

Consumer - Child

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A. RECORD MANAGEMENT

Consumer ID

Grant ID (Grant/Contract/Collaborative Agreement)

Site ID

Interview Type

Periodic Reassessment Month

Did you conduct an interview?

Consumer Type

Interview Date mm/dd/yyyy

Consumer - Child

Print Cancel Save Previous Next

A. RECORD MANAGEMENT - DEMOGRAPHICS

1. What is your child's gender? Other (Specify)

2. Is your child Hispanic or Latino?

(If yes) What ethnic group do you consider your child? Please answer yes or no for each of the following.
You may say yes to more than one.

Central American		Puerto Rican	
Cuban		South American	
Dominican		Other (Specify)	
Mexican			

3. What is your child's race? Please answer yes or no for each of the following.
You may say yes to more than one.

Black or African American		White	
Asian		American Indian	
Native Hawaiian or other Pacific Islander		Other (Specify)	
Alaska Native			

4. What is your child's month and year of birth? Month: Year:

B. FUNCTIONING

In order to provide the best possible mental health services, we need to know what you think about how well your child was able to deal with his/her everyday life during the last 30 days. Please indicate your disagreement/agreement with each of the following statements.

1. My child is handling daily life.
2. My child gets along with family members.
3. My child gets along with friends and other people.
4. My child is doing well in school and/or work.
5. My child is able to cope when things go wrong.
6. I am satisfied with our family life right now.

What was the consumer's GAF score?

Date GAF was administered mm/dd/yyyy

C. STABILITY III HOUSING

1. In the past 30 days, where has your child been living most of the time?

Other Housed (Specify)

2. Who has your child lived with during the past 30 of days? You may say yes to more than one.

— Biological Parent(s)

— Adoptive Parent(s)

— Relative Other Than Parent(s)

— Non-relative

— Independent Living

D. EDUCATION

1. During the last 30 days of school, how many days was your child absent for any reason?

A. How many days were unexcused absences?

2. What is the highest level of education your child has finished, whether or not he or she received a degree?

Consumer - Child

[Print](#)[Cancel](#)[Save](#)[Previous](#)[Next](#)

E. CRIME AND CRIMINAL JUSTICE STATUS

1. In the past 30 days, how many times has your child been arrested?



F. PERCEPTION OF CARE

In order to provide the best possible mental health services, we need to know what you think about the services your child received during the last 30 days, the people who provided it, and the results. Please indicate your disagreement/agreement with each of the following statements.

- | | |
|--|----------------------|
| 1. Staff here treated me with respect. | <input type="text"/> |
| 2. Staff respected my family's religious/spiritual beliefs. | <input type="text"/> |
| 3. Staff spoke with me in a way that I understood. | <input type="text"/> |
| 4. Staff was sensitive to my cultural/ethnic background. | <input type="text"/> |
| 5. I helped to choose my child's services. | <input type="text"/> |
| 6. I helped to choose my child's treatment goals. | <input type="text"/> |
| 7. I participated in my child's treatment. | <input type="text"/> |
| 8. Overall, I am satisfied with the services my child received. | <input type="text"/> |
| 9. The people helping my child stuck with us no matter what. | <input type="text"/> |
| 10. I felt my child had someone to talk to when he/she was troubled. | <input type="text"/> |
| 11. The services my child and/or family received were right for us. | <input type="text"/> |
| 12. My family got the help we wanted for my child. | <input type="text"/> |
| 13. My family got as much help as we needed for my child. | <input type="text"/> |

G. SOCIAL CONNECTEDNESS

Please indicate your disagreement/agreement with each of the following statements. Please answer for relationships with persons other than your child's mental health provider(s) over the past 30 days.

1. I know people who will listen and understand me when I need to talk.

2. I have people that I am comfortable talking with about my child's problems.

3. In a crisis, I would have the support I need from family or friends.

4. I have people with whom I can do enjoyable things.

Consumer - Child

[Print](#) [Cancel](#) [Save](#) [Previous](#) [Next](#)

I. PERIODIC REASSESSMENT STATUS

1. What is the periodic reassessment status of the consumer?

Other (Specify)

2. Is the consumer still receiving services from your program?

Consumer - Child

[Print](#) [Cancel](#) [Save](#) [Previous](#) [Next](#)

J. CLINICAL DISCHARGE STATUS

1. On what date was the consumer discharged? mm/dd/yyyy

2. What is the consumer's discharge status?

Other (Specify)

K. SERVICES RECEIVED

1. On what date did the consumer last receive services? mm/dd/yyyy

Identify all of the services your program provided to the consumer since his/her last NOMs interview; this includes CMHS-funded and non-funded services.

Core Services

- | | | |
|--|----------------------|---|
| 1. Screening | <input type="text"/> | ▼ |
| 2. Assessment | <input type="text"/> | ▼ |
| 3. Treatment Planning or Review | <input type="text"/> | ▼ |
| 4. Psychopharmacological Services | <input type="text"/> | ▼ |
| 5. Mental Health Services | <input type="text"/> | ▼ |
| If Yes, Delivery Frequency | <input type="text"/> | ▼ |
| 6. Co-Occurring Services | <input type="text"/> | ▼ |
| 7. Case Management | <input type="text"/> | ▼ |
| 8. Trauma-Specific Services | <input type="text"/> | ▼ |
| 9. Was the consumer referred to another provider for any of the above core services? | <input type="text"/> | ▼ |

Support Services

- | | | |
|--|----------------------|---|
| 1. Primary Care | <input type="text"/> | ▼ |
| 2. Employment Services | <input type="text"/> | ▼ |
| 3. Family Services | <input type="text"/> | ▼ |
| 4. Child Care | <input type="text"/> | ▼ |
| 5. Transportation | <input type="text"/> | ▼ |
| 6. Education Services | <input type="text"/> | ▼ |
| 7. Housing Support | <input type="text"/> | ▼ |
| 8. Social Recreational Activities | <input type="text"/> | ▼ |
| 9. Consumer Operated Services | <input type="text"/> | ▼ |
| 10. Medical Support & HIV Testing | <input type="text"/> | ▼ |
| 11. Was the consumer referred to another provider for any of the above support services? | <input type="text"/> | ▼ |