COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

OUTCOMES MEASURES APPLICATION

Adult 3-Month (3M)

Age Group: 26-59

ADMINISTRATIVE INFORMATION

Client ID		**Client DOB**	
Episode ID		**Provider Number**	
Client L. Name		**Client F. Name**	
Partnership Date		**Assessment Date**	
Partnership Service Coordinator (Last Name)		**Assessment Completed By**	

FINANCIAL

SOURCE OF FINANCIAL SUPPORT Indicate all the sources of financial support used to meet the needs of the client.	**CURRENT**	
	Check all that apply	**Monthly Average Amount**
Client's Wages	☐	
Client's Spouse / Significant Other's Wages	☐	
Savings	☐	
Other Family Member / Friend	☐	
Retirement / Social Security Income	☐	
Veteran's Assistance (VA) Benefits	☐	
Loan / Credit	☐	
Housing Subsidy	☐	
General Relief (GR) / General Assistance (GA)	☐	
Food Stamps	☐	
Temporary Assistance for Needy Families (TANF) / CalWORKs	☐	
Supplemental Security Income / State Supplementary Payment (SSI / SSP) Program	☐	
Social Security Disability Insurance (SSDI)	☐	
State Disability Insurance (SDI)	☐	
American Indian Tribal Benefits (e.g., per capita, revenue sharing, trust disbursements)	☐	
Unemployment	☐	
Child Support	☐	
Other	☐	
No Financial Support	☐	

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PHYSICAL HEALTH

	CURRENT (LAST 4 WEEKS) (circle one for each question)
Client states that he/she is in good physical health?	YES NO UNKNOWN
Client has access to needed medical services?	YES NO UNKNOWN
Client receives needed medical services?	YES NO UNKNOWN
Client has a primary care physician?	YES NO UNKNOWN
Client uses a primary care physician?	YES NO UNKNOWN
Client has access to needed dental services?	YES NO UNKNOWN
Client receives needed dental services?	YES NO UNKNOWN
Is the client obese (based on BMI)?	YES NO UNKNOWN
Has the client EVER been told by a physician that he/she has diabetes?	YES NO UNKNOWN

Did the client receive physical health services from a DHS clinic or hospital? **YES NO UNKNOWN** (circle one)

Does the client have a chronic physical health care problem or problems that require periodic medical services? **YES NO UNKNOWN** (circle one)

LEGAL

SUBSTANCE ABUSE

Client uses substances? **YES NO UNKNOWN** (circle one)

Client abuses substances? **YES NO UNKNOWN** (circle one)

In the opinion of the Partnership Service Coordinator, does the client CURRENTLY have an active co-occurring mental illness and substance use problem? **YES NO UNKNOWN** (circle one)

Is the client CURRENTLY receiving substance abuse services? **YES NO UNKNOWN** (circle one)

CUSTODY INFORMATION

Indicate the total number of children the **client** has who are CURRENTLY:
(If client has no children enter **0** in the following boxes.)

Placed on W & I 300 Status (Dependent of the court): _____

Placed in Foster Care: _____

Legally Reunified with the client: _____

Adopted Out: _____

Living with the client: _____

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