COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

OUTCOMES MEASURES APPLICATION

Transitional Age Youth (TAY) Baseline

Age Group: 16-25

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 #)

Program Name (select one)

- ◯ FSP-Child
- ◯ FSP-Transitional Age Youth (TAY)
- ◯ FSP-Adult
- ◯ Assisted Outpatient Treatment-FSP (AOT-LA-FSP)
- ◯ Integrated Mobile Health Team-FSP (IMHT-FSP)
- ◯ Wraparound FSP-Child
- ◯ Wraparound FSP-TAY
- ◯ Intensive FCCS-Child (IFCCS-Child)
- ◯ Forensic-FSP (F-FSP)

Who referred the client? (select one)

- ◯ Acute Psychiatric / State Hospital
- ◯ Emergency Room
- ◯ Faith-based Organization
- ◯ Family Member
- ◯ Friend / Neighbor
- ◯ Homeless Shelter
- ◯ Jail / Prison
- ◯ Juvenile Hall / Camp / Ranch / California Youth Authority / Division of Juvenile Justice
- ◯ Mental Health Facility / Community Agency
- ◯ Other
- ◯ Other County / Community Agency
- ◯ Primary Care / Medical Office
- ◯ School
- ◯ Self
- ◯ Significant Other
- ◯ Social Services Agency
- ◯ Street Outreach
- ◯ Substance Abuse Treatment Facility / Agency

PROGRAM INFORMATION

In which additional program(s) is the client CURRENTLY involved? (check all that apply)

- ☐ AB2034 Program
- ☐ Governor's Homeless Initiative (GHI) Program
- ☐ MHSA Housing Program

Name _____ IS# _____

Agency _____ Provider # _____

Los Angeles County - Department of Mental Health

LIVING ARRANGEMENTS

RESIDENTIAL TYPE	FROM	TO	TONIGHT (check one in this column)	YESTERDAY (as of 11:59 PM the day BEFORE partnership began) (check one in this column)	DURING THE PAST 12 MONTHS indicate the TOTAL: Number of Occurrences	DURING THE PAST 12 MONTHS indicate the TOTAL: Number of Days	PRIOR TO THE LAST 12 MONTHS (check all that apply)
GENERAL LIVING ARRANGEMENT							
With adult family members other than parents (non foster care)			☐	☐			☐
In an apartment or house alone / with spouse / partner / minor children / other dependents / roommate – must hold lease or share in rent / mortgage			☐	☐			☐
With one or both Biological / Adoptive Parents			☐	☐			☐
D-Rate Foster Home (non-relative)			☐	☐			☐
D-Rate Foster Home (relative)			☐	☐			☐
Foster Home (with non-relatives)			☐	☐			☐
Foster Home (with relatives)			☐	☐			☐
Single Room Occupancy (SRO) (must hold lease)			☐	☐			☐
Kin-Guardian Assist Program			☐	☐			☐
Therapeutic Foster Home			☐	☐			☐
SHELTER / HOMELESS							
Emergency Shelter			☐	☐			☐
Homeless (includes people living in their cars)			☐	☐			☐
Temporary Housing (includes people living with friends but paying no rent)			☐	☐			☐
HOSPITAL							
Acute Medical Hospital			☐	☐			☐
Acute Psychiatric Hospital / Psychiatric Health Facility (PHF)			☐	☐			☐
State Psychiatric Hospital				☐			☐
RESIDENTIAL PROGRAM							
Alcohol or Substance Abuse Residential Rehabilitation Center			☐	☐			☐
Crisis Residential Housing			☐	☐			☐
Group Home (L 0-9)			☐	☐			☐
Group Home (L 10-11)			☐	☐			☐
Group Home (L12)				☐			☐
Group Home (L 14)				☐			☐

