20_____)
Signature:	Signature:
Print Name:	Print Name:
Mobile Number:	Mobile Number:

NB: Date Stamp Required

Client Referral Form

1. The client referral form is standardized throughout the referral network to ensure that the same essential information is conveyed by referring and receiving organisations.

2. The form is divided into two sections:
   a) Part A, the referral slip, is completed by the organisation/person making the referral (referring organisation).
   b) Part B, services provided, is completed by the organisation/person filling the referral (receiving organisation).

3. The person/organisation initiating the referral completes the Referral Slip (Part A), which includes the following information:
   a) Date of referral.
   b) Ref Number: **To be provided and generated by the organisation**, e.g., 35/11/16 (35th referral of the 11th Month (November) of the Year 2016)
   c) Client's (name and date of birth.)
   d) Name of person initiating referral.
   e) Name, address and phone number of the organisation/facility initiating referral.
   f) Name of contact person at organisation where client is being referred.
   g) Name, address and phone number of organisation where client is being referred.
   h) List of the service(s) for which the client has been referred. Use the codes at the bottom right side of the form to indicate services needed. Space is provided to write additional notes regarding the client's needs.

4. Clients or family members are given the referral form directing them to the appropriate organisation(s) for the services they need.

5. Clients or family members present the referral form at the receiving organisation. The information on the referral form informs the service provider of the client's needs.

6. After the requested services are rendered, the provider at the receiving organisation completes Part B (services provided), which includes the following information:
   a) Date service(s) provided.
   b) Services provided.
   c) **Use codes at the bottom of the form to indicate services provided.** E.g., 11 (Code for ART Therapy)
      - Indicate if the services were completed as requested.
      - If follow-up services are needed, please specify using the code and schedule a date.
   d) Additional comments.

7. The completed client referral form is either sent directly to the referring organisation or returned there by the client on the next visit.

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CLIENT REFERRAL FORM

NAME OF ORGANISATION: _____

PART A: Referral Slip: To be filled out by the organisation making the referral (referring organisation)		PART B: Services Provided: To be filled out by the organisation fulfilling the referral	
Date:	Ref No.:	Date:	Name of Organisation/Dept.:
Client Name:	Date of Birth:	Client Name:	Assisted by:
Referred by: (Name of Organisation)		Services Provided: Services Provided (please use codes below): _____ Services COMPLETED as requested: Yes: _____ No: _____ Follow–up needed: Services: _____ Date for follow up: _	
Person:		Additional Comments:	
Telephone/Mobile:		CODES FOR SERVICES REQUIRED	
Address:			
E-mail:			
Referred to: (Name of Organisation/Dept.)			
Person:			
Address:			
Telephone/Mobile:			
E-mail:			
Services Required/Notes, please use codes: e.g., (9) HIV Testing Services			

Statutory social work services	1	HIV testing services (hospital, clinic, health funded NPO)	9	Psycho-social support	17	General health care	25	
Social grants	2	HIV prevention	10	Psychological care	18	Sexual and reproductive health	26	
Birth registration and ID documents	3	Antiretroviral therapy (ART)	11	Peer counselling	19	Support for gender-based violence	27	
Prevention and early intervention	4	Adherence counselling and disclosure	12	Youth support groups	20	TB treatment	28	
Succession planning	5	PLHIV support group	13	Spiritual support	21	Mental health	29	
Other HIV clinical services	6	PEP/PrEP services	14	Home-based care	22	Substance abuse management	30	
Educational support	7	Nutritional support	15	Legal support	23	Economic strengthening	31	
Other (specify)	8	Other (specify)	16	Other (specify)	24	Other (specify)	32	

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HIV Tracking Form

Beneficiary Details

First Name																							
Surname																							
Date of Birth	D	D	M	M	Y	Y	Y	Y	Age:						Sex: Male Female								
ID Number																							

CONFIDENTIAL INFORMATION - STORE AND HANDLE THIS FORM SECURELY AT ALL TIMES

Is the status of this beneficiary known? ☐ YES ☐ NO

If the status has been disclosed, please indicate below.

