COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

OUTCOMES MEASURES APPLICATION

Older Adult Baseline

Age Group: 60+

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** ☐☐☐☐☐☐☐

FSP Program Name (check one):

☐ FSP-Adult ☐ FSP-Older Adult

Who referred the client? (check one)

☐ Acute Psychiatric / State Hospital
☐ Emergency Room
☐ Faith-based Organization
☐ Family Member
☐ Friend / Neighbor
☐ Homeless Shelter
☐ Jail / Prison
☐ Mental Health Facility / Community Agency
☐ Other
☐ Other County / Community Agency
☐ Primary Care / Medical Office
☐ School
☐ Self
☐ Significant Other
☐ Social Services Agency
☐ Street Outreach
☐ Substance Abuse Treatment Facility / Agency

In which additional program(s) is the client CURRENTLY involved? (check all that apply)

AB2034 ☐
Governor's Homeless Initiative (GHI) ☐
MHSA Housing Program ☐

Rev. 8/1/2007--C.B.--

LIVING ARRANGEMENTS

RESIDENTIAL TYPE	FROM	TO	TONIGHT (check one in this column)	YESTERDAY (as of 11:59 PM the day BEFORE the partnership began) (check one in this column)	DURING PAST 12 MONTHS indicate the TOTAL:		PRIOR TO THE LAST 12 MONTHS (check all that apply)
					# Occurrences	# Days	
GENERAL LIVING ARRANGEMENT							
With adult family members other than parents			☐	☐			☐
In an apartment or house alone or with spouse / partner / minor children / other dependents / roommate - must hold lease or share in rent / mortgage			☐	☐			☐
With one or both Biological / Adoptive Parents			☐	☐			☐
Single Room Occupancy (SRO) (must hold lease)			☐	☐			☐
SHELTER / HOMELESS							
Emergency Shelter			☐	☐			☐
Homeless (includes people living in their cars)			☐	☐			☐
Temporary Housing (includes people living with friends but paying no rent)			☐	☐			☐
HOSPITAL							
Acute Medical Hospital			☐	☐			☐
Acute Psychiatric Hospital / Psychiatric Health Facility (PHF)			☐	☐			☐
State Psychiatric Hospital			☐	☐			☐
RESIDENTIAL PROGRAM							
Alcohol or Substance Abuse Residential Rehabilitation Center			☐	☐			☐
Crisis Residential Program			☐	☐			☐
Group Living Home			☐	☐			☐
Institution for Mental Disease (IMD)			☐	☐			☐
Long Term Residential Program			☐	☐			☐
Mental Health Rehabilitation Center (MHRC)			☐	☐			☐
Skilled Nursing Facility (physical)			☐	☐			☐
Skilled Nursing Facility (psychiatric)			☐	☐			☐
Transitional Residential Program			☐	☐			☐
JUSTICE PLACEMENT							
Jail			☐	☐			☐
Prison							☐
SUPERVISED PLACEMENT							
Assisted Living Facility			☐	☐			☐
Licensed Community Care Facility (Board and Care)			☐	☐			☐
Sober Living Home			☐	☐			☐
Unlicensed but supervised individual placement (includes paid caretakers, personal care attendants, etc.)			☐	☐			☐
OTHERS							
Other			☐	☐			☐
Unknown			☐	☐			☐

If the client was in a residential type more than once list it on the following page

LIVING ARRANGEMENTS *continued*

Is the client at risk of being removed from their CURRENT living arrangement?	**YES**	**NO**	**UNKNOWN**	**(circle one)**
Is the client's CURRENT living arrangement suitable? (According to clinician / FSP Team)	**YES**	**NO**	**UNKNOWN**	**(circle one)**
Is the CURRENT living arrangement in the least restrictive setting? (According to clinician / FSP Team)	**YES**	**NO**	**UNKNOWN**	**(circle one)**
Is the client satisfied with the CURRENT living arrangement?	**YES**	**NO**	**UNKNOWN**	**(circle one)**
Have there been Suspected Dependent Adult Abuse reports made related to living arrangements IN THE LAST 12 MONTHS?	**YES**	**NO**	**UNKNOWN**	**(circle one)**
Have there been incidents of violence related to living arrangements IN THE LAST 12 MONTHS?	**YES**	**NO**	**UNKNOWN**	**(circle one)**

