OUTCOMES MEASURES APPLICATION FORM
FCCS: SECOND YEAR AND LATER

Please use this form for FCCS services AFTER the first year and for all subsequent years
For the first year of service, use the 3-column FCCS Outcomes form.

ADMINISTRATIVE INFORMATION

Client ID		**Client DOB**	
Client Last Name		**Client First Name**	
Episode ID		**FCCS Program Age Group**	
FCCS Start Date			

Year of 6 and 12 Month Assessments: _____	**Year of 18 and 24 Month Assessments:** _____

FCCS OMA Completed By: (Write Staff Code in appropriate box below)

6 Months	12 Months	18 Months	24 Months

FCCS OMA Date: (Write Date in appropriate box below)

6 Months	12 Months	18 Months	24 Months

LIVING ARRANGEMENT

Please indicate the Client's Living Arrangement from the list below and write number in box

6 Months	12 Months	18 Months	24 Months

Living Arrangements

General

1. With Adult Family Members other than parents
2. In an apartment or house alone / with spouse / partner / minor children / other dependents / roommate - must hold lease or share in rent / mortgage
3. With one or both Biological / Adoptive Parents
4. D-Rate Foster Home (non-relative)
5. D-Rate Foster Home (relative)
6. Foster Home (with non-relatives)
7. Foster Home (with relatives)
8. Single Room Occupancy (SRO) (must hold lease)
9. Kin-Guardian Assist Program
10. Therapeutic Foster Home

Shelter/Homeless

11. Emergency Shelter
12. Homeless (includes people living in their cars)
13. Temporary Housing (includes people living with friends but paying no rent)

Hospital

14. Acute Medical Hospital
15. Acute Psychiatric Hospital / Psychiatric Health Facility (PHF)
16. State Psychiatric Hospital

Residential Program

17. Alcohol or Substance Abuse ResidentialRehabilitation Center
18. Crisis Residential Housing
19. Group Home (L 0-9)
20. Group Home (L10-11)
21. Group Home (L 12)
22. Group Home (L 14)
23. Community Treatment Facility (CTF)
24. Group Living Home
25. Institution for Mental Disease (IMD)
26. Long Term Residential Program
27. Mental Health Rehabilitation Center (MHRC)
28. Skilled Nursing (physical)
29. Skilled Nursing (psychiatric)
30. Transitional Residential Program

Justice Placement

31. California Youth Authority / Division of Juvenile Justice
32. Jail
33. Juvenile Hall
34. Juvenile Probation Camp/Ranch

Supervised Placement

35. Licensed Community Care Facility (Board and Care)
36. Sober Living Home
37. Unlicensed but supervised individual placement (includes paid caretakers, personal care attendants, etc.)

Others

38. Other
39. Unknown

Name: IS#:

Agency: Provider #:

Los Angeles County - Department of Mental Health

OUTCOMES MEASURES APPLICATION FORM
FCCS: SECOND YEAR AND LATER

LIVING ARRANGEMENTS

Is the Client's current living arrangement suitable?

6 Months	12 Months	18 Months	24 Months
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Is the Client's current living arrangement free from abuse, neglect, and domestic violence?

6 Months	12 Months	18 Months	24 Months
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Is the Client satisfied with their current living arrangement?

6 Months	12 Months	18 Months	24 Months
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If the Client's Living Arrangement changed, why? (Select from list below and write number in box)

6 Months	12 Months	18 Months	24 Months

1. Asked to leave by other(s)
2. At risk, sibling abuse
3. Caretaker Absent or Incapacitated
4. Decreased Functioning
5. Decrease in Financial Status
6. Desired increased independence
7. Dissatisfied with prior situation
8. Emotional Abuse
9. General Neglect
10. Health Reasons
11. Improved Functioning
12. Increase in financial resources
13. More affordable house/apartment
14. New/Better House/Apartment
15. Non-Payment of rent / evicted
16. Other
17. Physical Abuse
18. Sexual Abuse
19. Unable to maintain level of independence
20. **NOT APPLICABLE (No Change)**

SUPPORTIVE RELATIONSHIPS

Does the Client have access to at least one stable, supportive adult?

6 Months	12 Months	18 Months	24 Months
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

MEDICAL SERVICES

Does the Client have access to needed medical services?

6 Months	12 Months	18 Months	24 Months
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Does the Client receive needed medical services?

6 Months	12 Months	18 Months	24 Months
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

MEANINGFUL USE OF TIME

Does the Client have age appropriate involvement in the community?

6 Months	12 Months	18 Months	24 Months
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Does the Client have activities (could be solitary) that he/she defines as meaningful?

6 Months	12 Months	18 Months	24 Months
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

END OF SERVICES

If the Client has terminated FCCS Services, please write in their END DATE in the appropriate box

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