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)*

- ☐ Transient/ Homeless
- ☐ 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 (+ partner) responsible for all housing costs (their portion if roommates)
- ○ Client contributes to housing costs and family provides the rest
- ○ Family provides housing: lives with family
- ○ State/Other Institution funded housing
- ○ Other, specify _____

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

- ☐ None
- ☐ Probation/ Parole
- ☐ Incarcerated*
- ☐ Arrested*

} **Answer question to right**

- ☐ Unknown

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

- ☐ Symptoms
- ☐ Substance Use
- ☐ Other, specify _____
- ☐ Unknown

Tobacco use in the last quarter?

- ○ No
- ○ Yes

CLIENT IDENTIFIERS

Full Name _____ **DOB** __ __ / __ __ / __ __ **Agency ID** _____

LIVING SITUATION, SUPPORT, LEGAL & MISC.

Alcohol use during the last quarter?

- ○ No
- ○ Yes* } Answer question to right and if necessary add a diagnosis to Health section
- ○ Unknown

***Problems caused by alcohol use**

- ○ None
- ○ Some problems
- ○ Significant problems
- ○ Unknown

Marijuana use in the last quarter?

- ○ No
- ○ Yes* } Answer question to the right ('Problems caused by drug use')
- ○ Unknown

Drug use (nonprescription psychoactive) during the last quarter?

- ○ No
- ○ Yes* } Answer question to right and if necessary add a diagnosis to Health section
- ○ Unknown

***Problems caused by drug use**

- ○ None
- ○ Some problems
- ○ Significant problems
- ○ Unknown

EDUCATION & EMPLOYMENT

Last grade completed _____

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

- ☐ Middle school
- ☐ Some high school
- ☐ GED
- ☐ High school graduate
- ☐ AA or AS degree
- ☐ BA or BS degree
- ☐ Voc/ Tech certificate/degree, specify _____
- ☐ Unknown
- ☐ Other, specify _____
- ☐ None

School Status in the last quarter

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

- ☐ IEP
- ☐ 504
- ☐ College disability office
- ☐ Other, specify _____
- ☐ None
- ☐ Unknown

CLIENT IDENTIFIERS

Full Name _____ **DOB** __ __ / __ __ / __ __ **Agency ID** _____

LIVING SITUATION, SUPPORT, LEGAL & MISC.

Did Symptoms Impact School Situation in the last quarter *(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

EDUCATION & EMPLOYMENT

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 quarter

- ○ Full time*
- ○ Part time*

} **Answer 2 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)

CLIENT IDENTIFIERS

Full Name _____ **DOB** __ __ / __ __ / __ __ **Agency ID** _____

HEALTH

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

Insurance Status *(check all that apply)*

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

- ○ 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)
- ○ SSDI and SSI
- ○ Unknown

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

- ○ Yes
- ○ No
- ○ Unknown

CLIENT IDENTIFIERS

Full Name _____ **DOB** __ __ / __ __ / __ __ **Agency ID** _____

HEALTH

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

- ☐ Individual Therapy
- ☐ Medication Management
- ☐ Case Management
- ☐ Occupational Therapy Services
- ☐ Nursing Services
- ☐ Family Therapy
- ☐ Group Therapy
- ☐ Joining Sessions
- ☐ Single Family Sessions
- ☐ Multi Family Group
- ☐ Educational Workshop
- ☐ Peer Support Services
- ☐ Individual Placement and Support
- ☐ Resource Acquisition
- ☐ Job Search
- ☐ Job Retention
- ☐ Career Exploration
- ☐ School Search
- ☐ School Retention
- ☐ Skills Training
- ☐ No Services from EASA team this quarter
- ☐ 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