EASA PROGRAM - OUTCOME REVIEW FORM

County of Residence: Agency Name: Prime#:

Staff Name: Client ID #: DOB:

Client Name: Review completed Date:

Review Year: ○QTR1-Jan-Mar ○QTR2-Apr-Jun ○QTR3-Jul-Sept ○QTR4-Oct-Dec

DSM Diagnosis ICD 10 Code(s)-Enter up to 10 codes

☐ Psychosis Risk Syndrome (SIPS)

Primary Care Physician (PCP):

○Unknown if client has a PCP

○Client does not have a PCP

○Client has a PCP but EASA team is not in contact with them

○EASA team is in contact with clients PCP

How many months since client's last contact with their PCP? ☐Unknown

Insurance Status (check all that apply):

☐ None ☐ OHP ☐ Medicare

☐ Private Insurance/Managed Care Organization (Company)

☐ Other (e.g., TRICARE - VA, CHAMPUS) (specify)

☐ Unknown

Is client currently prescribed Psychiatric Medications?

○Yes

○No If No Skip to Employment Questions on Next Page

○Unknown

How consistently are they taking their prescribed medications?

○ Takes as prescribed

○ Takes sporadically not as prescribed

○Not taking at all

○Unknown

Employment Current

How many weeks did the client work in the quarter? ☐ Unknown

Employment Status this quarter: ○Full time ○Part time ○Not employed ○Unknown

Employment Type: ○ Competitive ○ Sheltered ○ Volunteer ○ Not employed ○ Unknown

Did symptoms impact employment situation in the quarter? (check all that apply)
- ☐ Yes, work was discontinued
- ☐ Yes, increased absences
- ☐ Yes, negatively impacted employment procurement activities
- ☐ Yes, other difficulty (specify)
- ☐ No
- ☐ Unknown

Clients current Vocational Rehabilitation (VR) status:
- ○ Not currently planning to apply
- ○ Planning to apply
- ○ Application submitted
- ○ Accepted by VR
- ○ On IPE
- ○ Applied but denied
- ○ Discharged from VR
- ○ Unknown

Clients current Disability benefits status:
- ○ Not currently planning to apply for disability
- ○ Planning to apply--application not started
- ○ Application in process or waiting for notification
- ○ Applied and denied not appealing
- ○ Denied but appealing
- ○ On Social Security Disability Insurance (SSDI)
- ○ On Supplemental Security Income (SSI)
- ○ On SSDI and SSI
- ○ Unknown

Educational History

Last grade completed? (count each year of post-high school as a grade) ☐ Unknown

Educational Milestones client has completed (check all that apply):
- ☐ Middle School
- ☐ GED
- ☐ High School
- ☐ AA or AS degree
- ☐ BA or BS degree
- ☐ Voc/Tech cert/degree (specify)
- ☐ Other (specify)
- ☐ Unknown
- ☐ None

Educational Current

School Status in the quarter:
- ○ Full time
- ○ Part time
- ○ Not in School If Not in School Skip to Symptoms Impact on School Situation Question
- ○ Unknown

Type of School Attending:
- ○ Middle School
- ○ GED classes
- ○ High School
- ○ Community College
- ○ University
- ○ Voc/Tech cert/degree (specify)
- ○ 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 quarter? (check all that apply)
- ☐ Yes, school was discontinued
- ☐ Yes, increased absences
- ☐ Yes, course load reduced, classes dropped
- ☐ Yes, grades lower than in the past
- ☐ Yes, negatively impacted school search activities
- ☐ Yes, other difficulty (specify _)
- ☐ No
- ☐ Unknown

If NOT in school, does the client convey desire to go to school (now or in the future)?
○ Yes ○ No ○ Unknown

Living situation:
- ○ Transient/Homeless (no permanent address)
- ○ Foster Home
- ○ Residential Facility
- ○ Jail
- ○ Prison
- ○ Supported Housing
- ○ Alcohol and Drug Free Housing
- ○ Private Residence (lives alone)
- ○ Private Residence (with relative)
- ○ Private Residence (with non-relative)
- ○ Other (specify)
- ○ Unknown

