

# **Baseline Survey**

## **COVER SHEET**

### **Directions**

Has the following document been: a) provided to the client, b) explained and c) completed/signed?

TDC Informed Participation Agreement

**If NO:** Distribute this document to the client and implement release of information and consent process.

#### **If YES:**

Write in the client's name below and assign a project identification number.

Then complete the SIF baseline assessment.

When the assessment is completed:

**TEAR OFF** this cover page and store in the master file folder in a locked cabinet.

**STORE** the client assessment in the data entry file.

**Client Name:** \_\_\_\_\_

**L2C ID#:** \_\_\_\_\_

\_\_\_\_\_  
PRINT (First) (MI) (Last)

**Date assessment completed:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Month Day Year

Date of Initial Client Contact: \_\_\_\_\_

Enrollment Date: \_\_\_\_\_

**1. L2C client type:**

- Out of HIV care [no HIV care for 1+ years]
- Newly diagnosed [HIV+ within the last 3 months]

**1a. If newly diagnosed, date HIV+:** \_\_\_\_\_

**2. How was the client recruited?**

- |  |  |
|--|--|
| <input type="checkbox"/> Linkage to Care Specialist (specify in 1a, below) | <input type="checkbox"/> AIDS Service Organization: specify: _____ |
| <input type="checkbox"/> In-Reach (TDC Testing)                            | <input type="checkbox"/> Social media/marketing                    |
| <input type="checkbox"/> In-Reach (TDC Care Coordination)                  | <input type="checkbox"/> Infectious disease provider               |
| <input type="checkbox"/> Street outreach                                   | <input type="checkbox"/> Other: _____                              |

**2a. If LTC specialist, specify which one below:**

- Brothers United
- Indiana Latino Institute
- Women in Motion
- The Damien Center

**3. Would you say that in general your health is: (*Read responses below*)**

- |                                    |   |
|------------------------------------|---|
| <input type="checkbox"/> Excellent | <b>Staff Only (Do Not Read):</b>                  |
| <input type="checkbox"/> Very good |   |
| <input type="checkbox"/> Good      |   |
| <input type="checkbox"/> Fair      |   |
| <input type="checkbox"/> Poor      |   |
|                                    | <input type="checkbox"/> Client didn't know       |
|                                    | <input type="checkbox"/> Client refused to answer |

**4. I am going to read a list of services and resources. Please tell me which ones you currently need:**

- |   |   |
|---|---|
| <input type="checkbox"/> Career services                  | <input type="checkbox"/> Non-HIV medical services (e.g. Primary Care)                 |
| <input type="checkbox"/> Drug and alcohol abuse treatment | <input type="checkbox"/> Pharmacy or medication services (for HIV or non-HIV reasons) |
| <input type="checkbox"/> Housing or shelter               | <input type="checkbox"/> Mental health services                                       |
| <input type="checkbox"/> Food or other subsistence need   | <input type="checkbox"/> Legal services   |
| <input type="checkbox"/> Dental services                  | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Vision services                  |   |
| <input type="checkbox"/> HIV-related medical services     |   |

**4a. (If more than one need is identified): Of those services which one is most urgent for you now?**

- |   |   |
|---|---|
| <input type="checkbox"/> Career services                  | <input type="checkbox"/> Vision services  |
| <input type="checkbox"/> Drug and alcohol abuse treatment | <input type="checkbox"/> HIV-related medical services                                 |
| <input type="checkbox"/> Housing or shelter               | <input type="checkbox"/> Non-HIV related medical services                             |
| <input type="checkbox"/> Food or other subsistence need   | <input type="checkbox"/> Pharmacy or medication services (for HIV or non-HIV reasons) |
| <input type="checkbox"/> Dental services                  |   |

Mental health services

Other: \_\_\_\_\_

Legal services

**5. Often people face barriers getting HIV care. What makes it hard for you to get care? (Do NOT read)**

Not applicable, newly diagnosed

Distrust of medical system

Lack of money

Lack of perceived need

Homelessness

Competing priorities (such as family, work)

