Ohio Department of Health • HIV CARE Services

Case Management Outcome Measures (CMOM)

FOR OFFICE USE ONLY

Ryan White ID#

☐☐☐☐☐☐☐☐☐☐

Agency name

New client to Case Management?

☐ Yes ☐ No

Was client assisted in completing this form?

☐ Yes ☐ No

Today's date (mm/dd/yyyy)

☐☐ / ☐☐ / ☐☐☐☐

Please read

- This form is used to collect information needed to assess how helpful the case management program is to clients.
- The information enables us to continue receiving funds for case management services (including emergency financial assistance).
- Your answers will be kept strictly confidential.
- Please answer all the questions as instructed on the form. However, if there is a question you do not want to answer, you may skip it. Your case manager will answer it on your behalf.
- If you are completing the form for a child, please refer to instructions for Parents/Guardians.
- This form must be completed every six months by/for all clients in the Case Management Program.

☐ I (client) do not want to complete this form.

Reason _____

1. Do you currently receive money from any of the following sources? (Please check all that apply)

   ☐ Work
   ☐ Work disability
   ☐ Public assistance (e.g., TANF/Ohio Works First)
   ☐ SSDI (Social Security Disability Income)
   ☐ SSI (Supplemental Security Income)
   ☐ Unemployment compensation
   ☐ Retirement
   ☐ Other (specify) _____
   ☐ No income

2. Have you been homeless in the past 6 months (e.g., no regular address, live in shelter, live in car, etc.)?

   ☐ Yes, currently homeless
   ☐ Yes, but no longer homeless
   ☐ No

3. In the past 6 months, in how many places have you lived (including shelters, friends' homes, etc.)?

   Number of places_____

4a. How much do you pay in rent or mortgage per month? (If you pay nothing, write "0" and skip to question 5.)

   $ _____ per month

4b. In the past 6 months, was there a time when you were unable to pay this amount?

   ☐ Yes
   ☐ No

5. On average, how much do you pay per month for the following services? (If the item is included in rent/mortgage, write "0".)

Gas	$ _____
Electric	$ _____
Water	$ _____
Heating fuel, oil or propane	$ _____
Telephone	$ _____

6. In the past 6 months, have utilities (gas, electric, etc.) been kept on because your case manager assisted you or referred you to another program?

   ☐ Yes, one or more utility services were kept on because of case manager's assistance
   ☐ No, utility services were disconnected
   ☐ N/A (did not need assistance with utility services)

7. In the past 6 months, have you ever gone without food because you could not afford to buy it?

   ☐ Yes
   ☐ No

8. In the past 6 months, have you used any of the following food services? (Please check all that apply)

- ☐ Food voucher
- ☐ Food stamps
- ☐ Food bank/pantry
- ☐ W.I.C. (Women, Infants and Children)
- ☐ Soup kitchens
- ☐ Home meal delivery
- ☐ Other (specify) _____
- ☐ Did not use any food services

9. Name the dentist or dental clinic where you get your dental care.

Print the name _____

- ☐ I do not have a dentist or dental clinic to go to for dental care

10. Name the doctor or clinic you go to most frequently for HIV/AIDS-related medical care.

Print the name _____

- ☐ I do not have a doctor or clinic to go to for HIV/AIDS-related medical care (skip to 19)

11 In the past 6 months, have you seen your doctor for an HIV/AIDS-related visit?

- ☐ Yes
- ☐ No

12a. In the past 6 months, have you missed any scheduled appointments with a doctor or clinic for HIV/AIDS-related medical care?

- ☐ Yes
- ☐ No (skip to 13)

12b. If you missed a scheduled appointment with the doctor or clinic, what was the most frequent (or the only) reason for missing the appointment(s)?

- ☐ I did not have a way to get to the doctor/clinic
- ☐ I forgot the appointment
- ☐ I decided not to go
- ☐ I couldn't pay for it
- ☐ I did not have anyone to watch my children
- ☐ Other (specify) _____

13. In the past 6 months, have you had a CD4 or Viral Load test completed? If so, please provide the results below. (Results must be provided by the client's doctor or copied from a lab report)

- ☐ No, I have not had a CD4 or Viral Load test in the past 6 months
- ☐ Yes, I had a CD4 test

Date_____ Result _____

- ☐ Yes, I had a Viral Load test

Date_____ Result _____

14. In the past 6 months, has your doctor prescribed HIV/AIDS medication(s) for you?

- ☐ Yes
- ☐ No (skip to 19a)

15. Are you in any of the following programs to help you pay for your HIV/AIDS medication(s)? (Please check all that apply)

- ☐ Ohio Medicaid Spend-down Payment Program
- ☐ OHDAP (Ohio HIV Drug Assistance Program)
- ☐ HIPP (Health Insurance Premium Payment) Program

16. How did you pay for your most recent HIV/AIDS medication(s)? (Please check all that apply)

- ☐ Medicaid
- ☐ Medicare Part D
- ☐ OHDAP (Ohio HIV Drug Assistance Program)
- ☐ Private insurance
- ☐ Drug company program/patient assistance program
- ☐ Cash/self-pay
- ☐ Ryan White assistance
- ☐ Veterans Administration assistance
- ☐ Clinical Trials
- ☐ Other (specify) _____
- ☐ I did not get my medications because I could not pay for them

17a. In the past 6 months, have you ever missed taking your HIV/AIDS medication(s) as prescribed by your doctor?

- ☐ Yes
- ☐ No (skip to 19a)

17b. If you missed taking your HIV/AIDS medications as prescribed by a doctor, what is the most frequent (or the only) reason why?

- ☐ I forgot to take my medication
- ☐ I got tired of taking my medication
- ☐ I was too sick to take my medication
- ☐ Side effects from my medication bothered me
- ☐ I ran out of medication
- ☐ I could not afford/did not have money for medication
- ☐ I chose not to take my medication (explain)
- ☐ Other (specify) _____

18. It is important for me to take **every dose** of my HIV/AIDS medication.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly Disagree

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19a. In the past 6 months, did you ask your case manager for any of the services listed below (in question 19b)?

☐ Yes

☐ No (skip question 19b. Please return this form to your case manager.)

19b. Please consider only the past 6-month period. Fifteen service categories are listed in the table below.

In the column labeled (i), please indicate the services you *did not need or already had received.*

In the column labeled (ii), please indicate the services *for which you asked and received,* or *were referred.*

In the column labeled (iii), please indicate the services you *needed* but *did not receive* and *were not referred,* and *explain* ***why.***

Services	**(i) Did not need or already had**	**(ii) Received or was referred**	**(iii) Needed but did not receive and was not referred—why?**
Alcohol/drug rehab	☐	☐	☐ _____
Child care	☐	☐	☐ _____
Counseling/support	☐	☐	☐ _____
Dental care	☐	☐	☐ _____
HIV/AIDS medical care	☐	☐	☐ _____
Housing/rental assistance	☐	☐	☐ _____
In-home health care	☐	☐	☐ _____
Legal assistance	☐	☐	☐ _____
Nutrition	☐	☐	☐ _____
Physical/occupational therapy	☐	☐	☐ _____
Primary health care	☐	☐	☐ _____
Transportation	☐	☐	☐ _____
Vocational training	☐	☐	☐ _____
Utilities	☐	☐	☐ _____
OHDAP enrollment	☐	☐	☐ _____

Please return this form to your case manager.

THANK YOU.

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