LIVING ARRANGEMENTS *continued*

RESIDENTIAL TYPE	FROM	TO	TONIGHT (check one in this column)	YESTERDAY (as of 11:59 PM the day BEFORE the partnership began) (check one in this column)	DURING PAST 12 MONTHS indicate the TOTAL:		PRIOR TO THE LAST 12 MONTHS (check all that apply)
					# Occurrences	# Days	
			☐	☐			☐
			☐	☐			☐
			☐	☐			☐
			☐	☐			☐
			☐	☐			☐
			☐	☐			☐
			☐	☐			☐
			☐	☐			☐
			☐	☐			☐
			☐	☐			☐
			☐	☐			☐
			☐	☐			☐

SOCIAL SUPPORT

IDENTIFY CURRENT STATUS

Socializes with others	YES	NO	UNKNOWN	(circle one)	Develops and maintains friendships	YES	NO	UNKNOWN	(circle one)
Receives spiritual support	YES	NO	UNKNOWN	(circle one)	Requires protection from abuse	YES	NO	UNKNOWN	(circle one)

Client has age appropriate, positive peer relationships? **YES NO UNKNOWN** (circle one)

Client has age appropriate involvement in family? **YES NO UNKNOWN N/A** (circle one)

Client has supportive interactions / relationships with:

- Parent **YES NO UNKNOWN N/A** (circle one)
- Family **YES NO UNKNOWN N/A** (circle one)
- Caregiver **YES NO UNKNOWN N/A** (circle one)

Is the family or significant other(s) involved in the client's treatment? **YES NO UNKNOWN** (circle one)

Client has access to at least one stable, supportive adult? **YES NO UNKNOWN N/A** (circle one)

FINANCIAL

BENEFITS

Identify CURRENT status **(check all that apply):**

- ☐ Medi-Cal
- ☐ Veteran's Assistance (VA) Benefits
- ☐ Private Insurance
- ☐ Medicare
- ☐ Participant in CalWORKs
- ☐ HMO

SOURCES OF FINANCIAL SUPPORT Indicate all the sources of financial support used to meet the needs of the client.	DURING THE PAST 12 MONTHS		CURRENT	
	Check all that apply	Monthly Average Amount	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	☐		☐	

FINANCIAL *continued*

PAYEE STATUS

Does the client CURRENTLY have a Payee?	YES	NO	UNKNOWN	(circle one)
Has the client had a Payee for finances IN THE LAST 12 MONTHS?	YES	NO	UNKNOWN	(circle one)
Did the client have a Payee anytime PRIOR TO THE LAST 12 MONTHS?	YES	NO	UNKNOWN	(circle one)

DAILY ACTIVITIES / VOCATIONAL / EDUCATIONAL LEVEL

IDENTIFY CURRENT STATUS

Adult Day Health Care	YES	NO	(circle one)
Senior Center Participation	YES	NO	(circle one)

EDUCATIONAL SETTING

Highest Level of Education Attained **(check one):**

- ☐ Day Care
- ☐ Preschool
- ☐ Kindergarten
- ☐ 1st Grade
- ☐ 2nd Grade
- ☐ 3rd Grade
- ☐ 4th Grade
- ☐ 5th Grade
- ☐ 6th Grade
- ☐ 7th Grade
- ☐ 8th Grade
- ☐ 9th Grade
- ☐ 10th Grade
- ☐ 11th Grade
- ☐ 12th Grade
- ☐ GED Coursework
- ☐ High School Diploma / GED
- ☐ Some College / Some Technical or Vocational Training
- ☐ Associate's Degree (e.g., A.A., A.S.) / Technical or Vocational Degree
- ☐ Bachelor's Degree (e.g., B.A., B.S.)
- ☐ Master's Degree (e.g., M.A., M.S.)
- ☐ Doctoral Degree (e.g., M.D., Ph.D.)
- ☐ Level Unknown (e.g., client in non-public school)

EDUCATIONAL SETTINGS DURING THE PAST 12 MONTHS Indicate how many weeks the client was enrolled at each of the following educational settings DURING THE LAST 12 MONTHS.			Number of Weeks	Average Number of Hours per Week
Not in school of any kind				
High School / GED Preparation / Adult Education				
Technical / Vocational School				
Community College / 4 year College				
Graduate School				
Other				

CURRENT EDUCATIONAL SETTING	Check all that apply	Average Number of Hours per Week
Not in school of any kind	☐	
High School / GED Preparation / Adult Education	☐	
Technical / Vocational School	☐	
Community College / 4 year College	☐	
Graduate School	☐	
Other	☐	

Does one of the client's CURRENT recovery goals include any kind of education AT THIS TIME? **YES NO UNKNOWN** (circle one)

DAILY ACTIVITIES / VOCATIONAL / EDUCATIONAL LEVEL *continued*

INDEX OF INDEPENDENT ACTIVITIES OF DAILY LIVING (ADL)

For each area of functioning listed below, check the description that applies:
(The word 'assistance' means supervision, direction or personal assistance.)

