

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH OUTCOMES MEASURES APPLICATION

Adult Baseline

Age Group: 26-59

ADMINISTRATIVE INFORMATION

Client ID	<input type="text"/>	Client DOB	<input type="text"/>
Episode ID	<input type="text"/>	Provider Number	<input type="text"/> (4 characters)
Client Last Name	<input type="text"/>	Client First Name	<input type="text"/>
Partnership Date	<input type="text"/>	Assessment Date	<input type="text"/>
Partnership Service Coordinator (Last Name)	<input type="text"/>	Assessment Completed By	<input type="text"/> (10 characters NPI #)

Program Name (select one)

- | | |
|--|--|
| <input type="radio"/> FSP-Adult | <input type="radio"/> Assisted Outpatient Treatment-FSP (AOT-LA-FSP) |
| <input type="radio"/> FSP-Transitional Age Youth (TAY) | <input type="radio"/> Integrated Mobile Health Team-FSP (IMHT-FSP) |
| <input type="radio"/> FSP-Older Adult | <input type="radio"/> Forensic-FSP (F-FSP) |

Who referred the client? (select one)

- | | | |
|--|---|---|
| <input type="radio"/> Acute Psychiatric / State Hospital | <input type="radio"/> Jail / Prison | <input type="radio"/> Self |
| <input type="radio"/> Emergency Room | <input type="radio"/> Mental Health Facility / Community Agency | <input type="radio"/> Significant Other |
| <input type="radio"/> Faith-based Organization | <input type="radio"/> Other | <input type="radio"/> Social Services Agency |
| <input type="radio"/> Family Member | <input type="radio"/> Other County / Community Agency | <input type="radio"/> Street Outreach |
| <input type="radio"/> Friend / Neighbor | <input type="radio"/> Primary Care / Medical Office | <input type="radio"/> Substance Abuse Treatment Facility / Agency |
| <input type="radio"/> Homeless Shelter | <input type="radio"/> School | |

PROGRAM INFORMATION

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

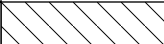
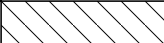
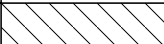
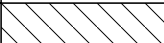
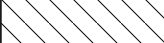
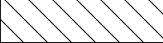
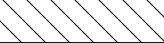
- ☐ AB2034 Program
- ☐ Governor's Homeless Initiative (GHI) Program
- ☐ MHSA Housing Program

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	<input type="text"/>	IS#	<input type="text"/>
Agency	<input type="text"/>	Provider #	<input type="text"/>

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:		PRIOR TO THE LAST 12 MONTHS (check all that apply)
					Number of Occurrences	Number of Days	
GENERAL LIVING ARRANGEMENT							
With adult family members other than parents (non foster care)			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
In an apartment or house alone / with spouse / partner / minor children / other dependents / roommate – must hold lease or share in rent / mortgage			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
With one or both Biological / Adoptive Parents			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Single Room Occupancy (SRO) (must hold lease)			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
SHELTER / HOMELESS							
Emergency Shelter			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Homeless (includes people living in their cars)			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Temporary Housing (includes people living with friends but paying no rent)			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
HOSPITAL							
Acute Medical Hospital			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Acute Psychiatric Hospital / Psychiatric Health Facility (PHF)			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
State Psychiatric Hospital				<input type="checkbox"/>			<input type="checkbox"/>
RESIDENTIAL PROGRAM							
Alcohol or Substance Abuse Residential Rehabilitation Center			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Crisis Residential Housing			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Group Living Home			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Institution for Mental Disease (IMD)				<input type="checkbox"/>			<input type="checkbox"/>
Long Term Residential Program			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Mental Health Rehabilitation Center (MHRC)				<input type="checkbox"/>			<input type="checkbox"/>
Skilled Nursing Facility (physical)			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Skilled Nursing Facility (psychiatric)				<input type="checkbox"/>			<input type="checkbox"/>
Transitional Residential Program			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
JUSTICE PLACEMENT							
Jail				<input type="checkbox"/>			<input type="checkbox"/>
Prison							<input type="checkbox"/>

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

OUTCOMES MEASURES APPLICATION FORM - ADULT BASELINE

LIVING ARRANGEMENTS <i>continued</i>							
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			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Licensed Community Care Facility (Board and Care)			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Sober Living Home			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Unlicensed but supervised individual placement (includes paid caretakers, personal care attendants, etc.)			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
OTHER							
Other			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Unknown			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>

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

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	<input type="text"/>	IS#	<input type="text"/>
Agency	<input type="text"/>	Provider #	<input type="text"/>
Los Angeles County - Department of Mental Health			

LIVING ARRANGEMENTS *continued*

[illegible]

