

EASA PROGRAM – QUARTERLY OUTCOME

(If Intake completed earlier in the same quarter, enter outcome review from date of intake to date of end of quarter)

AGENCY IDENTIFIERS – Entered at ‘Participant’ level – please update any ‘Unknown’ or ‘Missing’ values

Client (Agency) ID # _____ Prime # (OHP ID) _____
County of Residence _____ Agency Name _____

HIPAA IDENTIFIERS - Entered at ‘Participant’ level – please update any ‘Unknown’ or ‘Missing’ values

Full Name _____ DOB ___/___/___

FORM DETAILS

Year Quarter 1 Jan-Mar 2 Apr-Jun 3 Jul-Sep 4 Oct-Dec
Date Completed ___/___/___ Completed Form Staff Name _____

LIVING SITUATION, SUPPORT, LEGAL & MISC.

Living Situation for the last quarter *(check all that apply)*

<input type="checkbox"/> Transient/ Homeless	<input type="checkbox"/> Alcohol and Drug Free Housing
<input type="checkbox"/> Foster Home	<input type="checkbox"/> Private Residence (lives alone)
<input type="checkbox"/> Residential Facility	<input type="checkbox"/> Private Residence (with relative)
<input type="checkbox"/> Jail	<input type="checkbox"/> Private Residence (with non-relative)
<input type="checkbox"/> Prison	<input type="checkbox"/> Other, specify _____
<input type="checkbox"/> Supported Housing	<input type="checkbox"/> Unknown

Living Situation funded by

<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"/> Client (+ partner) responsible for all housing costs (their portion if roommates)	<input type="radio"/> Family provides housing: lives with family
	<input type="radio"/> State/Other Institution funded housing
	<input type="radio"/> Other, specify _____

Legal Involvement for the last quarter *(check all that apply)*

<input type="checkbox"/> None	} Answer question to right	*If arrested or incarcerated was this due to: <i>(check all that apply)</i>
<input type="checkbox"/> Probation/ Parole		<input type="checkbox"/> Symptoms
<input type="checkbox"/> Incarcerated*		<input type="checkbox"/> Substance Use
<input type="checkbox"/> Arrested*		<input type="checkbox"/> Other, specify _____
<input type="checkbox"/> Unknown		<input type="checkbox"/> Unknown

CLIENT IDENTIFIERS

Full Name _____ DOB ___/___/___ Agency ID _____

EDUCATION & EMPLOYMENT

Last grade completed _____

Educational Milestones client has Completed *(check all that apply)*

- | | |
|---|--|
| <input type="checkbox"/> Middle school | <input type="checkbox"/> BA or BS degree |
| <input type="checkbox"/> Some high school | <input type="checkbox"/> Voc/ Tech certificate/degree, specify _____ |
| <input type="checkbox"/> GED | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> High school graduate | <input type="checkbox"/> Other, specify _____ |
| <input type="checkbox"/> AA or AS degree | <input type="checkbox"/> None |

School Status in the last quarter

- Full time*
 Part time* } Answer question to right
 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)*

- | | |
|--|---|
| <input type="checkbox"/> IEP | <input type="checkbox"/> Other, specify _____ |
| <input type="checkbox"/> 504 | <input type="checkbox"/> None |
| <input type="checkbox"/> College disability office | <input type="checkbox"/> Unknown |

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

- | | |
|--|---|
| <input type="checkbox"/> Yes, school was discontinued | <input type="checkbox"/> Yes, grades lower than in the past |
| <input type="checkbox"/> Yes, increased absences | <input type="checkbox"/> Yes, other difficulty, specify _____ |
| <input type="checkbox"/> Yes, course load reduced, classes dropped | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes, negatively impacted school search activities | <input type="checkbox"/> 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

CLIENT IDENTIFIERS

Full Name _____ DOB ___/___/___ Agency ID _____

EDUCATION & EMPLOYMENT

Employment Status in the last quarter

- Full time*
- Part time* } Answer questions to right
- Not Employed
- Unknown

***No. of weeks the Client Worked in the last quarter**

_____ Check if Unknown

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

- Competitive
- Sheltered
- Volunteer
- Unknown

Did Symptoms Impact Employment Situation in the last quarter (check all that apply)

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

HEALTH

ICD-10 Codes _____

_____ SIPS (Psychosis Risk Syndrome)

Notes _____

Primary Care Physician

(check all that apply)

- 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

CLIENT IDENTIFIERS

Full Name _____ DOB ___/___/___ Agency ID _____

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

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

Is Client Currently Prescribed to Psychiatric Medications?

- Yes* } Answer question to the right
- No
- Unknown

***How Consistently are they Taking their Prescribed Medications?**

- Takes as prescribed
- Takes sporadically not as prescribed
- Not taking at all
- 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

- Yes
- No
- Unknown

Did the Client Experience a Change in Primary Counselor in the last quarter?

- Yes
- No
- Unknown

What Type of Services Did the EASA team Provide in the quarter?

- | | |
|--|--|
| <input type="checkbox"/> Individual Therapy | <input type="checkbox"/> Peer Support Services |
| <input type="checkbox"/> Medication Management | <input type="checkbox"/> Individual Placement and Support |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Resource Acquisition |
| <input type="checkbox"/> Occupational Therapy Services | <input type="checkbox"/> Job Search |
| <input type="checkbox"/> Nursing Services | <input type="checkbox"/> Job Retention |
| <input type="checkbox"/> Family Therapy | <input type="checkbox"/> Career Exploration |
| <input type="checkbox"/> Group Therapy | <input type="checkbox"/> School Search |
| <input type="checkbox"/> Joining Sessions | <input type="checkbox"/> School Retention |
| <input type="checkbox"/> Single Family Sessions | <input type="checkbox"/> Skills Training |
| <input type="checkbox"/> Multi Family Group | <input type="checkbox"/> No Services from EASA team this quarter |
| <input type="checkbox"/> Educational Workshop | <input type="checkbox"/> Unknown Services |

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

- Yes* } Complete 1 Hospitalization form for each hospitalization
- No
- Unknown

Was the Client Discharged or Transferred Out of the Program in the quarter?

- Yes * } Complete Discharge form
- No
- Unknown