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***

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 Admitted __ __ / __ __ / __ __ **Completed Form Staff Name** _____

DEMOGRAPHICS – *Entered in 'Participant Details- Demographics' form – please update any 'Unknown' or 'Missing'*

Race *(check all that apply)*
- ☐ Alaska Native
- ☐ American Indian
- ☐ Black of African American
- ☐ White
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other Race
- ☐ Unknown

Ethnicity *(check all that apply)*
- ☐ Not of Hispanic Origin
- ☐ Mexican
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other Specific Hispanic, specify _____
- ☐ Hispanic – Specific Origin Not Specified
- ☐ Unknown

Gender at Birth
- ○ Female
- ○ Male
- ○ Non-binary

Age at Intake _____

Gender Identity *(client identified)*
- ○ Cisgender (gender identity that is consistent with the sex they were assigned at birth)
- ○ Transgender (gender identity that does not match the sex they were assigned at birth)
- ○ Non-binary/ Genderqueer (gender identity that does not identify strictly as a boy or a girl)
- ○ Agender/ Neutrosis (gender identity that does not identify with any gender)
- ○ Gender fluid (gender identity varies over time)
- ○ A gender identity not represented above
- ○ Unknown

Preferred Language
- ○ English
- ○ Spanish
- ○ Other, specify _____
- ○ Unknown

Country of Origin
- ○ US
- ○ Mexico*
- ○ Other, specify* _____
- ○ Unknown

Answer question to right

***Years in USA** _____

CLIENT IDENTIFIERS

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

LIVING SITUATION, SUPPORT, LEGAL & MISC.

Does the client have natural supports (family or friends) who are willing to participate in treatment?

- ○ Yes
- ○ No
- ○ Unknown

Does the client want natural supports (family or friends) to participate in treatment?

- ○ Yes
- ○ No
- ○ Unknown

Living Situation for the last 3 months *(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 3 months *(check all that apply)*

- ☐ None
- ☐ Probation/ Parole
- ☐ Incarcerated* } **Answer question to right**
- ☐ 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 past 3 months?

- ○ No
- ○ Yes
- ○ Unknown

Alcohol use in the past 3 months?

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

***Problems caused by alcohol use**

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

CLIENT IDENTIFIERS

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

LIVING SITUATION, SUPPORT, LEGAL & MISC.

Marijuana use in the past 3 months?

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

Drug use (nonprescription psychoactive) during last 3 months?

- ○ No
- ○ Yes* } Answer question to right
- ○ 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 _____
- ☐ Other, specify _____
- ☐ Unknown
- ☐ None

School Status in the last 3 months

- ○ Full time* } Answer question below
- ○ 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 cert/degree
- ☐ 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

CLIENT IDENTIFIERS

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

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 3 months

- ○ Full time
- ○ Part time
- ○ Not Employed
- ○ Unknown

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

_____ ☐ Check if Unknown

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