Living Situation Funded by:
- ○ Client (+partner) responsible for all housing costs (their portion if roommates)
- ○ Client contributes to housing costs and family provides the rest
- ○ Family provides housing: lives apart from family (family pays client's housing costs)
- ○ Family provides housing: lives with family
- ○ State/Other Institution funded housing
- ○ Other (specify)

Did the client experience a change in primary counselor in the quarter?
- ○ Yes
- ○ No
- ○ Unknown

What type of services did the EASA team provide in the quarter? (check all that apply)

- ☐ Individual Therapy
- ☐ Family Therapy
- ☐ Medication Management
- ☐ Case Management
- ☐ Occupational Therapy Services
- ☐ Nursing Services
- ☐ Group Therapy

- ☐ Joining Sessions
- ☐ Single Family
- ☐ Multi-Family group
- ☐ Educational Workshop

- ☐ Peer Support Services

- ☐ Individualized Placement and Support Services
- ☐ Resource Acquisition
- ☐ Job Search
- ☐ Job Retention
- ☐ Career Exploration
- ☐ School Search
- ☐ School Retention
- ☐ Skills Training

- ☐ No Services from EASA Team this quarter
- ☐ Unknown

Legal involvement during the in the quarter? (check all that apply):

- ☐ None — If None Skip to Hospitalization Questions on Next Page
- ☐ Probation / Parole
- ☐ Incarcerated
- ☐ Arrested
- ☐ Unknown

If arrested or incarcerated was this due to (check all that apply):

- ☐ Symptoms
- ☐ Substance use
- ☐ Other (specify)
- ☐ Unknown

Psychiatric Hospitalization (any overnight treatment related to symptoms) during the quarter?

- ○ Yes
- ○ No If No Skip to Discharge Questions on the Next Page
- ○ Unknown

Hospitalization 1 : Hospital Name

Type Of Admit:

- ○ Voluntary
- ○ Involuntary
- ○ Unknown

Type Of Hospital:

- ○ State Hospital
- ○ Acute Hospitalization
- ○ Emergency Room Extended Stay (over 1 day)
- ○ Substance Abuse Residential Treatment
- ○ Sub Acute Care
- ○ Other (specify)
- ○ Unknown

Admit Date: ☐ In this hospital stay in previous quarter

Discharge Date: ☐ Still in the hospital

If Dates Unknown Number of Days in Hospital:

Hospitalization 2 : Hospital Name:

Type Of Admit:

- ○ Voluntary
- ○ Involuntary
- ○ Unknown

Type Of Hospital:

- ○ State Hospital
- ○ Acute Hospitalization
- ○ Emergency Room Extended Stay (over 1 day)
- ○ Substance Abuse Residential Treatment
- ○ Sub Acute Care
- ○ Other (specify)
- ○ Unknown

Admit Date: ☐ In this hospital stay in previous quarter

Discharge Date: ☐ Still in the hospital

If Dates Unknown Number of Days in Hospital:

Place information about any other Hospitalizations in the prior 3 months/this quarter on the Back of this Form

Was the client discharged or transferred out of the program in the quarter?

○ Yes ○ No If No Form is Complete

Discharge date: Last date client received services:

Did client have a transition plan when they were discharged? ○ Yes ○ No ○ Unknown

Reason for discharge from EASA:

○ Completed Program-Achieved all or most of program goals

○ Completed Program-Achieved some program goals

○ Completed Program-Achieved few or none of program goals

○ Moved (where to , Referred to EASA in a different county ○ Yes ○ No ○ Unknown

○ Disengaged/lost contact

○ Chose other services (specify services)

○ Not appropriate for the program

○ Never engaged

○ Incarceration

○ Suicide

○ Other death

○ Other (specify)

○ Unknown