Immigration

Transportation

Incarceration

Location of care

Drug use

Structure of testing

Fear

Lack of ancillary/support services

Stigma

None

Denial

Other: \_\_\_\_\_

Provider/staff language barrier

**5a. [If more than one barrier identified] which is the greatest barrier to care for you now?**

Lack of money

Distrust of medical system

Homelessness

Lack of perceived need

Immigration

Competing priorities (such as family, work)

Incarceration

Transportation

Drug use

Location of care

Fear

Structure of testing

Stigma

Lack of ancillary/support services

Denial

Other: \_\_\_\_\_

Provider/staff language barrier

**6. Can you please tell me whether any of the following were reasons for not getting HIV care or made it difficult to receive care in the last 6 months? [Read responses]**

Check here \_\_\_ if not applicable, newly diagnosed

	No	Yes	D/K
Inability to pay for treatment	1	2	8
Unsure of where to obtain care	1	2	8
Lack of transportation	1	2	8
Inconvenient clinic location, hours or appointment times	1	2	8
Had been treated poorly at clinic	1	2	8
Wanting to avoid being seen at clinic	1	2	8
Didn't want to think about HIV / denial	1	2	8
Distrust of doctors or medical system	1	2	8
Lack of childcare	1	2	8
Too drunk or high	1	2	8
Did not have a phone to make an appointment	1	2	8
Feeling too healthy to seek care	1	2	8
Too busy to go	1	2	8
Forgot to go/missed appointment	1	2	8

**7. Have you ever told anyone that you are living with HIV?**

- No
- Yes

**7a. [If yes] I am going to read you a list of people you might have told. Please tell me which ones apply. Have you told:**

- |  |  |
|--|--|
| <input type="checkbox"/> Family members          | <input type="checkbox"/> Friends               |
| <input type="checkbox"/> Sex partners            | <input type="checkbox"/> Someone you work with |
| <input type="checkbox"/> Injection drug partners | <input type="checkbox"/> Other                 |
| <input type="checkbox"/> Health care providers   | _____  |

**7b. [If yes] who was the first person you told?**

- Family member
- Sex partner
- Injection drug partner
- Health care provider
- Friend
- Someone you work with
- Other \_\_\_\_\_

**8. Now I will read you some statements. Please tell me how often you have felt this way in the past 6 months:**

**8a. [In the past 6 months] I've felt that people avoided me because I have HIV.**

Not at all       Rarely       Sometimes       Often       N/A

**8b. [In the past 6 months] I've feared I would lose friends if they learned about my HIV.**

Not at all       Rarely       Sometimes       Often       N/A

**8c. [In the past 6 months] I've thought other people were uncomfortable being with me because of my HIV.**

Not at all       Rarely       Sometimes       Often       N/A

**8d. [In the past 6 months] I've avoided getting treatment because someone might find out about my HIV.**

Not at all       Rarely       Sometimes       Often       N/A

**8e. [In the past 6 months] I've felt supported by my family since disclosure of my HIV status.**

Not at all       Rarely       Sometimes       Often       N/A

**8f. [In the past 6 months] someone avoided having sex with me because of my HIV status.**

Not at all       Rarely       Sometimes       Often       N/A

**8g. [In the past 6 months] I've been treated differently by a healthcare provider because of my HIV status.**

Not at all       Rarely       Sometimes       Often       N/A

**9. What is your sex/gender?** [Select one answer only.]

- Male
- Female
- Transgendered, male to female
- Transgendered, female to male
- Other \_\_\_\_\_

**10. Are you Hispanic or Latino/a?**

- No, not Hispanic/Latino
- Yes, Hispanic/Latino

**11. What is your race?** [One or more categories may be selected.]

- White
- Black or African-American
- American Indian or Alaska Native
- Asian
- Native Hawaiian or other Pacific Islander

**12. How old are you?** \_\_\_\_ years old

**13. What is the highest grade or year of school you finished?**

- Some high school or less education
- High school graduate or GED
- Some college or technical schooling
- College graduate (BA, BS etc.)
- Post-graduate/professional schooling (with or without post-graduate or professional degree)

**14. What best describes your employment status now?** [Select one answer only.]

- Employed full-time
- Employed part-time
- Homemaker, not employed outside the home
- Full-time student
- Retired
- Disabled for work
- Unemployed
- For one year or longer
- For less than a year
- Other: \_\_\_\_\_

When completed: **TEAR OFF** cover page and store in the master file folder.

