ARIES DATA FORMS

Entered Into ARIES ☐

RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Staff Member Completing Form: _____

Chart Number: _____

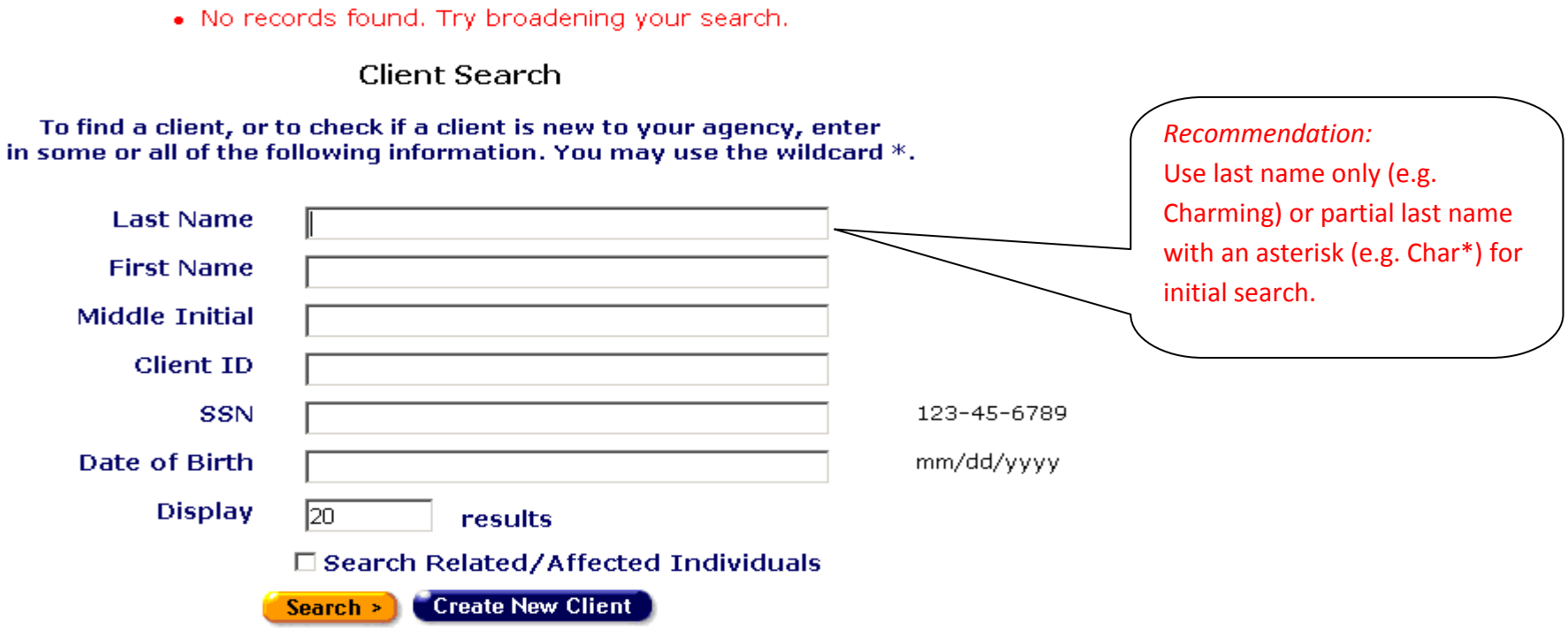
Agency: _____

Date: _____

Client Search:

1. The initial search determines if the client is already registered in ARIES with your agency.
2. If the client is not found, the system will ask you to broaden your search. For example, if you searched "Prince" (first name) and "Charming" (last name) on the first attempt, try leaving the first name blank and enter only "Char*" (C-h-a-r with an *asterisk*) or some other, shorter version of the last name you are searching. This will help to ensure duplicates are not created in the system due to spelling errors and the like.
3. If the client is still not found, click "Create New Client".

IMPORTANT: If the client informs you that they are already in ARIES but you are unable to pull up their record, please call either the ARIES Helpdesk or the Ryan White Program for assistance to avoid the creation of a duplicate record.



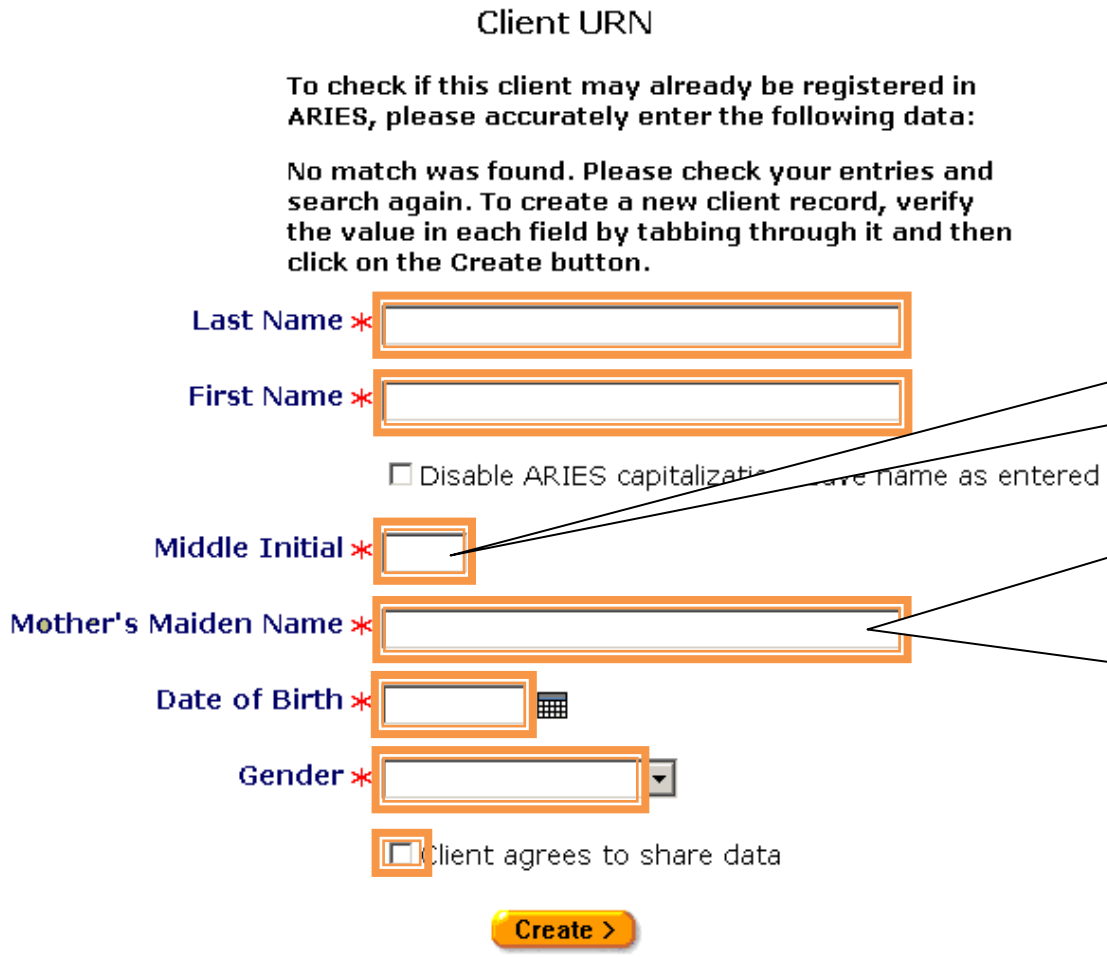
ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Adding Client:

1. If the client was not found in your agency in the search process mentioned above, the system will ask you to enter the 6 identifiers to search the entire ARIES system for the individual. *Note: The identifiers must be entered exactly to find a client that has already been entered into ARIES by another agency and to avoid creating a duplicate entry.*
2. If the client is not found, the system will ask you to check your entries and search once more.
3. If the client is still not found, you will need to create a new client record by tabbing through each field and clicking "Create".
4. ***Be certain to obtain a signed ARIES Consent form from the client before proceeding.



Tip: If client does not have middle initial or there is no way for you to obtain their middle initial, leave this field **blank**.

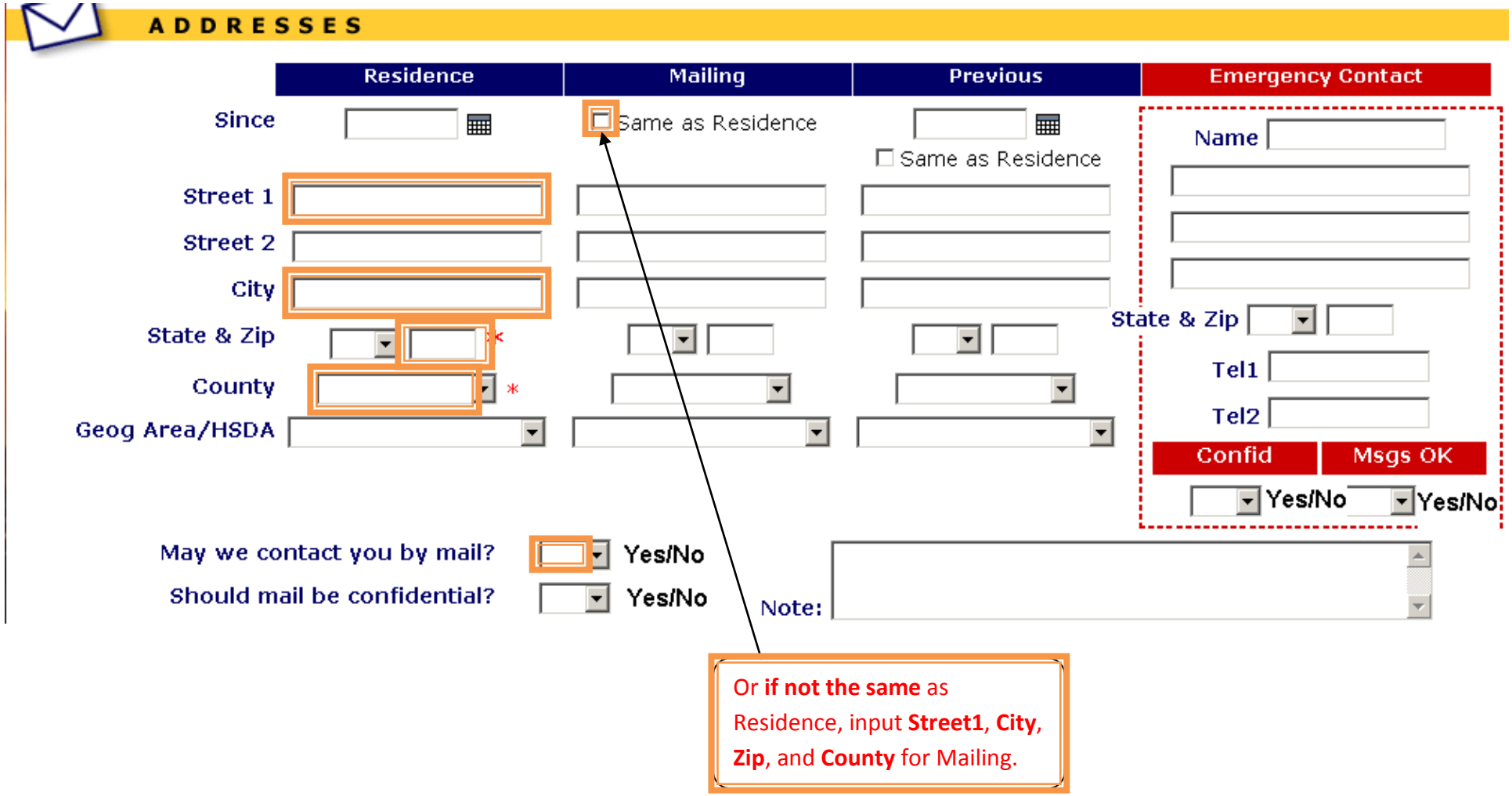
Tip: If client does not want to give their full Mother's Maiden Name, enter only the first 3 letters of their mother's maiden name. If the client will not give the first 3 letters OR the client does not know their mother's maiden name, use the client's last name. Example: Prince Charming = Charming. If the name is less than 3 characters, simply enter the letters available. **Instruct the client to use the same convention when enrolling at other agencies.**

ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Demographics: Contact Info: Contact Information: Addresses

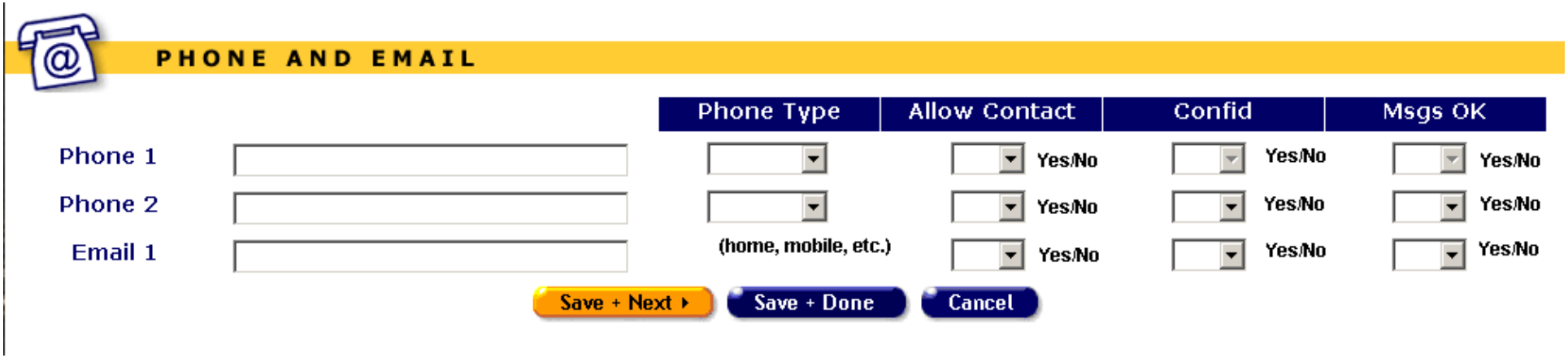


ARIES DATA FORMS

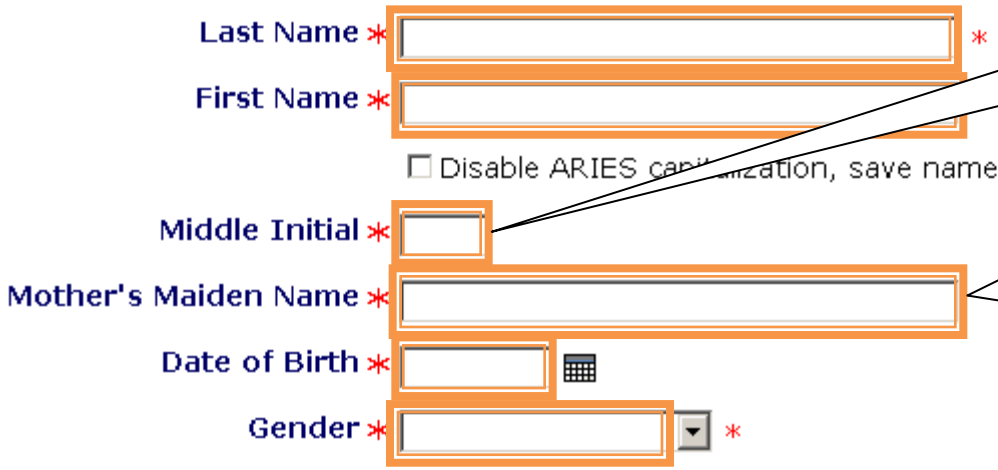
RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Demographics: Contact Info: Contact Information: Phone



Demographics: Demographic Detail: Identifiers



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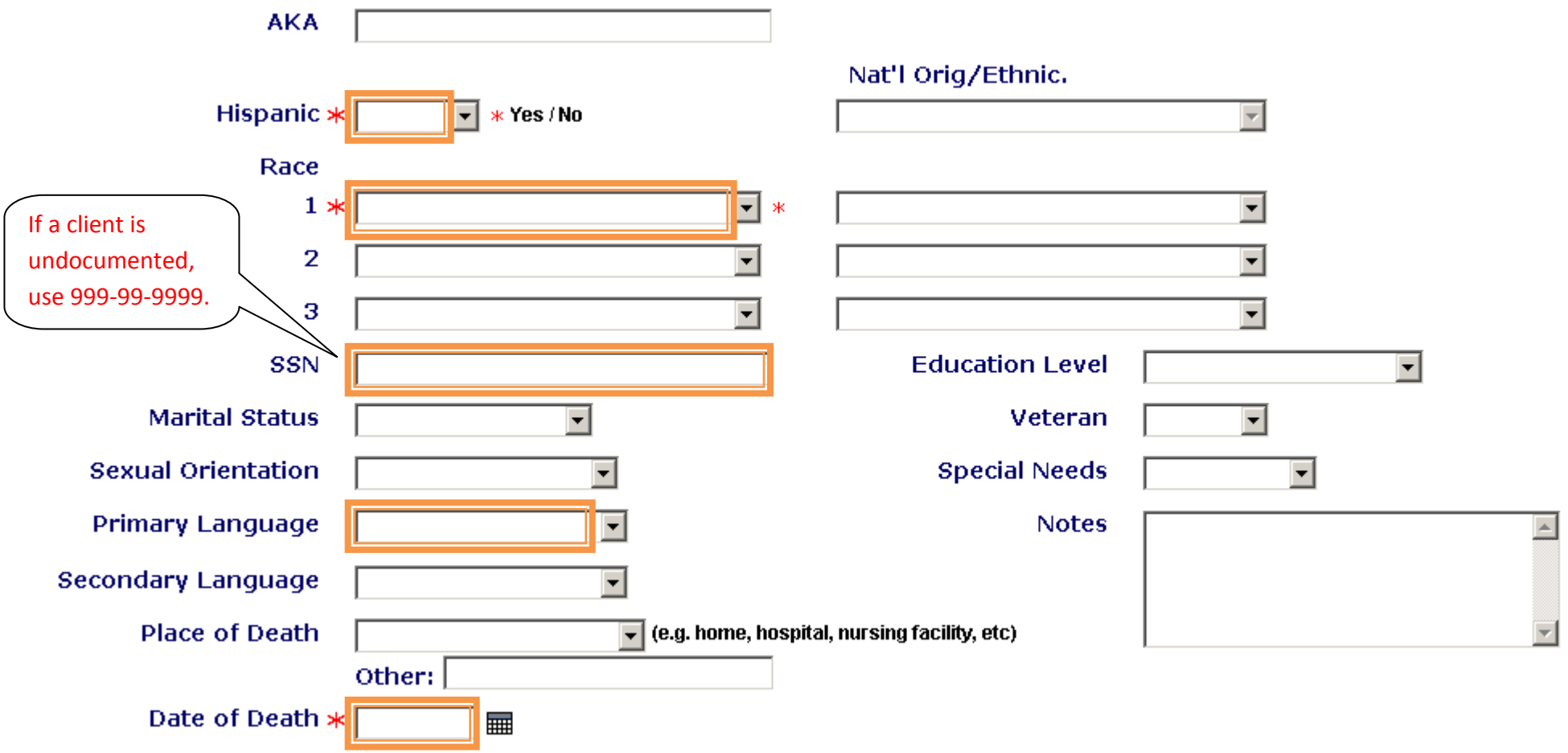
ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Demographics: Demographic Detail: Demographics



ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Demographics: Living Situation: Living Situation

Current Living Situation *

Housing Assistance

HOPWA, HUD, Section 8, etc.

Living Situation since *

HUD Application Date

If rent or own, do you have a signed lease, title or tax receipt?

Living Situation in last 12 months (check all that apply):

- ☐ Homeless from the streets
- ☐ Living with relatives/friends
- ☐ Homeless from emergency shelter
- ☐ Rental Housing
- ☐ Transitional housing
- ☐ Participant-owned housing
- ☐ Psychiatric facility
- ☐ Board care or assisted living
- ☐ Substance abuse treatment facility
- ☐ Rented room
- ☐ Hospital or other medical facility
- ☐ Refused to answer
- ☐ Jail/Prison
- ☐ Other

