

Consumer - Adult

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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 gender? Other (Specify)

2. Are you Hispanic or Latino?

[If yes] What ethnic group do you consider yourself? 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 race do you consider yourself? 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 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 you were able to deal with your everyday life during the last 30 days. Please indicate your disagreement/agreement with each of the following statements.

1. I deal effectively with daily problems.
2. I am able to control my life.
3. I am able to deal with crisis.
4. I am getting along with my family.
5. I do well in social situations.
6. I do well in school and/or work.
7. My housing situation is satisfactory.
8. My symptoms are not bothering me.

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 have you been living most of the time?

Other Housed (Specify)

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D. EDUCATION AND EMPLOYMENT

1. Are you currently enrolled in school or a job training program? *[If enrolled,] Is that full time or part time?*

Other (Specify)

2. What is the highest level of education you have finished, whether or not you received a degree?

3. Are you currently employed? *[Clarify by focusing on status during most of the previous week, determining whether consumer worked at all or had a regular job but was off work.]*

Other (Specify)

- 3a. *[If employed],* Is your employment competitive or supported?

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E. CRIME AND CRIMINAL JUSTICE STATUS

1. In the past 30 days, how many times have you 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 you 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 believe that I can grow, change and recover.
2. I felt free to complain.
3. I was given information about my rights.
4. Staff encouraged me to take responsibility for how I live my life.
5. Staff told me what side effects to watch out for.
6. Staff respected my wishes about who is and who is not to be given information about my treatment.
7. Staff were sensitive to my cultural background (race, religion, language, etc.)
8. Staff helped me obtain the information I needed so that I could take charge of managing my illness.
9. I was encouraged to use consumer run programs (support groups, drop-in centers, crisis phone line, etc.)
10. I felt comfortable asking questions about my treatment and medication.
11. I, not staff, decided my treatment goals.
12. I like the services I received here.
13. If I had other choices, I would still get services from this agency.
14. I would recommend this agency to a friend or family member.

G. SOCIAL CONNECTEDNESS

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

1. I am happy with the friendships I have.
2. I have people with whom I can do enjoyable things.
3. I feel I belong in my community.
4. In a crisis, I would have the support I need from family or friends.



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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 | <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"/> |