**STORE** the client assessment in the data entry file.

**Time One Survey - English**

**COVER SHEET**

**Directions**

Has the following document been: a) provided to the client, b) explained and c) completed/signed?

TDC Informed Participation Agreement

**If NO:** Distribute this document to the client and implement release of information and consent process.

**If YES:**

Write in the client's name below and assign a project identification number.

Then complete the SIF baseline assessment.

When the assessment is completed:

**TEAR OFF** this cover page and store in the master file folder in a locked cabinet.

**STORE** the client assessment in the data entry file.

**Client Name:** \_\_\_\_\_

**L2C ID#:** \_\_\_\_\_

\_\_\_\_\_  
PRINT (First) (MI) (Last)

**Date assessment completed:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Month Day Year

Time 1 Follow-up Date: \_\_\_\_\_

**1. Would you say that in general your health is: (Read responses below)**

- Excellent
- Very good
- Good
- Fair
- Poor

**Staff Only (Do Not Read):**

- Client didn't know
- Client refused to answer

**2. I am going to read a list of services and resources. Please tell me which ones you currently need:**

- |   |   |
|---|---|
| <input type="checkbox"/> Career services                  | <input type="checkbox"/> Non-HIV medical services (e.g. Primary Care)                 |
| <input type="checkbox"/> Drug and alcohol abuse treatment | <input type="checkbox"/> Pharmacy or medication services (for HIV or non-HIV reasons) |
| <input type="checkbox"/> Housing or shelter               | <input type="checkbox"/> Mental health services                                       |
| <input type="checkbox"/> Food or other subsistence need   | <input type="checkbox"/> Legal services   |
| <input type="checkbox"/> Dental services                  | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Vision services                  |   |
| <input type="checkbox"/> HIV-related medical services     |   |

**2a. (If more than one need is identified): Of those services which one is most urgent for you now?**

- |   |   |
|---|---|
| <input type="checkbox"/> Career services                  | <input type="checkbox"/> Non-HIV related medical services                             |
| <input type="checkbox"/> Drug and alcohol abuse treatment | <input type="checkbox"/> Pharmacy or medication services (for HIV or non-HIV reasons) |
| <input type="checkbox"/> Housing or shelter               | <input type="checkbox"/> Mental health services                                       |
| <input type="checkbox"/> Food or other subsistence need   | <input type="checkbox"/> Legal services   |
| <input type="checkbox"/> Dental services                  | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Vision services                  |   |
| <input type="checkbox"/> HIV-related medical services     |   |

**3. Often people face barriers getting HIV care. What makes it hard for you to get care? (Do NOT read)**

- |  |  |
|--|--|
| <input type="checkbox"/> Not applicable, newly diagnosed | <input type="checkbox"/> Distrust of medical system                  |
| <input type="checkbox"/> Lack of money                   | <input type="checkbox"/> Lack of perceived need                      |
| <input type="checkbox"/> Homelessness                    | <input type="checkbox"/> Competing priorities (such as family, work) |
| <input type="checkbox"/> Immigration                     | <input type="checkbox"/> Transportation                              |
| <input type="checkbox"/> Incarceration                   | <input type="checkbox"/> Location of care                            |
| <input type="checkbox"/> Drug use                        | <input type="checkbox"/> Structure of testing                        |
| <input type="checkbox"/> Fear                            | <input type="checkbox"/> Lack of ancillary/support services          |
| <input type="checkbox"/> Stigma                          | <input type="checkbox"/> None  |
| <input type="checkbox"/> Denial                          | <input type="checkbox"/> Other: _____                                |
| <input type="checkbox"/> Provider/staff language barrier |  |

**3a. [If more than one barrier identified] which is the greatest barrier to care for you now?**

- |  |                                   |
|--|-----------------------------------|
| <input type="checkbox"/> Lack of money | <input type="checkbox"/> Drug use |
| <input type="checkbox"/> Homelessness  | <input type="checkbox"/> Fear     |
| <input type="checkbox"/> Immigration   | <input type="checkbox"/> Stigma   |
| <input type="checkbox"/> Incarceration | <input type="checkbox"/> Denial   |