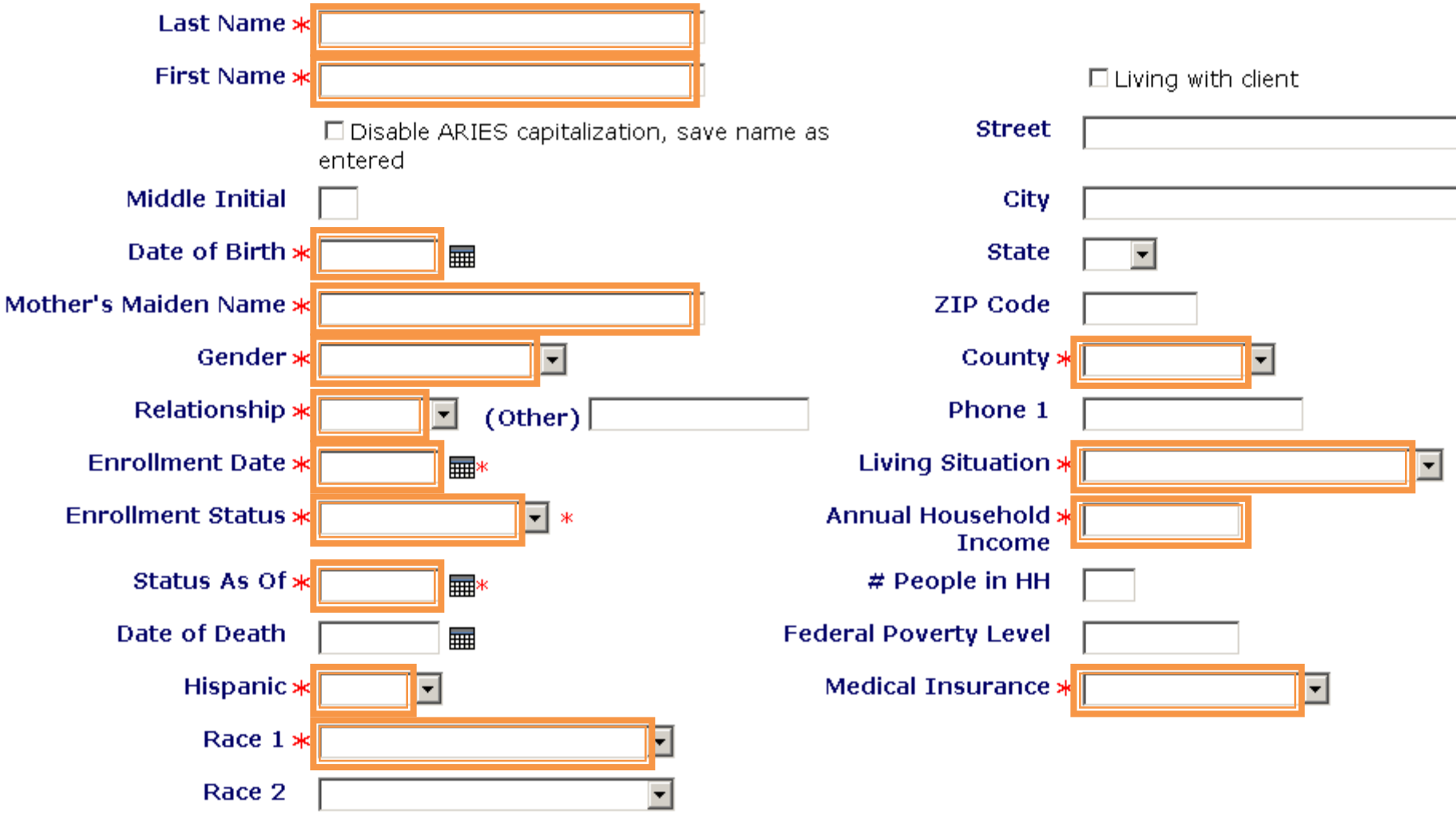
- ☐ Unknown

ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Demographics: Living Situation: Related or Affected Individuals



ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Demographics: Agency Specifics: Agency Specifics

Agrees to Share Data ○ Yes ○ No

Agency Status * *

Status as of Date * *

Agency Enrollment Date * *

Agency Client ID 1

Agency Client ID 2

Agency User Field 1

Agency User Field 2

Client Alert

Reason for Status Change

if Other

Referral Date

Referral Source

if Other

Eligibility: Eligibility Documents: Eligibility Documents

Type	Pend-ing	Doc Dated	Obtained	Expires	Source	Location	Note
Agency Consent Form →						*Must be your agency location.*	
ARIES Consent Form →						*Must be your agency location.*	
HIPAA →						*Must be your agency location.*	
Proof of Diagnosis →							
Proof of Income →							
Proof of Residency →							

ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Eligibility: Financial: Financial: Client Income

CLIENT INCOME

(Amounts are monthly) Employed [ ] Public Assistance [ ]

Full Time, Part Time, Not Employed, etc.

Employment/Wages		State Disability Ins/SDI		Retirement	
Supp Security Income/SSI		Long-term Disability/LTD		Investment	
Soc Sec Disability Ins/SSDI		Worker's Compensation		Gift	
Social Security Retirement		TANF CalWORKS			
other 1					
Gen Assist/Gen Relief GA/GR		Veterans Benefits/VA			
other 2					
Unemployment/UI		Alimony/Child Support			
other 3					
Total	calculates	☐ No source of income		Food Stamps	

ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Eligibility: Financial: Financial: Household Income

HOUSEHOLD INCOME

Monthly Household Income *

People in Household *

Children in Household

Percent Federal Poverty Level: calculates

HIV+ People in Household

FAMILY INCOME

Monthly Family Income

People in Family

Percent Federal Poverty Level: calculates

ASSETS

Do you own: a house? Yes/No

a car? Yes/No

Do you have other assets? Yes/No

Dollar Amount of Other Assets

INCOME HISTORY

Date	Monthly Client Income	Monthly Household Income	Monthly Family Income

Edit

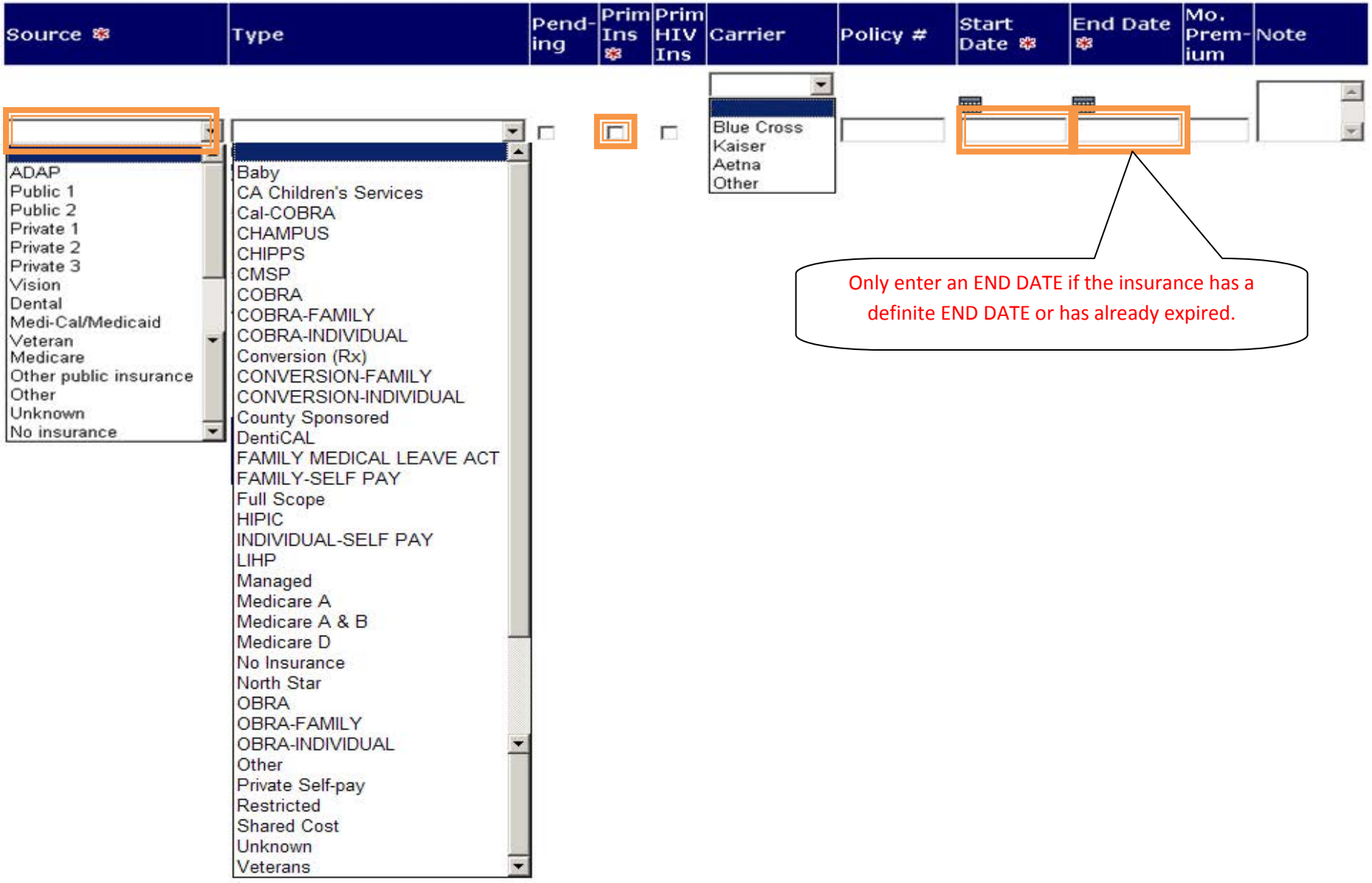
New

ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Eligibility: Insurance: Insurance



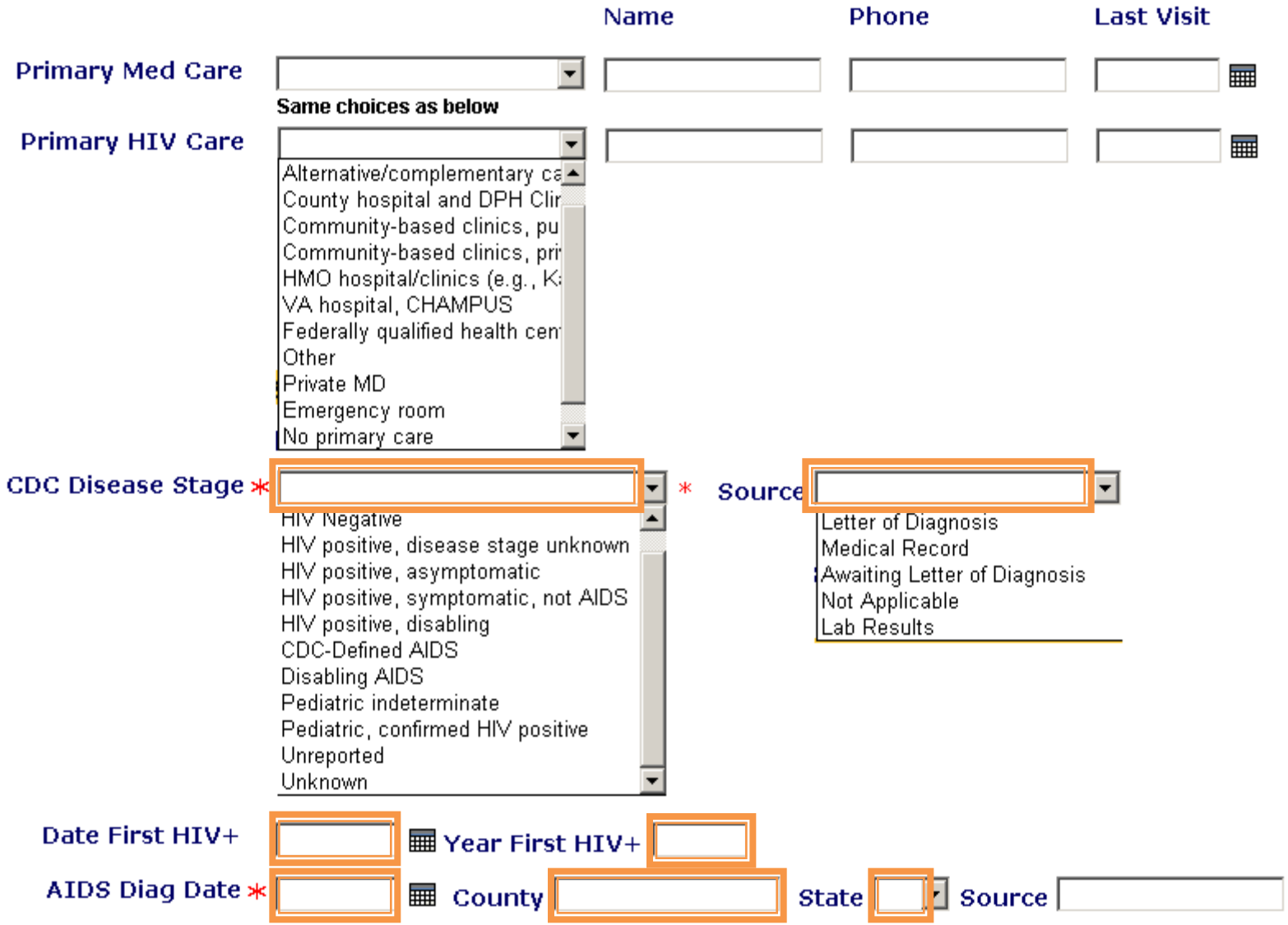
ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Programs Tab → Not Ryan White Programs, therefore, not Ryan White requirement.

