

### EASA PROGRAM – INTAKE

(ONLY complete more than 1 time if the person is discharged and returns, complete INTAKE back to the date of discharge OR 3 months if discharge was longer than 3 months ago) **Update Complete or Update the Participant Details Event & Current Status**

<b>AGENCY IDENTIFIERS</b> – Entered at 'Participant' level – please update any 'Unknown' or 'Missing' values			
Client (Agency) ID #	_____	Prime # (OHP ID)	_____
County of Residence	_____	Agency Name	_____

<b>HIPAA IDENTIFIERS</b> - Entered at 'Participant' level – please update any 'Unknown' or 'Missing' values			
Full Name	_____	DOB	___/___/___

<b>FORM DETAILS</b>			
Year	_ _ _	Quarter	<input type="radio"/> 1 Jan-Mar <input type="radio"/> 2 Apr-Jun <input type="radio"/> 3 Jul-Sep <input type="radio"/> 4 Oct-Dec
Date Admitted	___/___/___	Completed Form Staff Name	_____

<b>DEMOGRAPHICS</b> – Entered at 'Participant' level – please update any 'Unknown' or 'Missing' values	
<b>Race</b> (check all that apply) <input type="checkbox"/> Alaska Native <input type="checkbox"/> American Indian <input type="checkbox"/> Black of African American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other Race <input type="checkbox"/> Unknown	<b>Ethnicity</b> (check all that apply) <input type="checkbox"/> Not of Hispanic Origin <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other Specific Hispanic, specify _____ <input type="checkbox"/> Hispanic – Specific Origin Not Specified <input type="checkbox"/> Unknown
<b>Gender at Birth</b> <input type="radio"/> Female <input type="radio"/> Male <input type="radio"/> Non-binary	<b>Gender Identity</b> (client identified) <input type="radio"/> Cisgender (gender identity that is consistent with the sex they were assigned at birth) <input type="radio"/> Transgender (gender identity that does not match the sex they were assigned at birth) <input type="radio"/> Non-binary/ Genderqueer (gender identity that does not identify strictly as a boy or a girl) <input type="radio"/> Agender/ Neutrosis (gender identity that does not identify with any gender) <input type="radio"/> Gender fluid (gender identity varies over time) <input type="radio"/> A gender identity not represented above <input type="radio"/> Unknown
<b>Age at Intake</b> _____	
<b>Preferred Language</b> <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Other, specify _____ <input type="radio"/> Non-binary	<b>Country of Origin</b> <input type="radio"/> US <input type="radio"/> Mexico <input type="radio"/> Other, specify _____ <input type="radio"/> Non-binary

<b>CLIENT IDENTIFIERS</b>		
Full Name _____	DOB ___/___/___	Agency ID _____

<b>LIVING SITUATION, SUPPORT, LEGAL &amp; MISC.</b>				
<p><b>Does the client have natural supports (family or friends) who are willing to participate in treatment?</b></p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Unknown</p>	<p><b>Does the client want natural supports (family or friends) to participate in treatment?</b></p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Unknown</p>			
<p><b>Living Situation for the last 3 months</b> <i>(check all that apply)</i></p> <table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Transient/ Homeless  <input type="checkbox"/> Foster Home  <input type="checkbox"/> Residential Facility  <input type="checkbox"/> Jail  <input type="checkbox"/> Prison  <input type="checkbox"/> Supported Housing         </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Alcohol and Drug Free Housing  <input type="checkbox"/> Private Residence (lives alone)  <input type="checkbox"/> Private Residence (with relative)  <input type="checkbox"/> Private Residence (with non-relative)  <input type="checkbox"/> Other, specify _____  <input type="checkbox"/> Unknown         </td> </tr> </table>		<input type="checkbox"/> Transient/ Homeless <input type="checkbox"/> Foster Home <input type="checkbox"/> Residential Facility <input type="checkbox"/> Jail <input type="checkbox"/> Prison <input type="checkbox"/> Supported Housing	<input type="checkbox"/> Alcohol and Drug Free Housing <input type="checkbox"/> Private Residence (lives alone) <input type="checkbox"/> Private Residence (with relative) <input type="checkbox"/> Private Residence (with non-relative) <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Unknown	
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<p><b>Living Situation funded by</b></p> <table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="radio"/> Client (+ partner) responsible for all housing costs (their portion if roommates)  <input type="radio"/> Client (+ partner) responsible for all housing costs (their portion if roommates)         </td> <td style="width: 50%; vertical-align: top;"> <input type="radio"/> Client contributes to housing costs and family provides the rest  <input type="radio"/> Family provides housing: lives with family  <input type="radio"/> State/Other Institution funded housing  <input type="radio"/> Other, specify _____         </td> </tr> </table>		<input type="radio"/> Client (+ partner) responsible for all housing costs (their portion if roommates) <input type="radio"/> Client (+ partner) responsible for all housing costs (their portion if roommates)	<input type="radio"/> Client contributes to housing costs and family provides the rest <input type="radio"/> Family provides housing: lives with family <input type="radio"/> State/Other Institution funded housing <input type="radio"/> Other, specify _____	
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<p><b>Legal Involvement for the last 3 months</b> <i>(check all that apply)</i></p> <table style="width: 100%;"> <tr> <td style="width: 70%;"> <input type="checkbox"/> None  <input type="checkbox"/> Probation/ Parole  <input type="checkbox"/> Incarcerated*  <input type="checkbox"/> Arrested*  <input type="checkbox"/> Unknown         </td> <td style="width: 30%; vertical-align: middle; font-size: 2em;">}</td> <td style="width: 10%; vertical-align: middle; font-size: 0.8em;">Answer question to right</td> </tr> </table>	<input type="checkbox"/> None <input type="checkbox"/> Probation/ Parole <input type="checkbox"/> Incarcerated* <input type="checkbox"/> Arrested* <input type="checkbox"/> Unknown	}	Answer question to right	<p><b>*If arrested or incarcerated was this due to:</b> <i>(check all that apply)</i></p> <input type="checkbox"/> Symptoms <input type="checkbox"/> Substance Use <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Unknown
<input type="checkbox"/> None <input type="checkbox"/> Probation/ Parole <input type="checkbox"/> Incarcerated* <input type="checkbox"/> Arrested* <input type="checkbox"/> Unknown	}	Answer question to right		