- Provider/staff language barrier
- Location of care
- Distrust of medical system
- Structure of testing
- Lack of perceived need
- Lack of ancillary/support services
- Competing priorities *(such as family, work)*
- Other: \_\_\_\_\_
- Transportation

**4. Can you please tell me whether any of the following were reasons for not getting HIV care or made it difficult to receive care in the last 6 months? [Read responses]**

	No	Yes	D/K
Inability to pay for treatment	1	2	8
Unsure of where to obtain care	1	2	8
Lack of transportation	1	2	8
Inconvenient clinic location, hours or appointment times	1	2	8
Had been treated poorly at clinic	1	2	8
Wanting to avoid being seen at clinic	1	2	8
Didn't want to think about HIV / denial	1	2	8
Distrust of doctors or medical system	1	2	8
Lack of childcare	1	2	8
Too drunk or high	1	2	8
Did not have a phone to make an appointment	1	2	8
Feeling too healthy to seek care	1	2	8
Too busy to go	1	2	8
Forgot to go/missed appointment	1	2	8

**5. Have you ever told anyone that you are living with HIV?**

- No
- Yes

**5a. [If yes] I am going to read you a list of people you might have told. Please tell me which ones apply. Have you told:**

- Family members
- Friends
- Sex partners
- Someone you work with
- Injection drug partners
- Other \_\_\_\_\_
- Health care providers

**5b. [If yes] who was the first person you told?**

- Family member
- Sex partner
- Injection drug partner
- Health care provider
- Friend
- Someone you work with
- Other \_\_\_\_\_

**5c. About how long ago was it when you told the first person about your living with HIV?**

- Less than 6 months ago
- 6 months to less than a year ago
- 1 – 2 years ago
- More than 2 years ago

**6. Now I will read you some statements. Please tell me how often you have felt this way in the past 6 months:**

**6a. [In the past 6 months] I've felt that people avoided me because I have HIV.**

- Not at all       Rarely       Sometimes       Often        
N/A

**6b. [In the past 6 months] I've feared I would lose friends if they learned about my HIV.**

- Not at all       Rarely       Sometimes       Often        
N/A

**6c. [In the past 6 months] I've thought other people were uncomfortable being with me because of my HIV.**

- Not at all       Rarely       Sometimes       Often        
N/A

**6d. [In the past 6 months] I've avoided getting treatment because someone might find out about my HIV.**

- Not at all       Rarely       Sometimes       Often        
N/A

**6e. [In the past 6 months] I've felt supported by my family since disclosure of my HIV status.**

- Not at all       Rarely       Sometimes       Often  
 N/A

**6f. [In the past 6 months] someone avoided having sex with me because of my HIV status.**

- Not at all       Rarely       Sometimes       Often  
 N/A

**6g. [In the past 6 months] I've been treated differently by a healthcare provider because of my HIV status.**

- Not at all       Rarely       Sometimes       Often  
 N/A

**7. What is your sex/gender?** [Select one answer only.]

- Male  
 Female  
 Transgendered, male to female  
 Transgendered, female to male  
 Other \_\_\_\_\_

**8. What is the highest grade or year of school you finished?**

- Some high school or less education  
 High school graduate or GED  
 Some college or technical schooling  
 College graduate (BA, BS etc.)  
 Post-graduate/professional schooling (with or without post-graduate or professional degree)

**9. What best describes your employment status now?** [Select one answer only.]

- Employed full-time  
 Employed part-time  
 Homemaker, not employed outside the home  
 Full-time student  
 Retired  
 Disabled for work  
 Unemployed  
 For one year or longer  
 For less than a year  
 Other: \_\_\_\_\_

When completed:      **TEAR OFF** cover page and store in the master file folder.

**STORE** the client assessment in the data entry file.

## Time One Survey – Spanish

### PORTADA

#### Instrucciones

¿El siguiente documento ha sido: a) proporcionado al cliente, b) explicado y c) completado o firmado?

TDC informó del acuerdo de participación

**Si, no favor de:** Distribuir este documento al cliente y proporcionarle la información y el proceso de consentimiento.

#### En caso afirmativo:

Escriba el nombre del cliente y asígnele número de identificación.

Luego completa la evaluación inicial SIF.