Medical: Basic Medical: Basic Medical

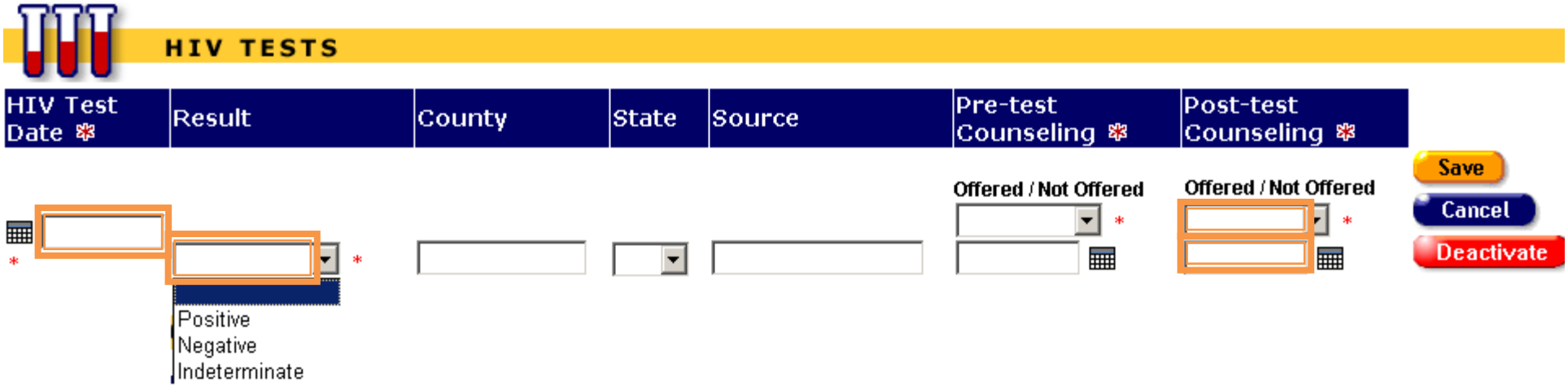


ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Medical: Basic Medical: Basic Medical: HIV Tests

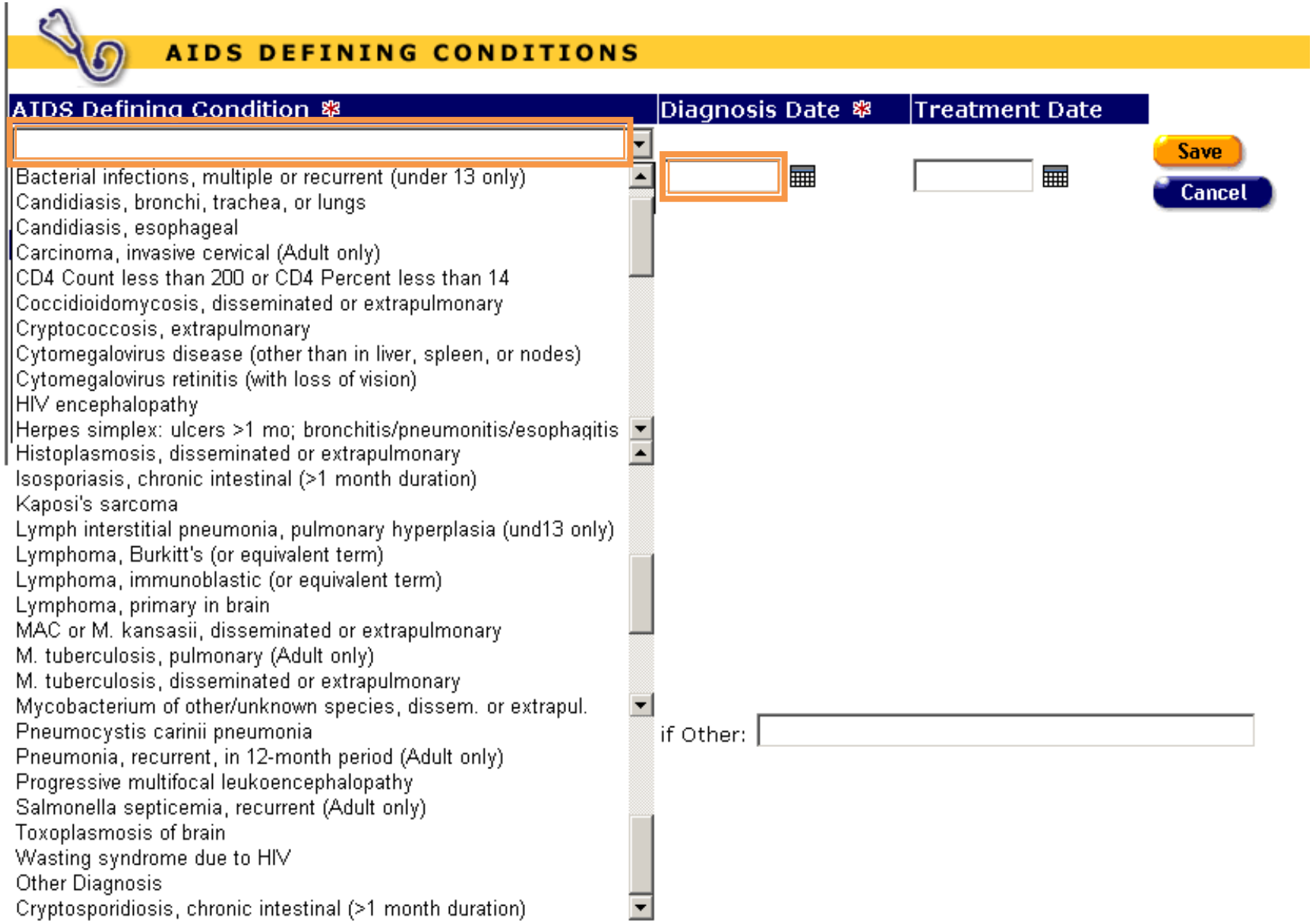


ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Medical: Basic Medical: Basic Medical: AIDS Defining Conditions

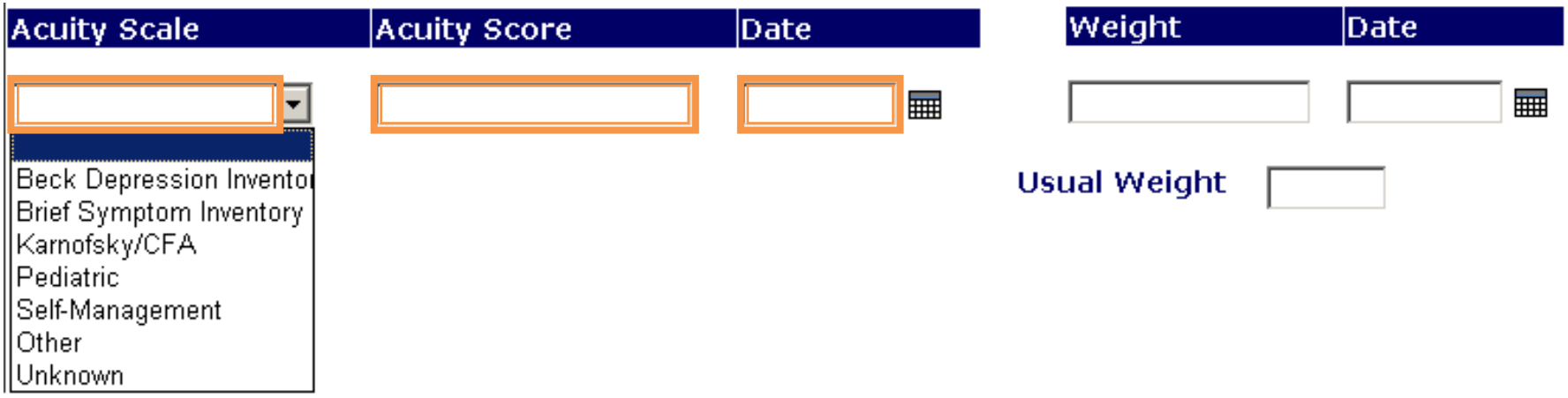


ARIES DATA FORMS

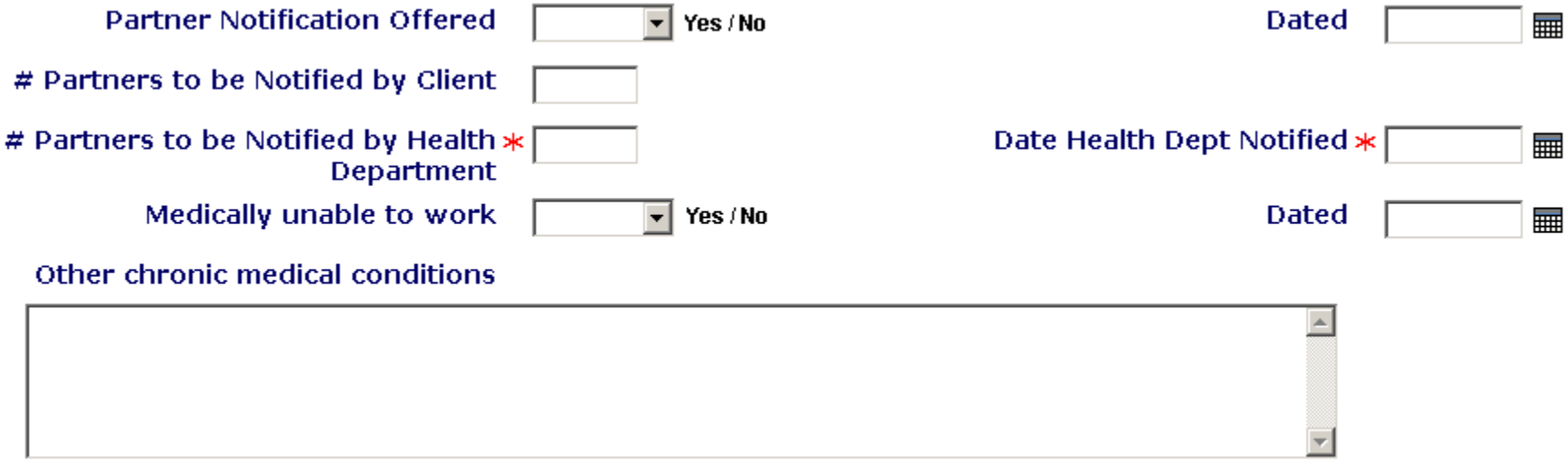
RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Medical: Basic Medical: Basic Medical: Acuity Scale / Weight



