EASA PROGRAM – INTAKE

(After the singular initial intake, an additional intake needs to be entered for each time the participant discharges and then returns to EASA. Unless otherwise noted, all questions refer to events over the past 3 months)

AGENCY 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** _____

CFAA Required Question: Did the participant have the opportunity to meet with an EASA psychiatric care provider within 7 business days of their intake? ○ Yes ○ No

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

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

Legal Involvement for the last 3 months
(check all that apply)
☐ None
☐ Probation/ Parole*
☐ Incarcerated*
☐ Arrested*
☐ Unknown

*** Answer question to right**

*** If arrested, incarcerated, or on probation was this due to**
(check all that apply)
☐ Symptoms
☐ Substance use
☐ Other _____
☐ Unknown

IDENTIFIERS

Full Name _____ **DOB** _____

HEALTH

Insurance Status *(check all that apply)*

- ☐ OHP/ Medicaid, *update Prime ID in Identifiers form*
- ☐ Medicare, specify no. _____
- ☐ None
- ☐ Private Insurance/ Managed Care Organization specify company _____
- ☐ Other, specify _____

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

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

Psychiatric Hospitalization (any overnight treatment related to symptoms) during the last 3 months (prior to intake)?

- ○ Yes* } Complete additional Hospitalization form
- ○ No
- ○ Unknown

IDENTIFIERS – *Entered at 'Participant' level – please update any 'Unknown' or 'Missing' values*

Full Name _____ **DOB** _____

EDUCATION & EMPLOYMENT

Last grade completed _____

Most Recent Educational Milestones *(check one)*

- ☐ Middle school
- ☐ Some high school
- ☐ GED
- ☐ High school graduate
- ☐ Some college
- ☐ 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*
- ○ Part time*

} **Answer question below**

- ○ Not in school
- ○ Unknown

If NOT in school, does the client convey desire to go to school (now/future)?

☐Yes ☐No ☐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

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

} **Answer question to right**

- ○ Not Employed
- ○ Unknown

Employment Type *(check all that apply)*

- ☐ Competitive
- ☐ Sheltered
- ☐ Volunteer
- ☐ Unknown