Name _____ IS# _____

Agency _____ Provider # _____

Los Angeles County - Department of Mental Health

OUTCOMES MEASURES APPLICATION FORM - TAY BASELINE

LIVING ARRANGEMENTS *continued*

RESIDENTIAL TYPE	FROM	TO	TONIGHT (check one in this column)	YESTERDAY (as of 11:59 PM the day BEFORE partnership began) (check one in this column)	DURING THE PAST 12 MONTHS indicate the TOTAL:		PRIOR TO THE LAST 12 MONTHS (check all that apply)
					Number of Occurrences	Number of Days	
Community Treatment Facility (CTF)				☐			☐
Group Living Home			☐	☐			☐
Institution for Mental Disease (IMD)				☐			☐
Long Term Residential Program			☐	☐			☐
Mental Health Rehabilitation Center (MHRC)				☐			☐
Skilled Nursing Facility (physical)			☐	☐			☐
Skilled Nursing Facility (psychiatric)			☐	☐			☐
Transitional Residential Program			☐	☐			☐
JUSTICE PLACEMENT							
California Youth Authority / Division of Juvenile Justice				☐			☐
Jail			☐	☐			☐
Juvenile Hall			☐	☐			☐
Juvenile Probation Camp / Ranch				☐			☐
Prison							☐
SUPERVISED PLACEMENT							
Licensed Community Care Facility (Board and Care)			☐	☐			☐
Sober Living Home			☐	☐			☐
Unlicensed but supervised individual placement (includes paid caretakers, personal care attendants, etc.)			☐	☐			☐
OTHER							
Other			☐	☐			☐
Unknown			☐	☐			☐

If the client was in a residential type more than once list it on the following page

Name _____ IS# _____

Agency _____ Provider # _____

Los Angeles County - Department of Mental Health

OUTCOMES MEASURES APPLICATION FORM - TAY BASELINE

LIVING ARRANGEMENTS *continued*

RESIDENTIAL TYPE	FROM	TO	TONIGHT (check one in this column)	YESTERDAY (as of 11:59 PM the day BEFORE partnership began) (check one in this column)	DURING THE PAST 12 MONTHS indicate the TOTAL:		PRIOR TO THE LAST 12 MONTHS (check all that apply)
					Number of Occurrences	Number of Days	
			☐	☐			☐
			☐	☐			☐
			☐	☐			☐
			☐	☐			☐
			☐	☐			☐
			☐	☐			☐
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			☐	☐			☐
			☐	☐			☐

Name _____ IS# _____

Agency _____ Provider # _____

Los Angeles County - Department of Mental Health

LIVING ARRANGEMENTS *continued*

Is the client at risk of being removed from their CURRENT living arrangement?	Yes	No
Is the client's CURRENT living arrangement suitable? (According to clinician / FSP Team)	Yes	No
Is the CURRENT living arrangement in the least restrictive setting? (According to clinician / FSP Team)	Yes	No
Is the client satisfied with CURRENT living arrangement?	Yes	No
Have there been Suspected Dependent Adult Abuse reports made related to living arrangements IN THE LAST 12 MONTHS?	Yes	No
Have there been Suspected Child Abuse reports made related to living arrangements IN THE LAST 12 MONTHS?	Yes	No
Have there been incidents of violence related to living arrangements IN THE LAST 12 MONTHS?	Yes	No

SOCIAL SUPPORT

IDENTIFY CURRENT STATUS

Socializes with others	Yes	No	Develops and maintains friendships	Yes	No
Receives spiritual support	Yes	No	Requires protection from abuse	Yes	No

Client has age appropriate, positive peer relationships?	Yes	No	
Client has age appropriate involvement in family?	Yes	No	N/A
Client has supportive interactions / relationships with:			
Parent	Yes	No	N/A
Family	Yes	No	N/A
Caregiver	Yes	No	N/A
Is the family or significant other(s) involved in the client's treatment?	Yes	No	
Client has access to at least one stable, supportive adult?	Yes	No	N/A

Name _____ IS# _____

Agency _____ Provider # _____

Los Angeles County - Department of Mental Health

FINANCIAL

BENEFITS

Identify CURRENT status **(check all that apply)**:

- ☐ Medi-Cal
- ☐ Medicare
- ☐ Veteran's Assistance (VA) Benefits
- ☐ AB3632 / SB90
- ☐ Healthy Families
- ☐ Participant in CalWORKs
- ☐ Private Insurance
- ☐ HMO
- ☐ Healthy Kids

SOURCES OF FINANCIAL SUPPORT Indicate all the sources of financial support used to meet the needs of the client.	DURING THE PAST 12 MONTHS		CURRENT	
	Check all that apply	Monthly Average Amount	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	☐		☐	

PAYEE INFORMATION

Does the client CURRENTLY have a Payee? ○ **Yes** ○ **No**

Has the client had a Payee for finances IN THE LAST 12 MONTHS? ○ **Yes** ○ **No**