Medical: Basic Medical: Basic Medical: Partner Notification

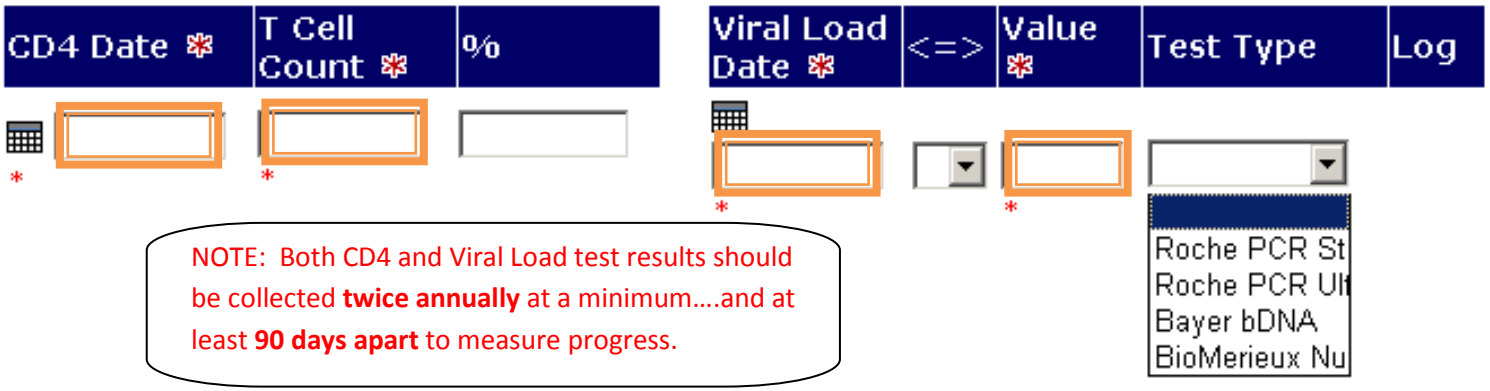


ARIES DATA FORMS

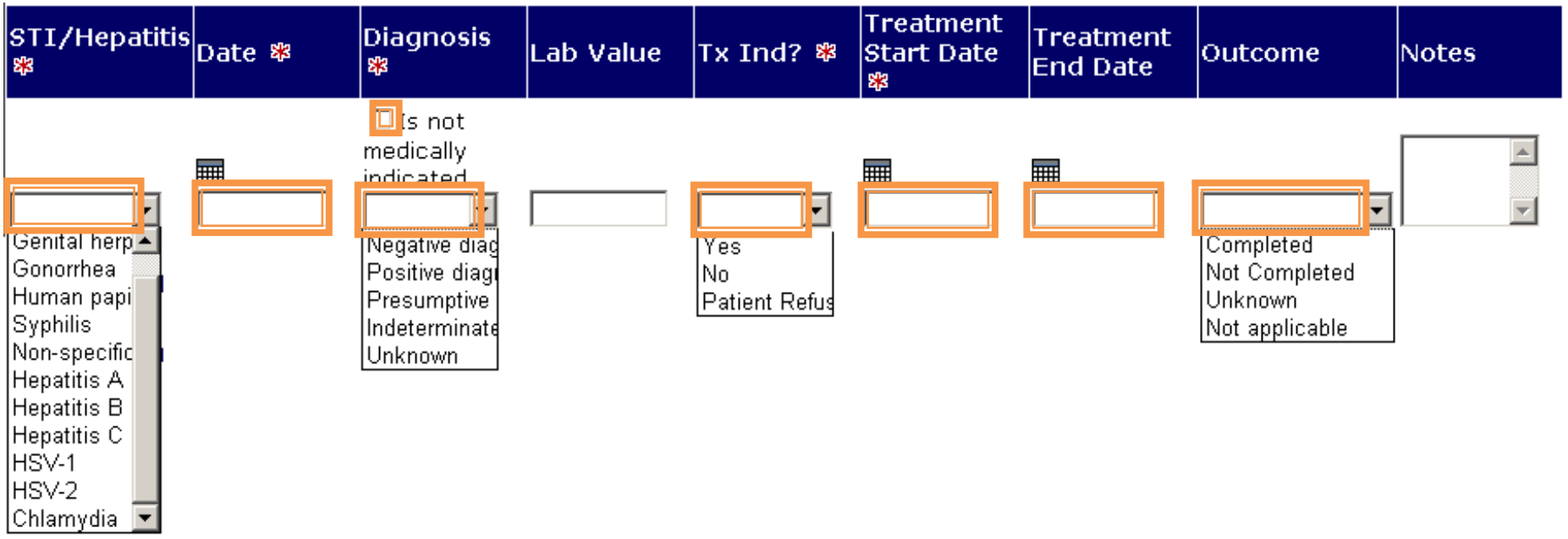
RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Medical: Medical History: Medical History: Tests / CD4 and Viral



Medical: Medical History: Medical History: Tests / STI Hepatitis



ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Medical: Medical History: Medical History: Tests / Tuberculosis

Tuberculosis

TB Test Medically Indicated * Yes / No

TB Test Medically Indicated * Date

Date PPD/TST Placed *

Date PPD/TST Read *

PPD/TST Result Reactive / Non

IGRA Date *

IGRA Result Pos / Neg

Chest X-Ray Date *

Chest X-Ray Result Pos / Neg

TB Diagnosis *

- None
- Active
- Inactive
- History of Positive PPD
- Unknown

Date of TB Diagnosis *

Treatment Start Date *

Multi-Drug Resistance * Yes / No

Treatment End Date *

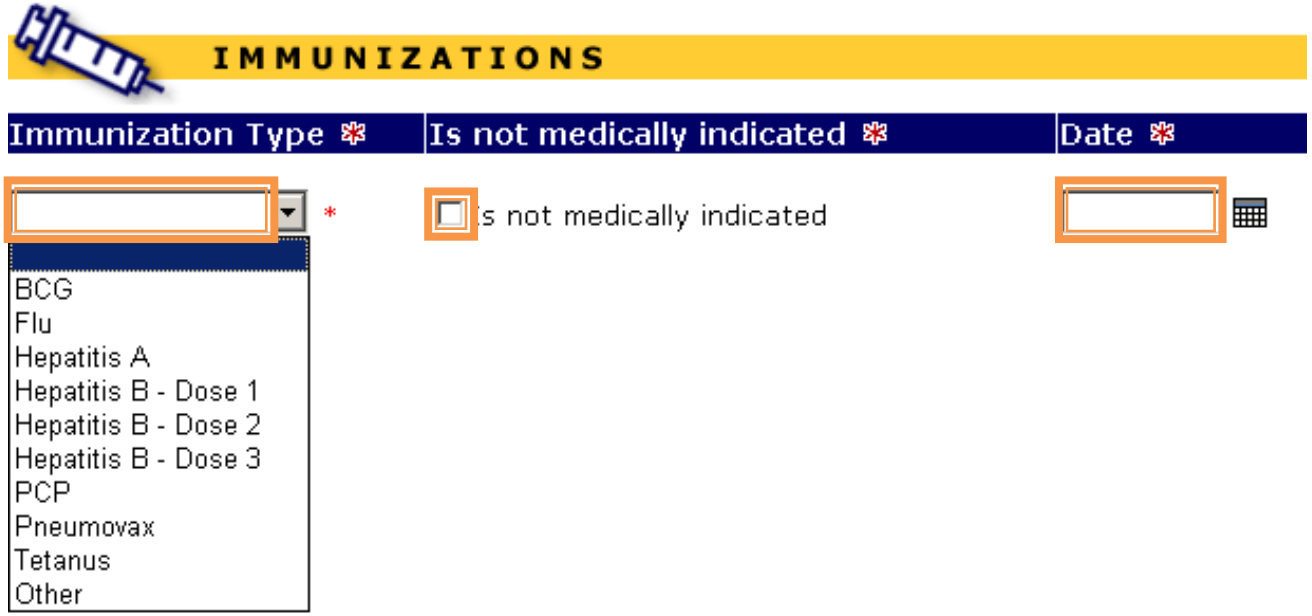
TB Treatment Type *	TB Treatment Status *	Date *
N/A Treatment Prophylaxis None Unknown	In progress Completed Not completed N/A Unknown	

ARIES DATA FORMS

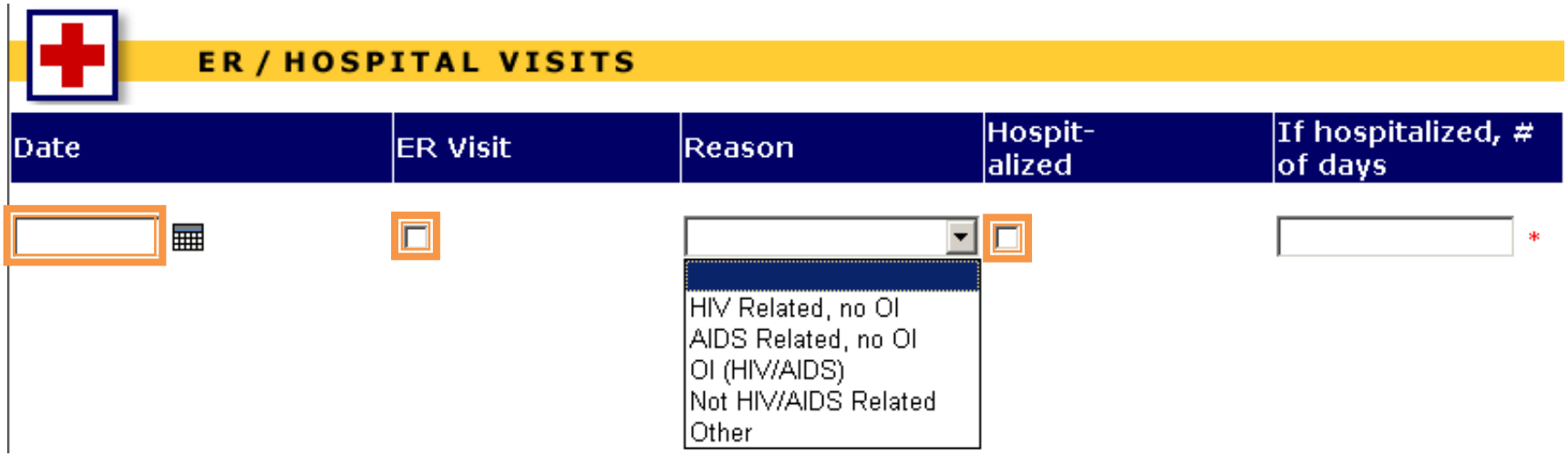
RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Medical: Medical History: Medical History: Immunizations