Cuando la evaluación ya ha sido completada:

**Desprenda** la portada y guárdela en la carpeta principal en un gabinete con llave.

**Archive** la evaluación del cliente en la carpeta de acceso de información.

Nombre del cliente: \_\_\_\_\_ L2C ID #: \_\_\_\_\_

\_\_\_\_\_

IMPRIME (primera) (MI) (última)

Fecha de Evaluación : \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Mes Día Año

Fecha de inscripción: \_\_\_\_\_

**1. Usted diría que en general su salud es: (Por Favor responda a las siguientes preguntas)**

- Excelente
- Muy buena
- Buena
- Razonable
- Pobre

**Usted diría que en general su salud es:  
(Por Favor responda a las siguientes preguntas)**

- Cliente no sabía
- Cliente se negó a responder

**2. A continuación le daré una lista de servicios y recursos. Por favor conteste cuáles son las que requiere ahora:**

- Servicio de carreras profesionales
- Tratamiento de abuso de alcohol y drogas
- Vivienda o refugio
- Alimentos o otra necesidad de subsistencia
- Servicios dentales
- Servicios de la visión

- Servicios médicos relacionados con el HIV
- Servicios médicos (por ejemplo atención primaria)
- Medicamentos (por razones de no-HIV o HIV)
- Servicios de salud mental
- Asistencia legal
- Otro: \_\_\_\_\_

**2a. ¿ (Si identifica más de una necesidad) ¿Cuáles son los servicios más urgentes que requiere ahora?**

- Servicio de carreras profesionales
- Tratamiento de abuso de alcohol y drogas
- Vivienda o refugio
- Alimentos o otra necesidad de subsistencia
- Servicios dentales
- Servicios de la visión

- Servicios médicos relacionados con el HIV
- Servicios médicos (por ejemplo atención primaria)
- Medicamentos (por razones de no-HIV o HIV)
- Servicios de salud mental
- Asistencia legal
- Otro: \_\_\_\_\_

**3. Cuales han sido los obstáculos que usted ha encontrado para recibir servicios médicos del HIV. ¿Cual fue el obstáculo para obtener asistencia? (No lea)**

- No aplica, recién diagnosticados
- Falta de dinero
- Falta de vivienda

- Inmigración
- Encarcelamiento
- Consumo de drogas

- Miedo
- Estigma
- Negación
- Obstaculo del idioma con proveedor o empleados de la clinica
- Desconfianza del sistema médico
- Falta de necesidad

- Competencia de Prioridades (*como familia, trabajo*)
- Transporte
  - Localización del cuidado
  - Estructura de la prueba
- Falta de servicios
- Ninguno
- Otro: \_\_\_\_\_

**3a. Si hay mas de un obstaculo ( indentificado ) cual de estos es el mas relevante?**

- Falta de dinero
- Falta de vivienda
- Inmigración
- Encarcelamiento
- Consumo de drogas
- Miedo
- Estigma
- Negación
- Obstaculo del idioma con proveedor o empleados de la clinica

- Desconfianza del sistema médico
- Falta de necesidad
- Competencia de Prioridades (*como familia, trabajo*)
- Transporte
- Ubicación del cuidado
- Estructura de la prueba
- Falta de servicios auxiliares de apoyo
- Ninguno
- Otro: \_\_\_\_\_

**4. ¿Podria decirme usted si alguna de las siguientes razones para no recibir atención de HIV o por que tuvo dificultad para recibir atención en los últimos 6 meses? [Ver respuestas]**

	No	Sí	D/K
Incapacidad para pagar por el tratamiento	1	2	8
No está seguro de dónde obtener atención	1	2	8
Falta de transporte	1	2	8
Inconveniente localización de la clínica, horas o tiempo de cita	1	2	8
Habían sido tratados mal en clínica	1	2	8
Queriendo evitar ser visto en la clínica	1	2	8
No quería pensar en HIV / negación	1	2	8
Desconfianza de los médicos o sistema médico	1	2	8
Falta de cuidado de niños	1	2	8
Borracho o tomando drogas	1	2	8
No tenía un teléfono para hacer una cita	1	2	8

Sentirse demasiado sano a buscar atención	1	2	8
Demasiado ocupado para ir	1	2	8
Se le olvidó de la cita	1	2	8

