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*

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

Psychiatric hospitalization (any overnight treatment related to symptoms) during the last 3 months/quarter?

☐ Yes* } Complete hospitalization form
☐ No
☐ Unknown

LIVING SITUATION, SUPPORT, LEGAL & MISC.

Living Situation for the last quarter *(check one)*

☐ 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 during the last 3 months/quarter? (check all that apply)

☐ None ☐ Pending charges ☐ Probation/Parole* ☐ Incarcerated* ☐ Arrested* ☐ Unknown

***If arrested, incarcerated, or on probation was this due to** (check all that apply)

☐ Symptoms
☐ Substance use
☐ Other _____
☐ Unknown

HEALTH

ICD-10 Codes (Only complete codes if it is the participants' FIRST quarter of treatment or if the participant has been discharged, otherwise leave blank)

Primary diagnosis, that allows the person to meet criteria for EASA _____

Secondary Diagnoses _____ _____ _____ _____

Notes

_____

_____

IDENTIFIERS

Full Name _____ **DOB** _____

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

Insurance Status *(check all that apply)*

- ☐ None
- ☐ OHP/ Medicaid **verify Prime ID is correct*
- ☐ Medicare, specify no. _____
- ☐ Unknown
- ☐ Private Insurance/ Managed Care Organization specify company _____
- ☐ Other, specify _____

Is Client Currently Prescribed to Psychiatric Medications?

- ☐ Yes
- ☐ 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 'Problems caused by drug use' --->**
- ☐ Unknown

***Problems caused by drug use**

- ☐ None
- ☐ Some problems
- ☐ Significant problems
- ☐ Unknown

This question corresponds to both marijuana and drug use. Problems caused by marijuana use are considered problems caused by drug use.

Drug use (nonprescription psychoactive) during last 3 months?

- ☐ No
- ☐ Yes* } **Answer 'Problems caused by drug use' --->**
- ☐ Unknown

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

- ☐ Yes
- ☐ No
- ☐ Unknown

IDENTIFIERS

Full Name _____ **DOB** _____

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

What Type of Services Did the EASA team Provide in the quarter?	Services Offered	Services Provided
• Individual Therapy or counseling	☐	☐
• Group therapy	☐	☐
• Case Management	☐	☐
• Services to or with family, friends, or support network (including case management, family therapy, skills training, treatment planning, relapse prevention/ wellness planning, and/or other family interventions)	☐	☐
• CFAA Required Question: Structured family psychoeducation (FPE) including joining sessions, educational workshop, single family intervention (SFI), and multi-family groups (MFG)	☐	☐
• Psychiatric Care Services	☐	☐
• Nursing Services	☐	☐
• CFAA Required Question: Education Services and Supports	☐	☐
• Occupational therapy	☐	☐
• Skills Training	☐	☐
• Peer support services	☐	☐
• Substance misuse counseling/treatment	☐	☐
• Substance use prevention activities	☐	☐
• Peer Activity Groups	☐	☐
• No services from EASA, for reporting quarter	☐	☐
• Vocational services	☐	☐
• Other _____	☐	☐

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

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

EDUCATION & EMPLOYMENT

Last grade completed: _____

Most Recent Educational Milestone *(check one)* <-- Only complete 'Most Recent Educational Milestone' if participant has been discharged for this quarter, if participant was not discharged leave blank

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

School Status in the last 3 months/quarter

- ○ Full time*
- ○ Part time*

} **Answer question to right --->**

- ○ 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 program
- ☐ Other, specify _____
- ☐ Unknown

Employment status in last 3 months?

- ○ Full time*
- ○ Part time*

} **Answer question to right --->**

- ○ Not Employed
- ○ Unknown

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

☐ Competitive ☐ Sheltered ☐ Volunteer ☐ Unknown