Bathing - either sponge bath, tub bath, or shower: **(check one)**

- ☐ Receives no assistance (gets in and out of tub by self, if tub is usual means of bathing)
- ☐ Receives assistance in bathing only one part of the body (such as back or leg)
- ☐ Receives assistance in bathing more than one part of the body (or not bathed)

Dressing - gets clothes from closets and drawers, including underclothes, outer garments and uses fasteners (including braces, if worn): **(check one)**

- ☐ Gets clothes and gets completely dressed without assistance.
- ☐ Gets clothes and gets completely dressed without assistance, except for assistance in tying shoes.
- ☐ Receives assistance in getting clothes or in getting dressed, or stays partly or completely undressed.

Toileting: **(check one)**

- ☐ Goes to "toilet room", cleans self, and arranges clothes without assistance (may use object for support such as cane, walker, or wheelchair and may manage night bed pan or commode, emptying same in AM).
- ☐ Receives assistance in going to the 'toilet room' or in cleansing self or in arranging clothes after elimination or in use of night bedpan or commode
- ☐ Doesn't go to room termed 'toilet' for the elimination process.

Transfer: **(check one)**

- ☐ Moves in and out of bed as well as in and out of chair without assistance (may be using object for support, such as cane or walker).
- ☐ Moves in and out of bed or chair with assistance.
- ☐ Doesn't get out of bed.

Continence: **(check one)**

- ☐ Controls urination and bowel movement completely by self.
- ☐ Has occasional 'accidents'.
- ☐ Supervision helps keep urine or bowel control; catheter is used, or person is incontinent.

Feeding: **(check one)**

- ☐ Feeds self without assistance.
- ☐ Feeds self except for getting assistance cutting meat or buttering bread.
- ☐ Receives assistance in feeding or is fed partly or completely by using tubes or I.V. fluids.

Walking: **(check one)**

- ☐ Walks on level without assistance.
- ☐ Walks without assistance but uses a single, straight cane.
- ☐ Walks without assistance but uses two points for mechanical support such as crutches, a walker, or two canes (or wears a brace).
- ☐ Walks with assistance.
- ☐ Uses wheelchair only.
- ☐ Not walking or using wheelchair.

DAILY ACTIVITIES / VOCATIONAL / EDUCATIONAL LEVEL *continued*

INDEX OF INDEPENDENT ACTIVITIES OF DAILY LIVING (ADL)

For each area of functioning listed below, check the description that applies**:**
(The word 'assistance' means supervision, direction or personal assistance.)

House-Confinement: **(check one)**

- ☐ Has been outside of residence 3 or more days DURING THE PAST 2 WEEKS.
- ☐ Has been outside of residence only 1 or 2 days DURING THE PAST 2 WEEKS.
- ☐ Has not been outside of residence IN THE PAST 2 WEEKS.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)

For each area of functioning listed below, check the description that applies:

Can the client use the telephone? **(check one)**
☐ Without help ☐ With some help ☐ Completely unable to do

Can the client get to places out of walking distance? **(check one)**
☐ Without help ☐ With some help ☐ Completely unable to do

Can the client go shopping for groceries? **(check one)**
☐ Without help ☐ With some help ☐ Completely unable to do

Can the client prepare his/her own meals? **(check one)**
☐ Without help ☐ With some help ☐ Completely unable to do

Can the client do his/her own housework? **(check one)**
☐ Without help ☐ With some help ☐ Completely unable to do

Can the client do his/her own handyman work? **(check one)**
☐ Without help ☐ With some help ☐ Completely unable to do

Can the client do his/her own laundry? **(check one)**
☐ Without help ☐ With some help ☐ Completely unable to do

If the client takes medication (or if the client had to take medication) could he/she take it on his/her own? **(check one)**
☐ Without help ☐ With some help ☐ Completely unable to do

Can the client manage his/her own money? **(check one)**
☐ Without help ☐ With some help ☐ Completely unable to do