Medical: Medical History: Medical History: ER / Hospital Visits

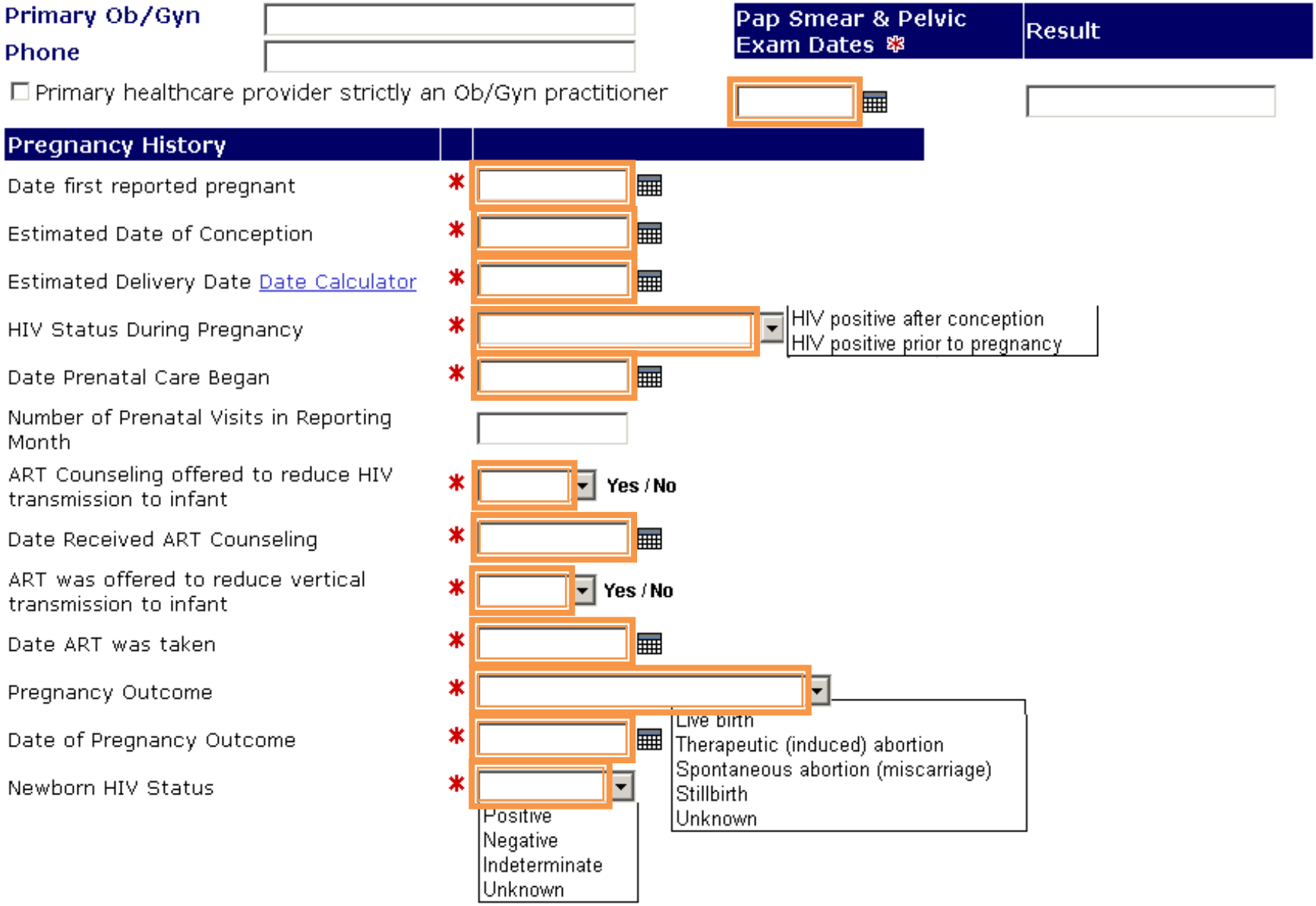


ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Medical: OB/GYN & Pregnancy: Ob/Gyn & Pregnancy: Pap Smear/Pelvic Exam – Pregnancy History



ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Medications: ART: ART Medications: ART Type / Anti-Retroviral Drugs / Adherence

	Name	Phone	Allergies
Pharmacy 1			
Pharmacy 2			
Pharmacy 3			

ART TYPE

ART Type *	Reason not on HAART *	Start Date *	End Date

ART Type options:
- Highly Active Anti-Retroviral Therapy (HAART) (Triple Therapy)
- Combination Anti-Retrovirals but not HAART (Dual Therapy)
- Mono therapy
- Salvage therapy
- None/not applicable
- Unknown/Unreported

Reason not on HAART options:
- Not medically indicated
- Not ready (determined by clinician)
- Client refused
- Intolerance, side-effects, toxicity
- Payment assistance unavailable
- Other
- Unknown

ANTI-RETROVIRAL DRUGS

Anti-retroviral Drugs *	Prescribed by	Side Effects	Start Date	End Date	Dosage

Anti-retroviral Drugs options:
- Agenerase (amprenavir) (d04428)
- Aptivus (tipranavir) (d05538)
- Atripla (tenofovir DF/emtricitabine/efavire
- Combivir (lamivudine-zidovudine) (d0421
- Crixivan (indinavir) (d03985)
- Emtriva (emtricitabine) (d04884)
- Epivir (lamivudine) (d03858)
- Epzicom (abacavir-lamivudine) (d05354)
- Fortovase (invirase/saquinavir) (d03860)
- Fuzeon (enfuvirtide) (d04853)
- HIVID (ddC, zalcitabine) (d00127)
- Intelence (etravirine) (d07076)
- Isentress (raltegravir) (d07048)
- Kaletra (lopinavir-ritonavir) (d04717)
- Lexiva (fosamprenavir) (d04901)
- Norvir (ritonavir) (d03984)
- Other (Other) (d99999)
- Prezista (darunavir, TMC-114) (d05825)
- Rescriptor (delavirdine) (d04119)
- Retrovir (AZT, ZDV, zidovudine) (d00034
- Reyataz (atazanavir) (d04882)
- Selzentry (maraviroc) (d06852)
- Sustiva (efavirenz) (d04355)
- Trizivir (abacavir/lamivudine/zidovudine) (
- Truvada (emtricitabine-tenofovir) (d05352
- Videx (ddI, idanosine, deoxyinosine) (d0
- Viracept (nelfinavir) (d04118)
- Viramune (nevirapine) (d04029)
- Viread (tenofovir) (d04774)
- Zerit (stavudine) (d03773)
- Ziagen (abacavir) (d04376)

Adherence

In the last three days, not including today, how many days did you take your ART medications at the times and in the amounts prescribed by your doctor? _____ as of _____

Adherence to HIV Treatment:	Percent of doses taken in the past four weeks	Date

Genotypic/Phenotypic testing performed to determine resistance to HIV medications? _____ Date of Test: _____

ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Medications: Other Medications: Other Medications: Other Medications

Other Medications *	Prescribed by	Used for *	Type *	Start/End Date *	Dosage

☐ Check if Other Drug

Prophylaxis Treatment

Adherence

In the last three days, not including today, how many days did you take your other medications at the times and in the amounts prescribed by your doctor? as of

Risk & Assessments: Risk Factors: Risk Factors

☐ Pediatric

* What behaviors did the client engage in prior to his/her first HIV positive test result? Check all that apply:

Client Risk Factors

- ☐ Sex with Male
- ☐ Sex with Female
- ☐ Injected nonprescription drugs
- ☐ Received clotting factor for hemophilia/coagulation disorder
- ☐ Received transfusion of blood/blood components (other than clotting factor), transplant of tissue/organs or artificial insemination
- ☐ Worked in healthcare or clinical lab setting
- ☐ Mother HIV infected/Perinatal transmission
- ☐ Sexual abuse (pediatric only)
- ☐ Other
- ☐ Unknown

Sex Partner Risk Factors, Heterosexual Contact ONLY

- ☐ Intravenous/injection drug user
- ☐ Bisexual Male
- ☐ Person with AIDS or documented HIV
- ☐ Other (person with hemophilia/coagulation disorder, transfusion recipient with documented HIV infection, Transplant recipient with documented HIV infection)
- ☐ Unknown

Primary HIV Exposure

Secondary HIV Exposure

Men who have sex with men (MSM)
Injection drug user (IDU)
Men who have sex with men and injection drug user (MSM and IDU)
Hemophilia/coagulation disorder
Heterosexual contact with an at-risk or infected partner
Receipt of transfusion of blood, blood components or tissue
Mother HIV infected/Perinatal transmission
Sexual abuse (pediatric only)
Other
Undetermined
Risk not reported

ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Risk & Assessments: Substance Abuse: Substance Abuse

Does the client have a history of substance abuse?

Substance Abuse History

- No
- Yes, active problem within the last 3 months
- Yes, but not active within the last 3 months
- Unknown

Dated

Age First Used

Frequency

Daily / Monthly / Weekly

Treatment Status	Date
In treatment Waiting list for treatment Refused treatment Completed treatment Pre-treatment process Dropped out of treatment No active treatment or cou Resumed treatment Other Unknown Not applicable	*

Screen Date *	Screening Tool	Outcome

Risk & Assessments: Mental Health: Mental Health

Does the client have a history of mental illness?

Treatment Status	Date
In treatment Waiting list for treatment Refused treatment Completed treatment Pre-treatment process Dropped out of treatment No active treatment or counseling Resumed treatment Other Unknown Not applicable	

Screen Date *	Screening Tool	Outcome

Risk & Assessments: Assessments: Psychosocial Factors – History of Abuse / Legal

History of Abuse

(YES or NO)

	Childhood (<17)	Adult (>=17)
Emotional		
Physical		
Sexual		
Domestic Violence Observed in Childhood		
Domestic Violence Adult Perpetrator		

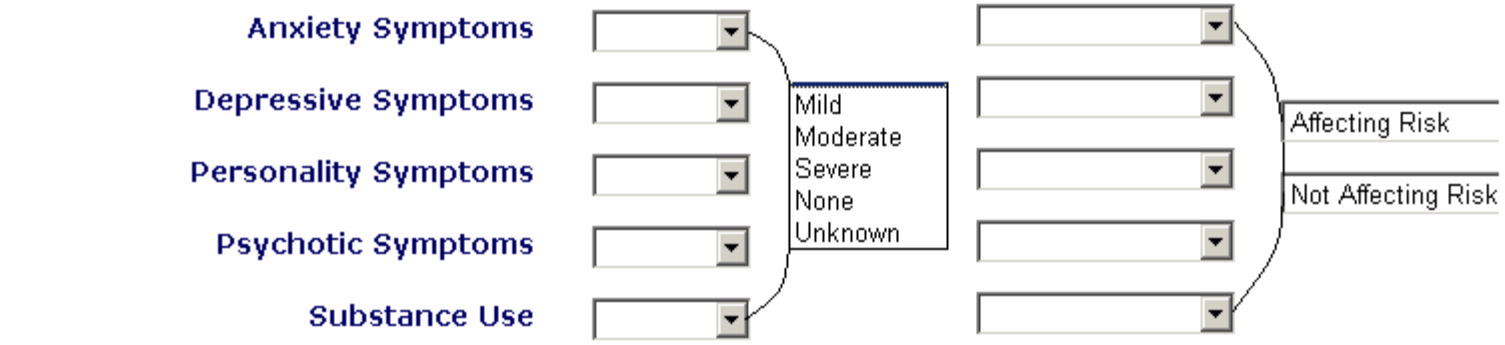
Legal

Does the client have legal issues pending in any of the following areas? (YES or NO)

Divorce, Child Support or Custody		Housing, Employment or Health Care Discrimination	
Immigration Status		Mental Health Commitment	
Social Security Disability or SSI		DUI	
Other			
Is the client currently on parole or probation?			
How much combined time has the client spent in jail or prison (Total Months)?			

Risk & Assessments: Assessments: Psychosocial Factors – Diagnostic Impression and Mental Health History

Diagnostic Impression and Mental Health History



How would you describe the client's current drug/alcohol use?

