COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

OUTCOMES MEASURES APPLICATION

Older Adult Baseline

Age Group: 60+

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-Adult
- ◯ FSP-Older Adult
- ◯ Assisted Outpatient-FSP (AOT-LA-FSP)
- ◯ Integrated Mobile Health Team-FSP (IMHT-FSP)
- ◯ 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
- ◯ 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#

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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			☐	☐			☐
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			☐	☐			☐
Single Room Occupancy (SRO) (must hold lease)			☐	☐			☐
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 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							
Jail				☐			☐
Prison							☐

Name _____ IS# _____

Agency _____ Provider # _____

OUTCOMES MEASURES APPLICATION FORM - OLDER ADULT 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	
SUPERVISED PLACEMENT							
Assisted Living Facility			☐	☐			☐
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# _____

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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 # _____

OUTCOMES MEASURES APPLICATION FORM - OLDER ADULT BASELINE

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 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

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FINANCIAL

BENEFITS

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

- ☐ Medi-Cal
- ☐ Medicare
- ☐ Veteran's Assistance (VA) Benefits
- ☐ Participant in CalWORKs
- ☐ Private Insurance
- ☐ HMO

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
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 # _____

DAILY ACTIVITIES / VOCATIONAL / EDUCATIONAL LEVEL

IDENTIFY CURRENT STATUS

- ☐ Adult Day Health Care
- ☐ Senior Center Participation

GRADE LEVEL INFORMATION

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

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

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	☐	

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

Name _____ IS# _____

Agency _____ Provider # _____

DAILY ACTIVITIES / VOCATIONAL / EDUCATIONAL LEVEL *continued*

INDEX OF INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)

For each area of functioning listed below, check the description that applies: (The word 'assistance' means supervision, direction or personal assistance).

Bathing - either sponge bath, tub bath or shower: **(select one)**

- ◯ Receives no assistace (gets in and out of tub by self, if tub is usual means of bathing).
- ◯ Receives assistance in bathing only one part of the body (such as back or leg).
- ◯ Receives assistance in bathing more than one part of the body (or not bathed).

Dressing - gets clothes from closet or drawers, including underclothes, outer garments and uses fasteners (including braces, if worn): **(select one)**

- ◯ Gets clothes and gets completely dressed without assistance.
- ◯ Gets clothes and gets completely dressed without assistance, except for assistance in tying shoes.
- ◯ Receives assistance in getting clothes or in getting dressed, or stays partly or completely undressed.

Toileting: **(select one)**

- ◯ Goes to "toilet room", cleans self, and arranges clotes without assistance (may use object to support such as cane, walker, or wheelchair and may manage night bed pan or commode, emptying same in AM).
- ◯ Receives assistance in going to the 'toilet room' or in cleansing self or in arranging clothes after elimination or in use of night bed pan or commode.
- ◯ Doesn't go to room termed 'toilet' for the elimination process.

Transfer: **(select one)**

- ◯ Moves in and out of bed as well as in and out of chair without assistance (may be using object for support, such as cane or walker)
- ◯ Moves in and out of bed or chair with assistance.
- ◯ Doesn't get out of bed.

Continence: **(select one)**

- ◯ Controls urination and bowel movement completely by self.
- ◯ Has occasional "accidents".
- ◯ Supervision helps keep urine or bowel control; catheter is used, or person is incontinent.

Feeding: **(select one)**

- ◯ Feeds self without assistance.
- ◯ Feeds self except for getting assistance cutting meal or buttering bread.
- ◯ Receives assistance in feeding or is fed partly or completely by using tubes or I.V. fluids.

Walking: **(select one)**

- ◯ Walks on level without assistance.
- ◯ Walks without assistance but uses a single, straight cane.
- ◯ Walks without assistance but uses two points for mechanical support such as crutches, a walker, or two canes (or wears a brace).
- ◯ Walks with assistance.
- ◯ Uses wheelchair only.
- ◯ Not walking or using wheelchair.

House-Confinement: **(select one)**

- ◯ Has been outside of residence 3 or more days DURING THE PAST 2 WEEKS.
- ◯ Has been outside of residence only 1 or 2 days DURING THE PAST 2 WEEKS.
- ◯ Has not been outside of residence IN THE PAST 2 WEEKS.

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Los Angeles County - Department of Mental Health

DAILY ACTIVITIES / VOCATIONAL / EDUCATIONAL LEVEL *continued*

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)

For each area of functioning listed below, select the description that applies:	Without Help	With Some Help	Completely Unable To Do
Can the client use the telephone?	○	○	○
Can the client get to places out of walking distance?	○	○	○
Can the client go shopping for groceries?	○	○	○
Can the client prepare his/her own meals?	○	○	○
Can the client do his/her own housework?	○	○	○
Can the client do his/her own handyman work?	○	○	○
Can the do his/her own laundry?	○	○	○
If the client takes medication (or if the client had to take medication) could he/she take it on his/her own?	○	○	○
Can the client manage his/her own money?	○	○	○

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			
Retired			

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# _____

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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
Client has a caretaker relationship?	Yes No	Yes No
Is the caretaker a paid In-Home Worker?	Yes No	Yes No
Is the caretaker a paid Supported Transitional Worker?	Yes No	Yes No
Is the caretaker a significant other?	Yes No	Yes No
Is the caretaker a family member?	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

Based on the Mini Mental Status Exam (MMSE), the client presented with symptoms of cognitive impairment? Yes No

If yes, what level? **(select one)**

- Mild
- Moderate
- Severe

Based on the Confusion Assessment Method (CAM) the client presented with symptoms of delirium? Yes No

If yes, identify the most appropriate: **(select one)**

- Acute Change
- Altered Level of Consciousness
- Disorganized Thinking
- Inattention

Based on the Geriatric Depression Scale (GDS), the client presented with depressive Symptoms? Yes No

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

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Los Angeles County - Department of Mental Health

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? _____

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 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

Is the client CURRENTLY on probation? ◯ Yes ◯ No

Name of Probation Officer: _____

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

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

Was the client on any kind of parole anytime PRIOR TO THE LAST 12 MONTHS? ◯ 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
Does the client have a Probate Conservator?	Yes	No
Does the client have a Power of Attorney?	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 # _____