**5. ¿Le ha platicado a alguien que usted es zero positivo o que sido diagnosticado con el virus del HIV?**

- No
- Sí

**5a. [en caso afirmativo] voy a leerle la siguiente lista de personas a las cuales les podría haber dicho. Por favor dígame cuáles aplicarán.**

- |   |  |
|---|--|
| <input type="checkbox"/> A miembros de la familia                             | <input type="checkbox"/> Amigos                            |
| <input type="checkbox"/> A sus parejas sexuales                               | <input type="checkbox"/> Una persona que trabaja con usted |
| <input type="checkbox"/> A conocidos con los que comparte drogas de inyección | <input type="checkbox"/>                                   |
| <input type="checkbox"/> A proveedores de atención médica                     | Otro _____   |
|   | _____  |

**5b. ¿ [ en caso afirmativo] quien fue la primera persona que le dijiste?**

- A miembros de la familia
  - A sus parejas sexuales
  - A conocidos con los que comparte drogas de inyección
  - A proveedores de atención médica
  - Amigos
  - Una persona que trabaja con usted
  - Otro
-

**5c. ¿Aproximadamente cuánto tiempo hace cuando le dijiste a la primera persona sobre su vida con HIV?**

- Hace menos de 6 meses
- 6 meses y menos de un año
- 1 – 2 años
- Hace más de 2 años

**6. Ahora voy a leer algunas declaraciones. Por favor dígame con qué frecuencia se ha sentido así en los últimos 6 meses:**

**6a. [en los últimos 6 meses] He sentido que la gente me evita porque tengo HIV.**

- En absoluto
- Raramente
- A veces
- A menudo
- N/A

**6b. [en los últimos 6 meses] He temido perder amigos si saben de mi status HIV.**

- En absoluto
- Raramente
- A veces
- A menudo
- N/A

**6c. [en los últimos 6 meses] He pensado que otras personas han sido incómodas conmigo debido a mi estatus de HIV.**

- En absoluto
- Raramente
- A veces
- A menudo
- N/A

**6d. [en los últimos 6 meses] He evitado recibir tratamiento porque alguien podría darse cuenta sobre mi estatus de HIV.**

- En absoluto
- Raramente
- A veces
- A menudo
- N/A

**6e. [en los últimos 6 meses] Me he sentido apoyado por mi familia desde la divulgación de mi estatus de HIV.**

- En absoluto
- Raramente
- A veces
- A menudo
- N/A

**6f. [en los últimos 6 meses] Alguien evito tener relaciones sexuales conmigo por mi estatus de HIV.**

- En absoluto
- Raramente
- A veces
- A menudo
- N/A

**6g. [en los últimos 6 meses] he sido tratado diferentemente con un médico debido a mi estatus de HIV.**

- En absoluto       Raramente       A veces       A menudo  
 N/A

**7. ¿Cuál es su sexo/género?** [Seleccione una respuesta solamente].

- Hombre  
 Mujer  
 Transexuales, Femenino a Masculino  
 Transexuales, Masculino a Femenino  
 Otro \_\_\_\_\_

**8. ¿Cuál es el más alto grado o año de escuela que alcanzado?**

- Algo de preparatoria o menos educación  
 Graduado de la High School secundaria o GED  
 Alguna universidad o escuela técnica  
 Graduado de una Universidad (BA, BS etc.)  
 Educación de post-Posgrado/profesional (con o sin título profesional o posgrado)

**9. ¿Describa su situación laboral actual?** [Seleccione una respuesta solamente].

- Empleado a tiempo completo  
 Empleados a tiempo parcial  
 Ama de casa, no trabajan fuera del hogar  
 Estudiante de tiempo completo  
 Jubilado  
 Con discapacidad para el trabajo  
 Desempleados  
 Durante un año o más  
 Hace menos de un año  
 Otro: \_\_\_\_\_

**Cuando haya completado la forma: Desprenda** la portada y guárdela en la carpeta principal en un gabinete con llave. **Archive** la evaluación del cliente en la carpeta de acceso de información

INICIALES: \_\_\_\_\_ FECHA DE EVALUACION: \_\_\_\_\_ FECHA DE ENTRADA: \_\_\_\_\_