- Recreation user
- Heavy user
- Dependent user
- Non-user
- Unknown

Psychiatric History? Yes / No

If yes, specify:

History of Drug Treatment? Yes / No

If yes, specify:

Current Psychiatric Medications? Yes / No

If yes, specify:

History of Psychiatric Hospitalization? Yes / No

If yes, specify:

Risk & Assessments: Assessments: Functional Status / Quality of Life

Quality of Life Section 1

As of Date

Staff

1. In general, would you say your health is:
   - Excellent
   - Very Good
   - Good
   - Fair
   - Poor
   - Unknown

2. Please select the option that best describes whether each of the following statements is true or false for you.

   a. I am somewhat ill.

   b. I am as healthy as anybody I know.

   c. My health is excellent.

   d. I have been feeling bad lately.

   - Definitely True
   - Mostly True
   - Don't Know
   - Mostly False
   - Definitely False
   - Unknown

Quality of Life Section 2

select the option for the one answer that comes closest to the way you have been feeling during the past month:

3. How much of the time, during the past month, has your health limited your social activities (like visiting with friends or close relatives)?

4. How much of the time, during the past month:

a. Have you been a very nervous person?

b. Have you felt calm and peaceful?

c. Have you felt downhearted and blue?

d. Have you been a happy person?

e. Have you felt so down in the dumps that nothing could cheer you up?

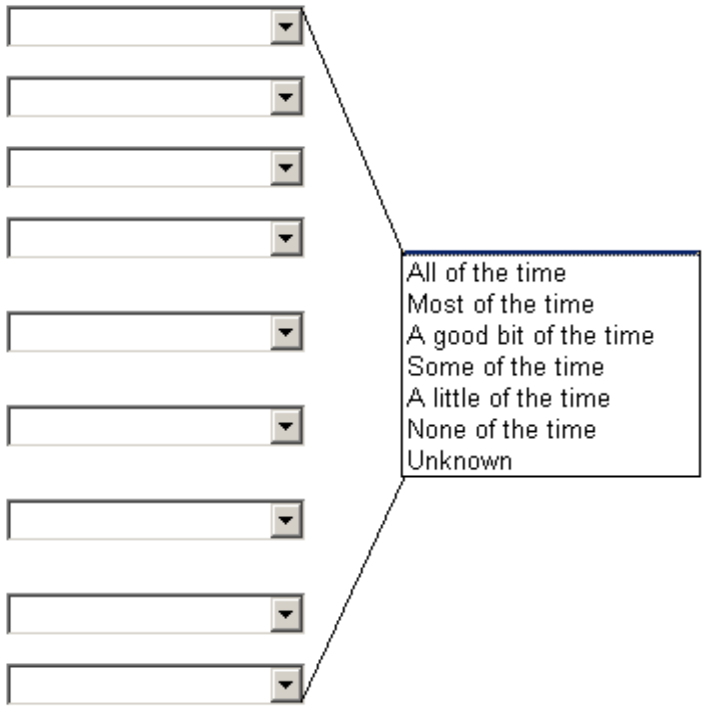
All of the time
Most of the time
A good bit of the time
Some of the time
A little of the time
None of the time
Unknown

Quality of Life Section 3

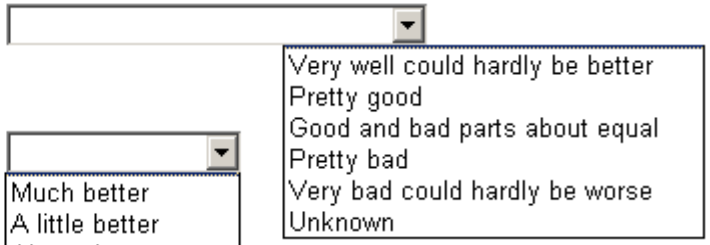
select the option for the one answer that comes closest to the way you have been feeling during the past month:

5. How often during the past month:

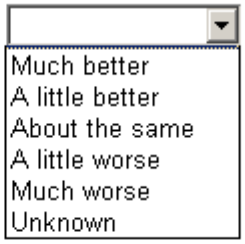
- a. Did you feel full of pep?
- b. Did you feel worn out?
- c. Did you feel tired?
- d. Did you have enough energy to do the things you wanted to do?
- e. Did you feel weighed down by your health problems?
- f. Were you discouraged by your health problems?
- g. Did you feel despair over your health problems?
- h. Were you afraid because of your health?
- i. Did you feel overwhelmed by the number and frequency of HIV medication you have to take each day?



6. How has the quality of your life been during the past month? That is, how have things been going for you?



7. How would you rate your physical health and emotional condition now compared to a month ago?



ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Risk & Assessments: Assessments: Behavioral Risk

Behavioral Risk Section 1

As of Date

Staff

In the past 3 months, have you... (YES or No)

- Been homeless?
- Been in alcohol or drug treatment?
- Had sex while high on drugs or alcohol?
- Had sex to get money, drugs, shelter, etc?
- Paid for sex with money or drugs?
- Had sex with a person who injects drugs?
- Had sex with a man who has sex with men?
- Been diagnosed with Hepatitis C?

Have you... (YES or No)

- Ever injected drugs?
- Ever been in alcohol or drug treatment?
- Ever has sex against his/her will?
- Ever had sex with other men (men only)?
- Are you now pregnant now? (women only)
- Been diagnosed with a sexually transmitted disease (e.g., Syphilis, Chlamydia, Gonorrhea, Hepatitis B?)
- Been in the correctional system? (Probation, parole, secured detention, juvenile corrections, etc.)

ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Behavioral Risk Section 2

In the past 3 months, have you had vaginal, oral or anal sex? Yes / No

If Yes, with a...

Man? Yes / No — If Yes, how many men?

Woman? Yes / No — If Yes, how many women?

Transgender? Yes / No — If Yes, how many transgender?

In the past 3 months, which types of sex have you had, and how often did you or your partner use condoms or barriers for each type of sex?

Had vaginal sex?

Performed anal sex? (top)

Received anal sex? (bottom)

Performed oral sex?

Received oral sex?

No
Yes, Always (4 out of 4 times)
Yes, Usually (3 out of 4 times)
Yes, Sometimes (2 out of 4 times)
Yes, Occasionally (1 out of 4 times)
Yes, Never (0 out of 4 times)
Unknown

In the past 3 months, have you had <u>unprotected</u> anal or vaginal sex with someone...

Who was HIV Positive (has HIV)? Yes / No — If Yes, how many partners?

Who was HIV Negative? Yes / No — If Yes, how many partners?

Whose HIV status you did not know? Yes / No — If Yes, how many partners?

Do you have a spouse or main partner? Yes / No

If yes, for how long? Years Months

Is your partner?

HIV Positive
HIV Negative
Client doesn't know
Unknown

Behavioral Risk Section 3

In the past 30 days, have you used any of the following non-injected drugs? [ ] Yes / No

If Yes, have you used the following drugs?

	Yes / No	If Yes, how many times in the past 30 days?
Crack		
Cocaine		
Heroin		
Amphetamines (speed, crystal)		
Amyl Nitrate (poppers)		
Party drugs (Ecstasy, Special K, GHB)		
Marijuana		
5 or more alcoholic drinks (in one sitting)		
Other:		

Client Name: _____

Behavioral Risk Section 4

In the past 30 days, have you injected any drugs or medication? Yes / No

If yes, have you injected any of the following drugs or medications?

	Yes / No	If Yes, how many times in the past 30 days?
Heroin		
Cocaine/Crack		
Amphetamines (speed, crystal)		
Steroids		
Insulin		
Hormones		
Prescription drugs (codeine, morphine)		
Other:		

If you have injected drugs in the past 30 days, what kind of needles did you use?

	Yes / No
New	
Bleached	
Shared (someone used before me)	
Shared (someone used after me)	
Reused my own	
Origin Unknown	

In the past 30 days, have you shared needles with someone...

	Yes / No
Who was HIV positive (has HIV)	
Who was HIV negative	
Whose HIV status you didn't know	

Risk & Assessments: Assessments: Barriers to Care

Barriers to Care

Assessment Date

Bridge Worker

Date of first HIV-positive test (auto-filled)

Date dropped out of HIV medical care

Current or former EIP client

Financial barriers

- ☐ Not enough money
- ☐ No health insurance/not enough health insurance
- ☐ Could not afford time off from work
- ☐ Other money-related reasons (specify)

Health barriers

- ☐ Felt too sick to go
- ☐ Felt too depressed to go
- ☐ Disability prevented going
- ☐ Drug or alcohol use prevented going)
- ☐ Other health-related reason (specify)

Clinic/Facility barriers

- ☐ Didn't know where to go to get care
- ☐ Clinic was inconvenient (location, hours, etc.)
- ☐ Clinic staff didn't speak client's language
- ☐ Clinic staff was rude/unkind
- ☐ Clinic waiting time was too long
- ☐ Unable to get appointment/appoint offered too far in future
- ☐ Clinic rules required abstinence and/or drug testing
- ☐ Other clinic/facility-related reasons (specify)

Housing/Responsibility barriers

- ☐ Unable to get childcare
- ☐ Unable to get time off from work
- ☐ Needed to care for an adult family member or friend
- ☐ Homeless
- ☐ In jail or prison
- ☐ Other reasons related to housing or responsibilities

Knowledge/belief barriers

- ☐ Didn't want to think about being HIV+
- ☐ Dislike of doctors/clinics
- ☐ Didn't believe they were infected with HIV
- ☐ Didn't feel sick
- ☐ Believed HIV medication wouldn't help
- ☐ Believed HIV treatment would be unpleasant or painful
- ☐ Too embarrassed or ashamed to go for medical care
- ☐ Didn't want anyone to know they were HIV-positive
- ☐ Other reasons related to knowledge or beliefs (specify)

Risk & Assessments: Assessments: Substance Abuse and Mental Illness Symptoms Screener (SAMISS)

SAMISS Assessment Part 1

As of Date *

Staff

Substance Abuse

1. How often do you have a drink containing alcohol?

- Never
- Monthly or less
- 2-4 times/mo
- 2-3 times/wk
- 4 or more times/wk
- Unknown

2. How many drinks do you have on a typical day when you are drinking?

- None
- 1 or 2
- 3 or 4
- 5 or 6
- 7-9
- 10 or more
- Unknown

3. How often do you have 4 or more drinks on 1 occasion?

4. In the past year, how often did you use nonprescription drugs to get high or to change the way you feel?

5. In the past year, how often did you use drugs prescribed to you or to someone else to get high or change the way you feel?