Did the client have a Payee anytime PRIOR TO THE LAST 12 MONTHS? ○ **Yes** ○ **No**

Name _____ IS# _____

Agency _____ Provider # _____

Los Angeles County - Department of Mental Health

DAILY ACTIVITIES / VOCATIONAL / EDUCATIONAL LEVEL

GRADE LEVEL INFORMATION

Highest Level of Education Attained **(check one)**:

- ◯ Day Care
- ◯ Preschool
- ◯ Kindergarten
- ◯ 1st Grade
- ◯ 2nd Grade
- ◯ 3rd Grade
- ◯ 4th Grade
- ◯ 5th Grade
- ◯ 6th Grade
- ◯ 7th Grade
- ◯ 8th Grade
- ◯ 9th Grade
- ◯ 10th Grade
- ◯ 11th Grade
- ◯ 12th Grade
- ◯ GED Coursework
- ◯ High School Diploma / GED
- ◯ Some College / Some Technical or Vocational Training
- ◯ Associate's Degree (e.g., A.A., A.S.) / Technical or Vocational Degree
- ◯ Bachelor's Degree (e.g., B.A., B.S.)
- ◯ Master's Degree (e.g., M.A., M.S.)
- ◯ Doctoral Degree (e.g., M.D., Ph.D.)
- ◯ Level Unknown (e.g., client in non-public school)

Is the client required by law to attend school? ◯ **Yes** ◯ **No**

EDUCATIONAL SETTINGS DURING THE PAST 12 MONTHS Indicate how many weeks the client was enrolled at each of the following educational settings DURING THE PAST 12 MONTHS.	**Number of Weeks**	**Average Number of Hours per Week**
Not in school of any kind		
High School / GED Preparation / Adult Education		
Technical / Vocational School		
Community College / 4 year College		
Graduate School		
Alternative Educational Setting		
Other		

CURRENT EDUCATIONAL SETTING	**Check All That Apply**	**Average Number of Hours per Week**
Not in school of any kind	☐	
High School / GED Preparation / Adult Education	☐	
Technical / Vocational School	☐	
Community College / 4 year College	☐	
Graduate School	☐	
Alternative Educational Setting	☐	
Other	☐	

Name _____ IS# _____

Agency _____ Provider # _____

DAILY ACTIVITIES / VOCATIONAL / EDUCATIONAL LEVEL *continued*

Does one of the client's CURRENT recovery goals include any kind of education AT THIS TIME?	Yes	No	
Does the client have age appropriate involvement in school activities?	Yes	No	N/A
Does the client have age appropriate involvement in the community?	Yes	No	
Does the client's performance meet developmental expectations?	Yes	No	N/A
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	
Is the client CURRENTLY receiving home study?	Yes	No	

DURING THE LAST 12 MONTHS, on an average, how many HOURS PER WEEK did the client participate in extra-curricular activities (sports, music, etc.)? _____

WITHIN THE LAST 4 WEEKS on an average, how many HOURS PER WEEK did the client participate in extra-curricular activities (sports, music, etc.)? _____

SCHOOL ATTENDANCE

Estimate the client's attendance level (excluding breaks and excused absences) DURING THE PAST 12 MONTHS: **(select one)**

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

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

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

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

Name _____ IS# _____

Agency _____ Provider # _____

Los Angeles County - Department of Mental Health

DAILY ACTIVITIES / VOCATIONAL / EDUCATIONAL LEVEL *continued*

IN THE LAST 12 MONTHS, his/her grades were: **(select one)**

- ○ Very Good
- ○ Good
- ○ Average
- ○ Below Average
- ○ Poor

DURING THE PAST 12 MONTHS, the client had:

Number of Suspensions _____ Number of Expulsions _____

EMPLOYMENT DURING THE PAST 12 MONTHS Indicate how many weeks the client was employed in each of the following settings DURING THE PAST 12 MONTHS.	**Number of Weeks**	**Average Number of Hours per Week**	**Average Hourly Wage**
Competitive Employment Paid employment in the community in a position that is also open to individuals without disability.			
Supportive Employment Competitive Employment (see above) with ongoing on-site or off-site job related support services provided.			
Transitional Employment / Enclave Paid jobs in the community that are 1) open only to individuals with a disability AND 2) are either time-limited for the purpose of moving to a more permanent job OR are part of a group of disabled individuals who are working as a team in the midst of teams of non-disabled individuals who are performing the same work.			
Paid In-House Work (Sheltered Workshop / Work Experience / Agency-Owned Business) Paid jobs open only to program participants with a disability. A Sheltered Workshop usually offers sub-minimum wage work in a simulated environment. A Work Experience (Adjustment) Program within an agency provides exposure to the standard expectations and advantages of employment. An Agency- Owned Business serves customers outside the agency and provides realistic work experiences and can be located at the program site or in the community.			
Non-paid (Volunteer) Work Experience Non-paid (volunteer) jobs in an agency or volunteer work in the community that provides exposure to the standard expectations of employment.			
Other Gainful / Employment Activity Any informal employment activity that increases the client's income (e.g., recycling, gardening, babysitting) OR participation in formal structured classes and/or workshops providing instruction on issues pertinent to getting a job. (Does NOT include such activities as panhandling or illegal activities such as prostitution).			
Unemployed			

Name _____ IS# _____

Agency _____ Provider # _____

Los Angeles County - Department of Mental Health

DAILY ACTIVITIES / VOCATIONAL / EDUCATIONAL LEVEL *continued*

CURRENT EMPLOYMENT	Average Number of Hours per Week	Average Hourly Wage
Competitive Employment Paid employment in the community in a position that is also open to individuals without disability.		
Supportive Employment Competitive Employment (see above) with ongoing on-site or off-site job related support services provided.		
Transitional Employment / Enclave Paid jobs in the community that are 1) open only to individuals with a disability AND 2) are either time-limited for the purpose of moving to a more permanent job OR are part of a group of disabled individuals who are working as a team in the midst of teams of non-disabled individuals who are performing the same work.		
Paid In-House Work (Sheltered Workshop / Work Experience / Agency-Owned Business) Paid jobs open only to program participants with a disability. A Sheltered Workshop usually offers sub-minimum wage work in a simulated environment. A Work Experience (Adjustment) Program within an agency provides exposure to the standard expectations and advantages of employment. An Agency- Owned Business serves customers outside the agency and provides realistic work experiences and can be located at the program site or in the community.		
Non-paid (Volunteer) Work Experience Non-paid (volunteer) jobs in an agency or volunteer work in the community that provides exposure to the standard expectations of employment.		
Other Gainful / Employment Activity Any informal employment activity that increases the client's income (e.g., recycling, gardening, babysitting) OR participation in formal structured classes and/or workshops providing instruction on issues pertinent to getting a job. (Does NOT include such activities as panhandling or illegal activities such as prostitution).		

Is the client unemployed AT THIS TIME? ◯ **Yes** ◯ **No**

Does one of the client's CURRENT recovery goals include any kind of employment AT THIS TIME? ◯ **Yes** ◯ **No**

Name _____ IS# _____

Agency _____ Provider # _____

Los Angeles County - Department of Mental Health

PHYSICAL HEALTH

	CURRENT (LAST 4 WEEKS) (select one for each question)	LAST 12 MONTHS (select one for each question)
Client states that he/she is in good physical health?	Yes No	Yes No
Client has access to needed medical services?	Yes No	Yes No
Client receives needed medical services?	Yes No	Yes No
Client has a primary care physician?	Yes No	Yes No
Client uses a primary care physician?	Yes No	Yes No
Client has access to needed dental services?	Yes No	Yes No
Client receives needed dental services?	Yes No	Yes No
Client demonstrates signs of regressive behavior (bed wetting, soiling)?	Yes No	Yes No
Client demonstrates self-injurious behavior?	Yes No	Yes No
Client has violent encounters?	Yes No	Yes No
Is the client obese (based on BMI)?	Yes No	Yes No
Has the client EVER been told by a physician that he/she has diabetes?	Yes No	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 IN THE PAST 12 MONTHS? Yes No

Does the client have a chronic physical health care problem or problems that require periodic medical services? Yes No

CRISIS STABILIZATION / PMRT

Did the client receive services in an Emergency Room or Crisis Stabilization IN THE LAST 12 MONTHS? Yes No

Identify how many times in Emergency Room for: Physical Health _____ Psychiatric _____ Substance Abuse _____

Identify how many times in Crisis Stabilization for: Psychiatric _____ Substance Abuse _____

