COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

OUTCOMES MEASURES APPLICATION

Adult 3-Month (3M)

Age Group: 26-59

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
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	☐	

Name | IS#

Agency | Provider #

Los Angeles County - Department of Mental Health

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
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

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

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 an active co-ocurring 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: _____

Name _____ IS# _____

Agency _____ Provider # _____

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OUTCOMES MEASURES APPLICATION FORM - ADULT 3M