INTERIOR AIDS ASSOCIATION
CLIENT INTAKE FORM

Client Name:_____ Date:_____

Home Address:_____

_____

Mailing Address:_____

_____

Telephone Number: Days_____ Eves:_____

Emergency Contact:_____

Birthdate:_____ Age:_____

Ethnicity: Caucasian African American Native Alaskan/Native Am.

Hispanic Asian Other:_____

Referral source:_____

Presenting problem/type of service requested (as identified by client):

Housing Benefits Assistance:_____
Permanent_____
Transitional_____

Advocacy_____ Other:_____

Long-term case management_____

Information/referral:_____

For completion by case manager:

Did client complete confidentiality statement? Yes No
Rights and responsibilities Yes No
Release (if appropriate) Yes No
Date of verification of HIV status:_____ Method:_____

All appropriate forms should be included in case file

Assigned client #_____

CSF#2/1999