

Minority AIDS Initiative (MAI) Reporting Form
Reporting Month _____ Year _____

Outreach Worker Name: _____

Local Health Jurisdiction Site: _____

Client's ID Number: _____

Date Form Completed: _____

Please complete ALL fields in Sections 1 through 4.

1. Date of first contact with client (phone, in person).
_____/_____/_____ (mm / dd / yy)

3. Client Demographics
1. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender
2. Age: _____
3. Race/Ethnicity: _____
4. Exposure (check all that apply):
<input type="checkbox"/> Sex with men
<input type="checkbox"/> Sex with women
<input type="checkbox"/> Sharing needles
<input type="checkbox"/> Other _____

2. Is person a current or former client who stopped receiving services?
<input type="checkbox"/> Yes
<input type="checkbox"/> No → Has client <u>ever</u> received any medical care for HIV?
<input type="checkbox"/> Yes <input type="checkbox"/> No

4. Date client FIRST tested HIV-positive.
_____/_____/_____ (mm / dd / yy)

FAX completed form to Matthew Willis at (916) 449-5959 or email at matthew.willis@cdph.ca.gov. Matthew's direct number is (916) 449-5797. Any incomplete forms will be returned. Thank you!
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Questions should be directed to (1) Toni Post at (916) 449-5970 or email toni.post@cdph.ca.gov or (2) Carol Russell at (916) 449-5962 or email carol.russell@cdph.ca.gov.