

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)

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

Client (Agency) ID # _____ **Prime # (OHP/ Medicaid ID)** _____ **Client Initials** _____

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** _____

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

Yes* } Complete Discharge form
 No
 Unknown

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

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

CLIENT IDENTIFIERS

Client (Agency) ID # _____ Prime # (OHP/ Medicaid ID) _____ Client Initials _____

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

- | | |
|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> OHP/ Medicaid *verify Prime ID is correct | <input type="checkbox"/> Private Insurance/ Managed Care Organization
specify company _____ |
| <input type="checkbox"/> Medicare, specify no. _____ | <input type="checkbox"/> Other, specify _____ |

Is Client Currently Prescribed to Psychiatric Medications?

- Yes* } Answer question to the right
 No
 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

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

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

Client (Agency) ID # _____ Prime # (OHP/ Medicaid ID) _____ Client Initials _____

HEALTH

OPTIONAL: 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 |

EDUCATION & EMPLOYMENT

School Status in the last quarter

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

Employment Status in the last quarter

- Full time* } Answer 2 questions to right
 Part time* }
 Not Employed
 Unknown

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

- Competitive
 Sheltered
 Volunteer
 Unknown