6. In the past year, how often did you drink or use drugs more than you meant to?

7. How often did you feel you wanted or needed to cut down on your drinking or drug use in the past year, and were not able to?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily
- Unknown

Refer to Substance Abuse Treatment **(auto-fills)**

SAMISS Assessment Part 2

Mental Health

	Yes / No
8. In the past year, when not high or intoxicated, did you ever feel extremely energetic or irritable and more talkative than usual?	
9. In the past year, were you ever on medication or antidepressants for depression or nerve problems?	
10. In the past year, was there ever a time when you felt sad, blue, or depressed for more than 2 weeks in a row?	
11. In the past year, was there ever a time lasting more than 2 weeks when you lost interest in most things like hobbies, work, or activities that usually give you pleasure?	
12. In the past year, did you ever have a period lasting more than 1 month when most of the time you felt worried and anxious?	
13. In the past year, did you have a spell or an attack when all of a sudden you felt frightened, anxious, or very uneasy when most people would not be afraid or anxious?	
14. In the past year, did you ever have a spell or an attack when for no reason your heart suddenly started to race, you felt faint, or you couldn't catch your breath?	
If yes, please explain	
15. During your lifetime, as a child or adult, have you experienced or witnessed traumatic event(s) that involved harm to yourself or to others?	
If yes: In the past year, have you been troubled by flashbacks, nightmares, or thoughts of the trauma?	
16. In the past 3 months, have you experienced any event(s) or received information that was so upsetting it affected how you cope with everyday life?	
Refer to Mental Health Counseling	(auto-fills)

ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Risk & Assessments: Assessments: Risk Reduction Screening

Screening Date *

Screening Tool

Outcome

Care Plan: Needs Assessment

Program (e.g. Ryan White, Bridge, HOPWA, etc) Dated

Category	Need	Create Care Plan
Outpatient/Ambulatory Medical Care	○	☐
AIDS Pharmaceutical Assistance (local)	○	☐
Oral Health Care	○	☐
Early Intervention Services (Parts A and B)	○	☐
Health Insurance Premium and Cost Sharing Assistance	○	☐
Home Health Care	○	☐
Home and Community-Based Health Services	○	☐
Hospice Services	○	☐
Mental Health Services	○	☐
Medical Nutrition Therapy	○	☐
Medical Case Management (including Trt Adherence)	○	☐
Substance Abuse Services - Outpatient	○	☐
Case Management (non-medical)	○	☐
Child Care Services	○	☐

	Need	Create Care Plan
Pediatric Dev Assessment/Early Interv Srv	○	☐
Emergency Financial Assistance	○	☐
Food Bank/Home-Delivered Meals	○	☐
Health Education/Risk Reduction	○	☐
Housing Services	○	☐
Legal Services	○	☐
Linguistic Services	○	☐
Medical Transportation Services	○	☐
Outreach Services	○	☐
Permanency Planning	○	☐
Psychosocial Support Services	○	☐
Referral for Health Care/Supportive Services	○	☐
Rehabilitation Services	○	☐
Respite Care	○	☐
Substance Abuse Services - Residential	○	☐
Treatment Adherence Counseling	○	☐

Other Services

ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Care Plan: Care Plan – Need, Goal, Interventions

Date Need Identified

Date Completed

Staff

Outcome

Program

Ryan White
Care Services Program (RW Part B)
EIP
Positive Changes
Bridge Project
LIFE
TMP
CMP
MCWP
CARE-HIPP
HOPWA

Completed
Pending
Some Progress
Cancelled
Unfunded
Not available in area
Completed Substance Abuse Program

Need

if other

Subneed

if other

Goal

Interventions

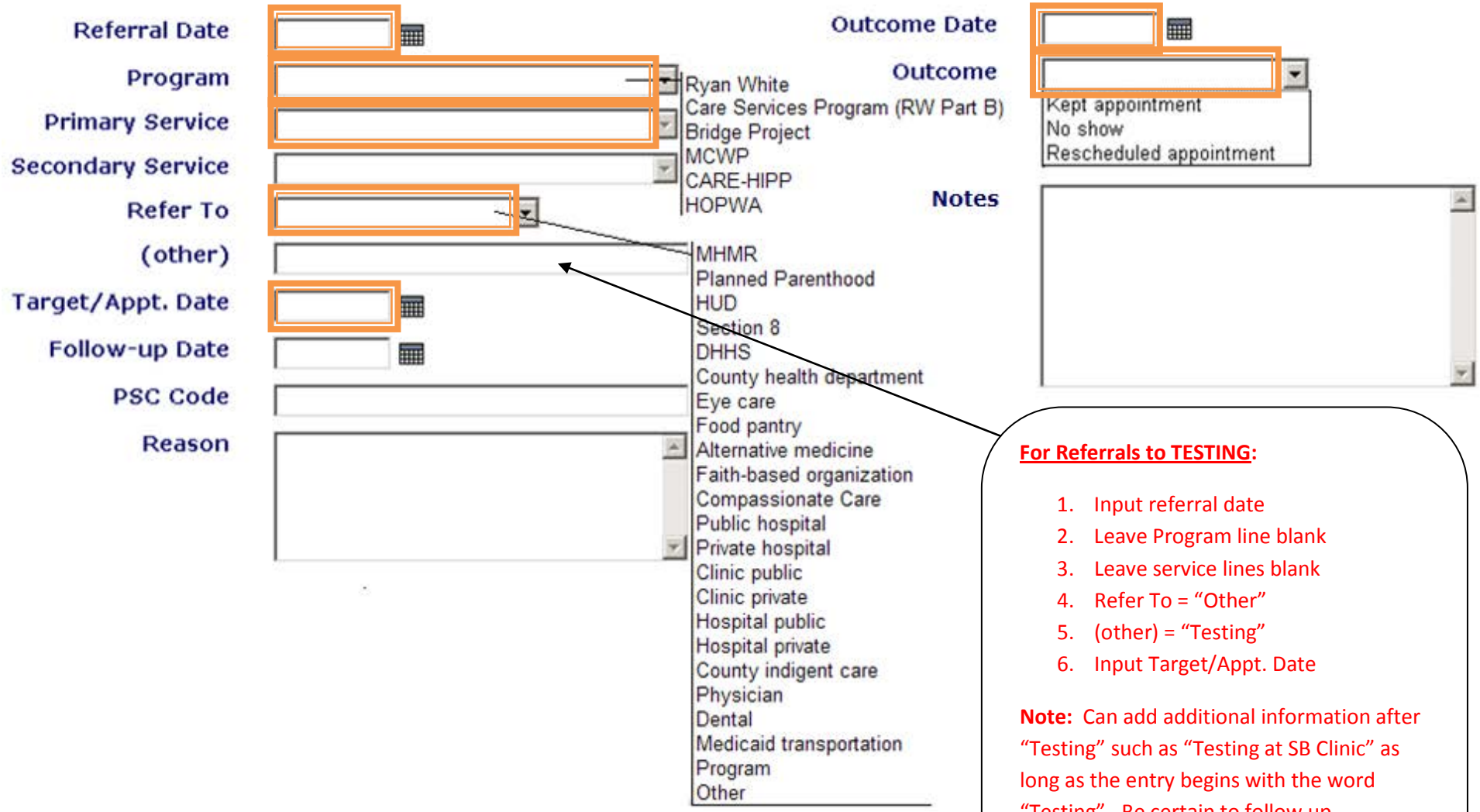
Tasks	Assigned to	Date Initiated	Target Date	Follow-Up Date	PSC	Outcome	Outcome Date

ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Care Plan: Referral: Referrals



For Referrals to TESTING:

1. Input referral date
2. Leave Program line blank
3. Leave service lines blank
4. Refer To = "Other"
5. (other) = "Testing"
6. Input Target/Appt. Date

Note: Can add additional information after "Testing" such as "Testing at SB Clinic" as long as the entry begins with the word "Testing". Be certain to follow up (Outcome) to document whether the client actually got tested.

ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Case Notes: Case Notes

Staff

Created

Type

Activity Date

- Initial Assessment
- Service Assessment
- Progress Note
- Client Update
- Crisis Note
- Case Conference

[New Note]

Category

characters (max 7,750)

Don't share

- Legal
- Mental Health
- Substance Use
- Incident Report
- Adherence
- Administrative
- Client Contact
- Education/Training
- Employment
- Family/Social Support
- Dental
- Financial
- Health Education
- Housing
- Impressions
- Medical
- Nutrition
- Presenting Problem
- Risk Reduction

New Paragraph

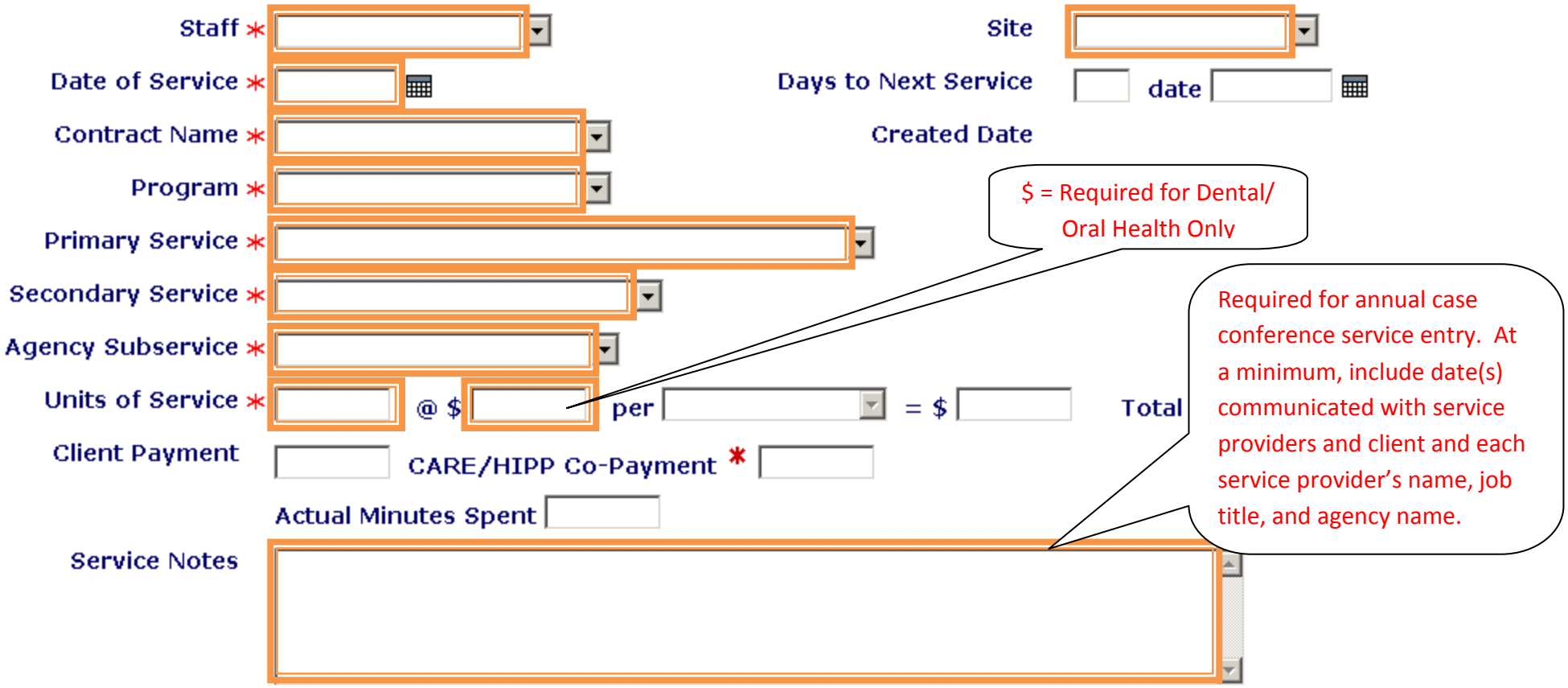
Password to sign and seal note

ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: _____

Services: Services



NEW CLIENTS: Also remember to include data related to any new clients on this screen (see *Policy #9* for details):

Contract Name = New Client
Program = Ryan White
Primary Service = Other Services
Secondary Service = Other Services

Agency Subservice Categories (more than one may apply…requiring multiple entries)

1. HIV Pos in Last 12 Months
2. New Link – Unmet Need
3. Re-Linked – Unmet Need
4. New to Riv/SB Counties
5. New to RW Funded Services
6. New to Agency