Total Services _____

Was the client seen by a Psychiatric Mobile Response Team or 24/7 Response Team WITHIN THE LAST 12 MONTHS? Yes No How many times? _____

Did any of the Psychiatric Mobile Response Team or 24/7 Response Team calls result in a hospitalization? Yes No How many times? _____

Name _____ IS# _____

Agency _____ Provider # _____

Los Angeles County - Department of Mental Health

LEGAL

JUSTICE SYSTEM INVOLVEMENT

Did the client have contact with the police WITHIN THE LAST 12 MONTHS? ◯ Yes ◯ No

Was the contact related to mental health issues? ◯ Yes ◯ No ◯ N/A

Was the contact related to substance abuse issues? ◯ Yes ◯ No ◯ N/A

Was the client arrested anytime DURING THE LAST 12 MONTHS? ◯ Yes ◯ No

Indicate the number of times the client was arrested DURING THE PAST 12 MONTHS: _____

How many were misdemeanor arrests? _____

How many were felony arrests? _____

Were any of the arrests related to a mental health issue? ◯ Yes ◯ No ◯ N/A

Were any of the arrests related to a substance abuse issue? ◯ Yes ◯ No ◯ N/A

Was the client detained in the juvenile justice system **or** incarcerated WITHIN THE LAST 12 MONTHS? ◯ Yes ◯ No

Was treatment court ordered WITHIN THE LAST 12 MONTHS? ◯ Yes ◯ No

Was the client arrested anytime PRIOR TO THE LAST 12 MONTHS? ◯ Yes ◯ No

Was the client on probation DURING THE PAST 12 MONTHS? ◯ Yes ◯ No

If yes, what type: **(check one)**

- ◯ Voluntary Probation (i.e., WIC 236/654)
- ◯ Informal Types of Probation (i.e., 601, 790, Summary Probation)
- ◯ Formal Probation (i.e., 602)

Is the client CURRENTLY on probation? ◯ Yes ◯ No

Was the client on probation anytime PRIOR TO THE LAST 12 MONTHS? ◯ Yes ◯ No

Is the client CURRENTLY a ward of the court according to W & I Code 601 / 602 Status? ◯ Yes ◯ No

Has the client been a ward of the court according to W & I Code 601 / 602 Status at anytime DURING THE LAST 12 MONTHS? ◯ Yes ◯ No

Was the client on any kind of parole anytime DURING THE PAST 12 MONTHS? ◯ Yes ◯ No

Is the client CURRENTLY on parole from the California Youth Authority / Division of Juvenile Justice? ◯ Yes ◯ No

Was the client on any kind of parole anytime PRIOR TO THE LAST 12 MONTHS? ◯ Yes ◯ No

DEPENDENT (W & I CODE 300 STATUS) INFORMATION

Was the client detained in child welfare system WITHIN THE LAST 12 MONTHS? ◯ Yes ◯ No

Did the client become a dependent of the court IN THE LAST 12 MONTHS? ◯ Yes ◯ No

Was the client a dependent of the court anytime PRIOR TO THE LAST 12 MONTHS? ◯ Yes ◯ No

If the client was EVER a dependent of the court, indicate the year he/she was FIRST PLACED on W & I Code 300 Status: _____

Is the client CURRENTLY a dependent of the court according to W & I Code 300 Status? ◯ Yes ◯ No

Name _____ IS# _____

Agency _____ Provider # _____

Los Angeles County - Department of Mental Health

LEGAL *continued*

SUBSTANCE ABUSE

Client uses substances?	◯ Yes	◯ No
Client abuses substances?	◯ Yes	◯ No
In the opinion of the Partnership Service Coordinator, has the client EVER had a co-occurring mental illness and substance use problem?	◯ Yes	◯ No
In the opinion of the Partnership Service Coordinator, does the client CURRENTLY have an active co-occurring mental illness and substance use problem?	◯ Yes	◯ No
Is the client CURRENTLY receiving substance abuse services?	◯ Yes	◯ No

CONSERVATORSHIP INFORMATION

Was the client on conservatorship DURING THE LAST 12 MONTHS?	◯ Yes	◯ No
Was the client on conservatorship anytime PRIOR to the last 12 months?	◯ Yes	◯ No
Is the client CURRENTLY on conservatorship?	◯ 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:	

Name _____ IS# _____

Agency _____ Provider # _____

Los Angeles County - Department of Mental Health