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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

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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:

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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

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C. STABILITY IN 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

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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?

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E. CRIME AND CRIMINAL JUSTICE STATUS

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

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

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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.

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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?

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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) _____

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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
2. Assessment
3. Treatment Planning or Review
4. Psychopharmacological Services
5. Mental Health Services
   - If Yes, Delivery Frequency
6. Co-Occurring Services
7. Case Management
8. Trauma-Specific Services
9. Was the consumer referred to another provider for any of the above core services?

Support Services

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