☐ Positive	☐ Negative	☐ Unknown >>> Offer HIV test or referral
Is this person on ART? ☐ Yes ☐ No >>> Refer for ART services Confirmation of the referral for ART completed ☐ Yes ☐ No If Yes >>> Date of completion of referral: Month_____Year_____ Date of most recent ART initiation? Month_____Year_____ Date of last CD4 count? Month_____Year_____ What was their CD4 count? _____ Date of last viral load test? Month_____Year_____ What was their viral load? ☐ ≥1000 (Not virally suppressed) ☐ ≥50 and <1000 (Virally suppressed, but still detectable) ☐ <50 (Undetectable/LDL) Name of Facility where ART is received: _____	>>> If Negative it is recommended that a risk assessment be conducted every 12 months for beneficiaries over the age of 13. (Provide Proof where possible)	Why is status unknown? ☐ Never tested ☐ Refuse to disclose whether they've ever tested ☐ Refuse to disclose HIV status ☐ Other reason, Specify: _____ _____ Has this child been risk assessed? ☐ Yes ☐ No Outcome of risk assessment: ☐ test not indicated (low risk) ☐ test required (high risk) If test is required, indicate referral date ____/____/_____ Clinic name: _____ If referral is completed, please complete a new form with updated status

Please be sure to complete the table below.

Personnel Name		Data Capture Name	
Personnel Signature	Date	Data Capture Signature	Date
Supervisor Name		Data Validation Name	
Supervisor Signature	Date	Data Validation Signature	Date

3. Vital Documents

4. Process notes

Site Visit form

Name of care giver: .....

Family: .....

Date visited: .....

Purpose of the visit

.....

.....

.....

.....

.....

Planned actions

.....

.....

.....

.....

.....

Achievements

.....

.....

.....

.....

.....

Client signature..... Date.....

Caregiver's ..... Date .....

Family Exit form

Family Name: .....

CYCW's name: .....

Supervisor name: .....

Registration Date: .....

Date visited: .....

Purpose of the visit

.....

.....

.....

.....

.....

.....

Achievements

.....

.....

.....

.....

.....

.....

Outcome of the visit

.....

.....

.....

.....

.....

Client signature..... Date.....

CYCW's ..... Date .....

Supervisors signature: .....

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CW 11: CASE WORK PROCESS NOTE

CONFIDENTIAL

The process note must be completed for each engagement with a client(s), whether in person or telephonically. All SSP's working on a case should record their engagements on a process note

Client(s) Surname	Client(s) First name		Client(s) ID Number	File No
Name and Contact details of person(s) engaged	**Problem Code**	**Intervention Code**	**Type of Engagement**	
			☐ Office ☐ Home ☐ School	☐ Court ☐ Telephone ☐ Other _____

Purpose of engagement and what transpired

Outcome and Follow-up

Evaluation / reflection of engagement

Date of next follow up			
SSP Name and Surname	**Signature**	**SACSSP Number**	**Date**

Additional information (*to be used if space on first page is not sufficient*)

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CW 13: TERMINATION REPORT
CONFIDENTIAL

A Termination report should be completed only once an evaluation has been done and it has been found that the intervention should be terminated.

Client Surname	Client First name	Client ID Number	File No

Were all planned interventions implemented as per Planning and Contracting? If no, please explain

Reasons for terminating the service *Please select relevant reason and briefly describe below*			
☐ Intervention completed	☐ Client declined service	☐ Client unavailable	☐ Other

If intervention completed, was client informed and did they consent to terminating service?	☐ Client informed and consented ☐ Client informed but did not consent. Please explain below ☐ Client not informed. Please explain below

Client Name and Surname	Signature		Date
SSP Name and Surname	**Signature**	**SACSSP Number**	**Date**

Supervisor Comments:

Supervisor Name and Surname	Signature	SACSSP Number	Date

5. School Visit Reports

Educational Progress Record

Family name: _____

Year:_____

	Surname	Name	Sex	Age	School	Grade	Term 1		Term 2		Term 3		Term 4			Intervention needed	
							Days Absent	Average	Days Absent	Average	Days Absent	Average	Days Absent	Average	Progressing to next grade	Yes	No

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CW 04B: EXTERNAL REFERRAL FORM

CONFIDENTIAL

To be completed in all instances where a client is referred to an external service provider. Provide Client with original copy of referral and keep copy of referral either on client's file or on Referral file

