HMIS ACP XXX:

CRPDDP RECIPIENT OF CARE ELIGIBILITY ASSESSMENT FORM

HEALTH UNIT NAME: ....

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

DISTRICT: ....

HEALTH SUB DISTRICT: ....

OPENING DATE: ....

CLOSING DATE: ....

HMIS ACP XXX: CRPDDP RECIPIENT OF CARE ELIGIBILITY ASSESSMENT FORM

Health Facility: .... Date of Assessment: ....

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

Criteria	Finding		Decision
Is the recipient of care (RoC) stable?	YES	☐	
	NO	☐	*Ineligible*
Has the RoC been on ART for at least one year?	YES	☐	
	NO	☐	*Ineligible*
Is the RoC 20 years of age or older?	YES	☐	
	NO	☐	*Ineligible*
Is the RoC pregnant or breastfeeding?	YES	☐	*Ineligible*
	NO	☐	
Is the RoC on TB treatment or TB preventive Therapy?	YES	☐	*Ineligible*
	NO	☐	
Does the ROC have a child/dependant <2years in HIV care at this facility?	YES	☐	*Ineligible*
	NO	☐	
Is the RoC eligible for CRPDDP approach?			YES ☐
			NO ☐

Clinician declaration

I____ a clinician at this health facility

hereby declare that I've assessed ____ and

found him/her eligible for enrolment onto CRPDDP approach.

Signature: ________________________________