
MINISTRY OF HEALTH

## HMIS ACP 013:

# COMMUNITY ART MODEL
# ELIGIBILITY AND READINESS FORM

HEALTH UNIT NAME:.....

HEALTH UNIT CODE.....LEVEL.....

DISTRICT:.....

HEALTH SUB DISTRICT :.....

OPENING DATE:.....

CLOSING DATE:.....

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Health Facility:..... Date of Visit:.....

Name of client:..... ART No:..... Age:..... Sex:.....

| Criteria | | Decision |
|---|---|---|
| **ART regimen** | ☐ First line | |
| | ☐ Second line | |
| | ☐ Third Line | *Ineligible* |
| **Period on the same regimen** | ☐ < 1 year | *Ineligible* |
| | ☐ 1 year or More | |
| **Clinical Stage** | ☐ 1 or 2 | |
| | ☐ 3 or 4 | *Ineligible* |
| **Adherence level for the last 6 consecutive months** | ☐ Good ≥95% all the 6 consecutive months | |
| | ☐ ≥95% less than 6 consecutive months | *Ineligible* |
| | ☐ <95% | *Ineligible* |
| **Viral Suppression** | ☐ Suppressed | |
| | ☐ Unsuppressed | *Ineligible* |
| **Uncontrolled Non Communicable Diseases (NCD)** | ☐ Hypertension | *Ineligible* |
| | ☐ Diabetes | *Ineligible* |
| **Willingness to know other clients on ART in his/her community** | ☐ Yes | |
| | ☐ No | *Ineligible* |
| **Willingness to be known by other clients on ART in his/her community** | ☐ Yes | |
| | ☐ No | *Ineligible* |
| **Eligible to receive ART in community** | ☐ Yes | *Not eligible if a client has any ineligible* |
| | ☐ No | |
| **Community ART model approach** | ☐ CDDP | |
| | ☐ CCLAD | |

**Consent**

I ……, Have been informed about the ART community models and how they are implemented, benefits to me, my roles and responsibilities, and criteria for exiting the approach allocated to me. I fully understand that joining or not joining the community model will not affect my continuous receipt of services in anyway at the health facility.

Client signature/ thumb print:.....Date:.....

Attending clinician Name:.....Signature:.....