

BRIEF CLIENT ASSESSMENT

AREA OF NEED	ASSESSMENT OF NEED	EXPLANATION OF NEED
Basic Necessities/Life Skills	<input type="checkbox"/> Need <input type="checkbox"/> No Need	
Education	<input type="checkbox"/> Need <input type="checkbox"/> No Need	
Cultural/Linguistic Barriers	<input type="checkbox"/> Need <input type="checkbox"/> No Need	
Employment/Income	<input type="checkbox"/> Need <input type="checkbox"/> No Need	
HIV Knowledge/Prevention		
Housing/Living Situation	<input type="checkbox"/> Need <input type="checkbox"/> No Need	
Insurance Benefits (including ADAP)	<input type="checkbox"/> Need <input type="checkbox"/> No Need	
Medical/Clinical Linkage to Care		
Medical/Medication Adherence	<input type="checkbox"/> Need <input type="checkbox"/> No Need	
Mental Health/Psychosocial	<input type="checkbox"/> Need <input type="checkbox"/> No Need	
Substance/Alcohol Abuse	<input type="checkbox"/> Need <input type="checkbox"/> No Need	
Transportation	<input type="checkbox"/> Need <input type="checkbox"/> No Need	

Care Coordinator's Signature

Date

JIMS Booking / Alias

Release Date: _____
Court Date _____
CD4 _____ Date _____
VL _____ Date _____

Last Name	First Name	DOB
SPN#	Race/Sex	LOC.