Case referred from			
Service Point		**Tel**	

Case referred to			
Organisation name		**E-mail**	
Physical Address		**Tel**	

Referral of client	
Dear Sir/ Madam The below named consulted our offices on _____. You are requested to assist him / her with services linked to the following (*mark X where applicable*)	
Social Welfare Services (Focus areas)	
☐ Poverty alleviation ☐ Social integration ☐ Family preservation ☐ Social Crime Prevention ☐ Victim Empowerment ☐ Care and protection of Vulnerable Groups - Children	☐ Care and protection of Vulnerable Groups – Persons with Disabilities ☐ Care and protection of Vulnerable Groups – Older Persons ☐ Prevention, Care and Support of Substance abuse ☐ Prevention, Care and Support of HIV and Aids ☐ Mental Health/Psychosocial ☐ Other (specify) _____
Other services	
☐ Grants ☐ Food and nutrition ☐ Education ☐ Health ☐ Other (specify) _____	☐ Shelter for victims of violence ☐ Police ☐ Legal assistance ☐ HIV services

Details of the client			
Client name**		**Contact number/s**	
DSD Reference Number		**Identity no**	
Gender	☐ Male ☐ Female	**If foreign national, complete section below**	
Date of Birth		**Type of identification**	
Address, including district		**Country of origin**	
		Language spoken	
If child, add parent/caregiver name **			

*** For confidentiality purposes, social service practitioner may complete only the preferred first name that the client/caregiver wishes to be used. If there are concerns for safety or confidential information included below, do not complete identifying details such as name, and ID/DSD reference number*

Risk Level **Response required within**	☐ Emergency 24 hours – 48 hours	☐ High 1 week	☐ Mild 3 weeks

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Consent and information sharing		
Describe preferred way to contact the client and any restrictions on contacting the client		
Has the client consented to share information with the service provider?	☐ Yes ☐ No	If yes, add signature

Briefly describe service required and any relevant information that client has consented to share with service provider. *Ensure sufficient information is provided for service provider to provide relevant service; avoid sharing details not required for the provision of that specific service.*

Feedback required from service provider	**Date Feedback required**
☐ Yes ☐ No	

SW/SAW Name and Surname	**Signature**	**SACSSP Number**	**Date**

CLIENT REFERRAL FORM

- Referring organisations: please fill out Part A and ask client to take it to the receiving organisation.
- Please fill out one form per service needed.
- Receiving organisation: please fill out Part B and either return it directly to the referring organisation or ask the client to return it to the referring organisation at next visit.

Part A: Referral Slip: To be filled out by the organisation making the referral (referring organisation)

Date:

Client Name: | **Date of Birth:**

Referred from: (Name of Organisation)

Referred by:

Address:

Telephone/Mobile:

E-mail:

Referred to: (Name of Organisation)

Person:

Address:

Telephone/Mobile:

E-mail:

Services Needed/notes (please use codes below): e.g.

Part B: Services Provided: To be filled out by the organization fulfilling the referral

Name of Organisation: **Assisted by (name):** **Date:**

Services Provided:

☐ **Services provided (please use codes below):** _____

☐ **Services completed as requested: Yes:_____No:_____ Signature:** _____

☐ **Follow–up needed: Services:**_____ **Date for follow up:** _____

Additional Comments:

For services use the following codes:

SERVICES PROVIDED

Child Protection (please tick)		HIV Prevention, Care and Support (please tick)		Psychological Care (please tick)		General Health (please tick)		Other (please tick)	
1. Statutory social work services		8. HIV Counselling		15. Psychosocial support		22. General health care		29. Educational support	
2. Social grants		9. HIV prevention		16. Psychological care		23. Sexual & Reproductive Health		30. Nutritional support	
3. Birth registration & ID documents		10. Antiretroviral therapy		17. Peer counselling		24. Support for gender based violence		31. Legal support	
4. Prevention & early intervention		11. Adherence counselling		18. Youth support groups		25. TB treatment		32. Economic strengthening	
5. Succession planning		12. PLHA support group		19. Spiritual support		26. Mental health		33. Other (specify)	
6. Other (specify) _____		13. Other HIV clinical services		20. Home based care		27. Substance abuse management		34. Other (specify)	
7. Other (specify)		14. PEP/PrEP services		21. Other specify)		28. Other (specify)		35. Other specify)	

7. Success Stories

8. Monthly Reports

C06: Monthly Household Services Report (V2.0)

CCG Name

CCG Form

Head of Household Details					Number of services received										Month:
Page 1					Start date :							Date ended			
Number	First Name	Surname	Org #	ID #	Food parcels	Home visits	Blankets	Health Education	Food Garden supplies	Attend Support groups	Income project established	Inheritance	Awareness Campaigns	Group Therapy	Signature Household Head
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
11															
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19															
20															

Date Captured: ___/___/20___ Name of Data Capturer: _____ Signature: _____

Date Validated: ___/___/20___ Name of Quality Assurer: _____ Signature: _____