<b>EDUCATION &amp; EMPLOYMENT</b>		
<p><b>Last grade completed</b> _____</p> <p><b>Educational Milestones client has Completed</b> <i>(check all that apply)</i></p> <table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Middle school  <input type="checkbox"/> Some high school  <input type="checkbox"/> GED  <input type="checkbox"/> High school graduate  <input type="checkbox"/> AA or AS degree         </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> BA or BS degree  <input type="checkbox"/> Voc/ Tech certificate/degree, specify _____  <input type="checkbox"/> Other, specify _____  <input type="checkbox"/> Unknown  <input type="checkbox"/> None         </td> </tr> </table>	<input type="checkbox"/> Middle school <input type="checkbox"/> Some high school <input type="checkbox"/> GED <input type="checkbox"/> High school graduate <input type="checkbox"/> AA or AS degree	<input type="checkbox"/> BA or BS degree <input type="checkbox"/> Voc/ Tech certificate/degree, specify _____ <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Unknown <input type="checkbox"/> None
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**CLIENT IDENTIFIERS**

Full Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ Agency ID \_\_\_\_\_

**EDUCATION & EMPLOYMENT**

**School Status in the last 3 months**

- Full time\*
- Part time\* } Answer question below
- Not in school
- Unknown

**\* Type of School Attending** (check all that apply)

- Middle school
- Some high school
- High school
- Community College
- University
- Voc/ Tech program
- Other, specify \_\_\_\_\_
- Unknown

**Receiving School Accommodations?** (check all that apply)

- IEP
- 504
- College disability office
- Other, specify \_\_\_\_\_
- None
- Unknown

**Did Symptoms Impact School Situation in the last 3 months** (check all that apply)

- Yes, school was discontinued
- Yes, increased absences
- Yes, course load reduced, classes dropped
- Yes, negatively impacted school search activities
- Yes, grades lower than in the past
- Yes, other difficulty, specify \_\_\_\_\_
- No
- Unknown

**How Much Job Experience (competitive, sheltered, or volunteer) does this client have?**

- None
- Less than 6 months
- 6 months to 1 year
- 1 year
- 1 to 2 years
- Over 2 years
- Unknown

**Employment Status in the last 3 months**

- Full time
- Part time
- Not Employed
- Unknown

**How Many Weeks Did the Client Work in the last 3 months?**

\_\_\_\_\_  Check if Unknown

**CLIENT IDENTIFIERS**

Full Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ Agency ID \_\_\_\_\_

**EDUCATION & EMPLOYMENT**

**Employment Type** *(check all that apply)*

- Competitive
- Sheltered
- Volunteer
- Unknown

**Did Symptoms Impact Employment Situation in the last 3 months?** *(check all that apply)*

- Yes, work was discontinued
- Yes, increased absences
- Yes, negatively impacted employment procurement activities
- Yes, other difficulty, specify \_\_\_\_\_
- No
- Unknown

**HEALTH**

**Notes** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Insurance Status** *(check all that apply)*

- None
- OHP/ Medicaid, specify no. \_\_\_\_\_
- Medicare, specify no. \_\_\_\_\_
- Unknown
- Private Insurance/ Managed Care Organization specify company \_\_\_\_\_
- Other, specify \_\_\_\_\_

**Psychiatric Hospitalization (any overnight treatment related to symptoms) during the last 3 months?**

- Yes\* } Complete additional Hospitalization form
- No
- Unknown

**Did the Participant Fail to Engage/ Receive Any Services After Intake was Completed?** *Only answer 'Yes' if client didn't complete any quarterly outcomes AND an intake visit was completed*

- Yes, failed to engage after intake
- No