DAILY ACTIVITIES / VOCATIONAL / EDUCATIONAL LEVEL *continued*

EMPLOYMENT DURING THE PAST 12 MONTHS Indicate how many weeks the client was employed in each of the following settings DURING THE PAST 12 MONTHS.	Number of Weeks	Average Number of Hours per Week	Average Hourly Wage
Competitive Employment Paid employment in the community in a position that is also open to individuals without disability			
Supported Employment Competitive Employment (see above) with ongoing on-site or off-site job related support services provided			
Transitional Employment / Enclave Paid jobs in the community that are 1) open only to individuals with a disability AND 2) are either time-limited for the purpose of moving to a more permanent job OR are part of a group of disabled individuals who are working as a team in the midst of teams of non-disabled individuals who are performing the same work			
Paid In-House Work (Sheltered Workshop / Work Experience / Agency-Owned Business) Paid jobs open only to program participants with a disability. A Sheltered Workshop usually offers sub-minimum wage work in a simulated environment. A Work Experience (Adjustment) Program within an agency provides exposure to the standard expectations and advantages of employment. An Agency-Owned Business serves customers outside the agency and provides realistic work experiences and can be located at the program site or in the community			
Non-paid (Volunteer) Work Experience Non-paid (volunteer) jobs in an agency or volunteer work in the community that provides exposure to the standard expectations of employment			
Other Gainful / Employment Activity Any informal employment activity that increases the client's income (e.g., recycling, gardening, babysitting) OR participation in formal structured classes and/or workshops providing instruction on issues pertinent to getting a job. (Does NOT include such activities as panhandling or illegal activities such as prostitution)			
Unemployed			
Retired			

CURRENT EMPLOYMENT	Average Number of Hours per Week	Hourly Wage
Competitive Employment Paid employment in the community in a position that is also open to individuals without disability		
Supported Employment Competitive Employment (see above) with ongoing on-site or off-site job related support services provided		
Transitional Employment / Enclave Paid jobs in the community that are 1) open only to individuals with a disability AND 2) are either time-limited for the purpose of moving to a more permanent job OR are part of a group of disabled individuals who are working as a team in the midst of teams of non-disabled individuals who are performing the same work		
Paid In-House Work (Sheltered Workshop / Work Experience / Agency-Owned Business) Paid jobs open only to program participants with a disability. A Sheltered Workshop usually offers sub-minimum wage work in a simulated environment. A Work Experience (Adjustment) Program within an agency provides exposure to the standard expectations and advantages of employment. An Agency-Owned Business serves customers outside the agency and provides realistic work experiences and can be located at the program site or in the community		
Non-paid (Volunteer) Work Experience Non-paid (volunteer) jobs in an agency or volunteer work in the community that provides exposure to the standard expectations of employment		
Other Gainful / Employment Activity Any informal employment activity that increases the client's income (e.g., recycling, gardening, babysitting) OR participation in formal structured classes and/or workshops providing instruction on issues pertinent to getting a job. (Does NOT include such activities as panhandling or illegal activities such as prostitution)		

Is the client unemployed AT THIS TIME? **YES** **NO** **UNKNOWN** **(circle one)**

Does one of the client's CURRENT recovery goals include any kind of employment AT THIS TIME? **YES** **NO** **UNKNOWN** **(circle one)**

PHYSICAL HEALTH

	CURRENT (LAST 4 WEEKS) (circle one for each question)	LAST 12 MONTHS (circle one for each question)
Client states that he/she is in good physical health?	YES NO UNKNOWN	YES NO UNKNOWN
Client has access to needed medical services?	YES NO UNKNOWN	YES NO UNKNOWN
Client receives needed medical services?	YES NO UNKNOWN	YES NO UNKNOWN
Client has a primary care physician?	YES NO UNKNOWN	YES NO UNKNOWN
Client uses a primary care physician?	YES NO UNKNOWN	YES NO UNKNOWN
Client has access to needed dental services?	YES NO UNKNOWN	YES NO UNKNOWN
Client receives needed dental services?	YES NO UNKNOWN	YES NO UNKNOWN
Client demonstrates signs of regressive behavior (bed wetting, soiling)?	YES NO UNKNOWN	YES NO UNKNOWN
Client demonstrates self-injurious behavior?	YES NO UNKNOWN	YES NO UNKNOWN
Client has violent encounters?	YES NO UNKNOWN	YES NO UNKNOWN
Client has a caretaker relationship?	YES NO UNKNOWN	YES NO UNKNOWN
Is the caretaker a paid In-Home Worker?	YES NO UNKNOWN	YES NO UNKNOWN
Is the caretaker a paid Supported Transitional Worker?	YES NO UNKNOWN	YES NO UNKNOWN
Is the caretaker a significant other?	YES NO UNKNOWN	YES NO UNKNOWN
Is the caretaker a family member?	YES NO UNKNOWN	YES NO UNKNOWN
Is the client obese (based on BMI)?	YES NO UNKNOWN	YES NO UNKNOWN
Has the client EVER been told by a physician that he/she has diabetes?	YES NO UNKNOWN	YES NO UNKNOWN

