COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

OUTCOMES MEASURES APPLICATION

Child 3-Month (3M)

Age Group: 0-15

ADMINISTRATIVE INFORMATION

Client ID		Client DOB	
Episode ID		Provider Number	(4 characters)
Client Last Name		Client First Name	
Partnership Date		Assessment Date	
Partnership Service Coordinator (Last Name)		Assessment Completed By	(10 characters NPI #)

FINANCIAL

SOURCES OF FINANCIAL SUPPORT Indicate all the sources of financial support used to meet the needs of the client.	**CURRENT**	
	Check all that apply	**Monthly Average Amount**
Caregiver's Wages	☐	
Client's Wages	☐	
Client's Spouse / Significant Other's Wages	☐	
Savings	☐	
Other Family Member / Friend	☐	
Retirement / Social Security Income	☐	
Veteran's Assistance (VA) Benefits	☐	
Loan / Credit	☐	
Housing Subsidy	☐	
General Relief (GR) / General Assistance (GA)	☐	
Food Stamps	☐	
Temporary Assistance for Needy Families (TANF) / CalWORKs	☐	
Supplemental Security Income / State Supplementary Payment (SSI / SSP) Program	☐	
Social Security Disability Insurance (SSDI)	☐	
State Disability Insurance (SDI)	☐	
American Indian Tribal Benefits (e.g., per capita, revenue sharing, trust disbursements)	☐	
Unemployment	☐	
Child Support	☐	
Other	☐	
No Financial Support	☐	

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law.

Name _____ IS# _____

Agency _____ Provider # _____

Los Angeles County - Department of Mental Health

DAILY ACTIVITIES / VOCATIONAL / EDUCATIONAL LEVEL

EDUCATIONAL SETTING

Is the client CURRENTLY receiving special education due to a Serious Emotional Disturbance (SED)? ◯ Yes ◯ No

Is the client CURRENTLY receiving special education due to another reason? ◯ Yes ◯ No

Does the client have a CURRENT Individualized Education Plan (IEP) or Individualized Family Services Plan (IFSP)? ◯ Yes ◯ No

Does this client CURRENTLY receive Regional Center Services? ◯ Yes ◯ No

SCHOOL ATTENDANCE

Estimate the client's attendance level (excluding breaks and excused absences) CURRENTLY: **(select one)**

- ◯ Always attends school (never truant)
- ◯ Attends school most of the time
- ◯ Sometimes attends school
- ◯ Infrequently attends school
- ◯ Never attends school

If change reflects a DECREASE in attendance check the reasons why: **(check all that apply)**

- ☐ Physical Health Reasons
- ☐ Mental Health Reasons
- ☐ Substance Abuse Reasons
- ☐ Personal / Family Reasons
- ☐ Juvenile Justice Reasons
- ☐ Truant

If the DECREASE due to change in education plan requirements? ◯ Yes ◯ No

Other Reason? ◯ Yes ◯ No Specify: _____

On average, how many HOURS PER DAY did the client attend classes? _____

On average, how many HOURS PER WEEK did the client participate in extra-curricular activities (sports, music, etc.)? _____

CURRENTLY, his/her grades are: **(select one)**

- ◯ Very Good
- ◯ Good
- ◯ Average
- ◯ Below Average
- ◯ Poor

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PHYSICAL HEALTH

	CURRENT (LAST 4 WEEKS) (select one)
Client states that he/she is in good physical health?	Yes No
Client has access to needed medical services?	Yes No
Client receives needed medical services?	Yes No
Client has a primary care physician?	Yes No
Client uses a primary care physician?	Yes No
Client has access to needed dental services?	Yes No
Client receives needed dental services?	Yes No
Client demonstrates signs of regressive behavior (bed wetting, soiling)?	Yes No
Client demonstrates self-injurious behavior?	Yes No
Client has violent encounters?	Yes No
Is the client obese (based on BMI)?	Yes No
Has the client EVER been told by a physician that he/she has diabetes?	Yes No
Is the client pregnant?	Yes No N/A
Is the client receiving prenatal care?	Yes No N/A
Did the client receive physical health services from a DHS clinic or hospital?	Yes No
Does the client have a chronic physical health care problem or problems that require periodic medical services?	Yes No

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LEGAL

SUBSTANCE ABUSE

Client uses substances? ◯ Yes ◯ No

Client abuses substances? ◯ Yes ◯ No

In the opinion of the Partnership Service Coordinator, does the client CURRENTLY have a co-occurring mental illness and substance use problem? ◯ Yes ◯ No

Is the client CURRENTLY receiving substance abuse services? ◯ Yes ◯ No

CUSTODY INFORMATION

Indicate the total number of children the **client** has who are CURRENTLY:

(If the client has no children enter **0** in the following boxes.)

Placed on W & I Code 300 Status (Dependent of the court): _____

Placed in Foster Care: _____

Legally Reunified with the client: _____

Adopted Out: _____

Living with the client: _____

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