Name		IS#	
Agency		Provider #	
Los Angeles County - Department of Mental Health			

FINANCIAL

BENEFITS

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

- | | | |
|-----------------------------------|---|--|
| <input type="checkbox"/> Medi-Cal | <input type="checkbox"/> Veteran's Assistance (VA) Benefits | <input type="checkbox"/> Private Insurance |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Participant in CalWORKs | <input type="checkbox"/> 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	<input type="checkbox"/>		<input type="checkbox"/>	
Client's Spouse / Significant Other's Wages	<input type="checkbox"/>		<input type="checkbox"/>	
Savings	<input type="checkbox"/>		<input type="checkbox"/>	
Other Family Member / Friend	<input type="checkbox"/>		<input type="checkbox"/>	
Retirement / Social Security Income	<input type="checkbox"/>		<input type="checkbox"/>	
Veteran's Assistance (VA) Benefits	<input type="checkbox"/>		<input type="checkbox"/>	
Loan / Credit	<input type="checkbox"/>		<input type="checkbox"/>	
Housing Subsidy	<input type="checkbox"/>		<input type="checkbox"/>	
General Relief (GR) / General Assistance (GA)	<input type="checkbox"/>		<input type="checkbox"/>	
Food Stamps	<input type="checkbox"/>		<input type="checkbox"/>	
Temporary Assistance for Needy Families (TANF) / CalWORKs	<input type="checkbox"/>		<input type="checkbox"/>	
Supplemental Security Income / State Supplementary Payment (SSI / SSP) Program	<input type="checkbox"/>		<input type="checkbox"/>	
Social Security Disability Insurance (SSDI)	<input type="checkbox"/>		<input type="checkbox"/>	
State Disability Insurance (SDI)	<input type="checkbox"/>		<input type="checkbox"/>	
American Indian Tribal Benefits (e.g., per capita, revenue sharing, trust disbursements)	<input type="checkbox"/>		<input type="checkbox"/>	
Unemployment	<input type="checkbox"/>		<input type="checkbox"/>	
Child Support	<input type="checkbox"/>		<input type="checkbox"/>	
Other	<input type="checkbox"/>		<input type="checkbox"/>	
No Financial Support	<input type="checkbox"/>		<input type="checkbox"/>	

PAYEE INFORMATION

- | | | |
|--|---------------------------|--------------------------|
| Does the client CURRENTLY have a Payee? | <input type="radio"/> Yes | <input type="radio"/> No |
| Has the client had a Payee for finances IN THE LAST 12 MONTHS? | <input type="radio"/> Yes | <input type="radio"/> No |
| Did the client have a Payee anytime PRIOR TO THE LAST 12 MONTHS? | <input type="radio"/> Yes | <input type="radio"/> No |

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

GRADE LEVEL INFORMATION

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

- | | | |
|--|---|---|
| <input type="radio"/> No High School Diploma / GED | <input type="radio"/> Some College / Some Technical or Vocational Training | <input type="radio"/> Master's Degree (e.g., M.A., M.S.) |
| <input type="radio"/> GED Coursework | <input type="radio"/> Associate's Degree (e.g., A.A., A.S.) /
Technical or Vocational Degree | <input type="radio"/> Doctoral Degree (e.g., M.D., Ph.D.) |
| <input type="radio"/> High School Diploma / GED | <input type="radio"/> Bachelor's Degree (e.g., B.A., B.S.) | |

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		
Other		

CURRENT EDUCATIONAL SETTING

	Check all that apply	Average Number of Hours per Week
Not in school of any kind	<input type="checkbox"/>	
High School / GED Preparation / Adult Education	<input type="checkbox"/>	
Technical / Vocational School	<input type="checkbox"/>	
Community College / 4 year College	<input type="checkbox"/>	
Graduate School	<input type="checkbox"/>	
Other	<input type="checkbox"/>	

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

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 *continued*

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			

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	<input style="width: 95%;" type="text"/>	IS#	<input style="width: 95%;" type="text"/>
Agency	<input style="width: 95%;" type="text"/>	Provider #	<input style="width: 95%;" type="text"/>
Los Angeles County - Department of Mental Health			

DAILY ACTIVITIES / VOCATIONAL / EDUCATIONAL LEVEL *continued*

<u>CURRENT EMPLOYMENT</u>	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

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	<input style="width: 95%;" type="text"/>	IS#	<input style="width: 95%;" type="text"/>
Agency	<input style="width: 95%;" type="text"/>	Provider #	<input style="width: 95%;" type="text"/>
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?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Client has access to needed medical services?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Client receives needed medical services?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Client has a primary care physician?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Client uses a primary care physician?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Client has access to needed dental services?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Client receives needed dental services?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Is the client obese (based on BMI)?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Has the client EVER been told by a physician that he/she has diabetes?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Did the client receive physical health services from a DHS clinic or hospital IN THE PAST 12 MONTHS?		<input type="radio"/> Yes <input type="radio"/> No
Does the client have a chronic physical health care problem or problems that require periodic medical services?		<input type="radio"/> Yes <input type="radio"/> No

CRISIS STABILIZATION / PMRT

Did the client receive services in an Emergency Room or Crisis Stabilization IN THE LAST 12 MONTHS? <input type="radio"/> Yes <input type="radio"/> No			
Identify how many times in Emergency Room for:	Physical Health <input style="width: 80px;" type="text"/>	Psychiatric <input style="width: 80px;" type="text"/>	Substance Abuse <input style="width: 80px;" type="text"/>
Identify how many times in Crisis Stabilization for:		Psychiatric <input style="width: 80px;" type="text"/>	Substance Abuse <input style="width: 80px;" type="text"/>
Total Services <input style="width: 80px;" type="text"/>			
Was the client seen by a Psychiatric Mobile Response Team or 24/7 Response Team WITHIN THE LAST 12 MONTHS?		<input type="radio"/> Yes <input type="radio"/> No	How many times? <input style="width: 80px;" type="text"/>
Did any of the Psychiatric Mobile Response Team or 24/7 Response Team calls result in a hospitalization?		<input type="radio"/> Yes <input type="radio"/> No	How many times? <input style="width: 80px;" type="text"/>

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 <input style="width: 180px;" type="text"/>	IS#	<input style="width: 180px;" type="text"/>
Agency <input style="width: 180px;" type="text"/>	Provider #	<input style="width: 180px;" type="text"/>
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 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

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

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

LEGAL *continued*

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:

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