Based on the Mini Mental Status Exam (MMSE), the client presented with symptoms of cognitive impairment. **YES NO UNKNOWN (circle one)**

If yes, what level: **(check one)**

☐ Mild ☐ Moderate ☐ Severe

Based on the Confusion Assessment Method (CAM), the client presented with symptoms of delirium. **YES NO UNKNOWN (circle one)**

If yes, identify the most appropriate: **(check one)**

☐ Acute Change ☐ Altered Level of Consciousness ☐ Disorganized Thinking ☐ Inattention

Based on the Geriatric Depression Scale (GDS), the client presented with depressive symptoms. **YES NO UNKNOWN (circle one)**

Did the client receive physical health services from a DHS clinic or hospital IN THE PAST 12 MONTHS? **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)**

CRISIS STABILIZATION / PMRT

Did the client receive services in an Emergency Room or Crisis Stabilization IN THE LAST 12 MONTHS? **YES NO UNKNOWN (circle one)** How many times? _____

Identify how many times in Emergency Room for: Physical Health _____ Psychiatric _____ Substance Abuse _____

Identify how many times in Crisis Stabilization for: Psychiatric _____ Substance Abuse _____

Was the client seen by a Psychiatric Mobile Response Team or 24/7 Response Team WITHIN THE LAST 12 MONTHS? **YES NO UNKNOWN (circle one)** How many times? _____

Did any of the Psychiatric Mobile Response Team or 24/7 Response Team calls result in a hospitalization? **YES NO UNKNOWN (circle one)** How many times? _____

LEGAL

JUSTICE SYSTEM INVOLVEMENT

Did the client have contact with the police WITHIN LAST 12 MONTHS? **YES NO UNKNOWN (circle one)**

Was the contact related to mental health issues? **YES NO UNKNOWN N/A (circle one)**

Was the contact related to substance abuse issues? **YES NO UNKNOWN N/A (circle one)**

Was the client arrested anytime DURING THE LAST 12 MONTHS? **YES NO UNKNOWN (circle one)**

Indicate the number of times the client was arrested DURING THE PAST 12 MONTHS: _____

How many were misdemeanor arrests? _____ How many were felony arrests? _____

Were any of the arrests related to a mental health issue? **YES NO UNKNOWN N/A (circle one)**

Were any of the arrests related to a substance abuse issue? **YES NO UNKNOWN N/A (circle one)**

Was the client incarcerated anytime WITHIN THE LAST 12 MONTHS? **YES NO UNKNOWN (circle one)**

Was treatment court ordered WITHIN THE LAST 12 MONTHS? **YES NO UNKNOWN (circle one)**

Was the client arrested anytime PRIOR TO THE LAST 12 MONTHS? **YES NO UNKNOWN (circle one)**

Was the client on probation DURING THE PAST 12 MONTHS? **YES NO UNKNOWN (circle one)**

Is the client CURRENTLY on probation? **YES NO UNKNOWN (circle one)**

Name of Probation / Parole Officer: _____

Was the client on probation PRIOR TO THE LAST 12 MONTHS? **YES NO UNKNOWN (circle one)**

Was the client on any kind of parole DURING THE PAST 12 MONTHS? **YES NO UNKNOWN (circle one)**

Was the client on any kind of parole PRIOR TO THE LAST 12 MONTHS? **YES NO UNKNOWN (circle one)**

LEGAL *continued*

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, has the client EVER had a co-occurring mental illness and substance use problem?	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)

CONSERVATORSHIP INFORMATION

Was the client on conservatorship DURING THE LAST 12 MONTHS?	YES	NO	UNKNOWN	(circle one)
Was the client on conservatorship anytime PRIOR to the last 12 months?	YES	NO	UNKNOWN	(circle one)
Is the client CURRENTLY on conservatorship?	YES	NO	UNKNOWN	(circle one)
Does the client have a Probate Conservator?	YES	NO	UNKNOWN	(circle one)
Does the client have a Power of Attorney?	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 Code 300 Status (Dependent of the court):	
Placed in Foster Care:	
Legally Reunified with the client:	
Adopted Out:	
Living with the client:	