NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

Patient Characteristics Survey for the week ending **10/25/2015**

Sheet Number: _____

1. Unit Code **2. Site Code**

3a. Client's First Name **3b. Client's Last Name**

4. Date of Birth *(MMDDYYYY format)*

5. Assigned Sex at Birth or Sex on Birth Certificate *(check one)*
❍ Male ❍ Female ❍ Unknown

6. Client Self-identifies as Transgender? *(check one)*
❍ No
❍ Yes, transgender female to male
❍ Yes, transgender male to female
❍ Yes, transgender does not identify as male or female
❍ Client didn't answer
❍ Unknown

7. Sexual Orientation *(check one)*
❍ Straight or heterosexual ❍ Bisexual ❍ Client didn't answer
❍ Lesbian or gay ❍ Other ❍ Unknown

8a. Hispanic Ethnicity *(check one)*
❍ No, not Hispanic/Latino
❍ Yes
❍ Unknown

8b. If Hispanic is selected *(check one)*
❍ Not Applicable ❍ Mexican ❍ Dominican ❍ Other
❍ Cuban ❍ Puerto Rican ❍ Ecuadorian ❍ Unknown

9. Race *(select all that apply)*
☐ White ☐ American Indian/Alaska Native ☐ Unknown
☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander
☐ Asian ☐ Other

9h. If Black/African American is selected *(check one)*
❍ Not Applicable ❍ Afro-Caribbean ❍ Other Black
❍ African-American ❍ African Continent ❍ Unknown

Sheet Number:	_____	Client's Name:	_____

10. Living Situation *(Inpatient programs and Residential Treatment Facilities should report residence before admission)*

- ❍ Private residence (home, apartment, rooming house, hotel, motel, supported housing, supported Single Room Occupancy (SRO), permanent housing programs, transient housing programs, and shelter plus care housing)
- ❍ Inpatient setting or children's Residential Treatment Facility (RTF)
- ❍ OMH Residential Care, LICENSED programs, community residence (child or adult), crisis residence, family care, teaching family home, apartment treatment, congregate treatment, apartment support, congregate support, community residence – SRO
- ❍ Adult home (Department of Health (DOH) licensed residential program for adults)
- ❍ Agency-operated Boarding Home through Department of Social Services/Administration for Children's Services (DSS/ACS) (Foster Home)
- ❍ Institutional setting for youth: Office of Children and Family Services (OCFS) Juvenile Justice Facility
- ❍ Institutional setting for youth: OCFS Residential Treatment Center
- ❍ Youth community-based residence (OCFS, DSS/ACS)
- ❍ Nursing or health-related facility (nursing home, skilled nursing facility)
- ❍ Homeless (e.g., shelter, street, transitional living center)
- ❍ Incarcerated
- ❍ Other (e.g., non-OMH residential care such as group home or halfway house)
- ❍ Unknown

11. Household Composition *(select all that apply; Inpatient programs and Residential Treatment Facilities should report household composition before admission)*

- ☐ Not applicable, client is not in a private residence
- ☐ Client lives alone
- ☐ Client's child, stepchild, foster child, grandchild
- ☐ Client's parent (biological, adoptive, stepparent)
- ☐ Client's sibling(s)
- ☐ Client's spouse or domestic partner
- ☐ Other relatives of client not specified above
- ☐ Foster parent
- ☐ Other people unrelated to client
- ☐ Unknown

12. Parental Status *(select all that apply)*

- ☐ No children
- ☐ Has children over 18 yrs old
- ☐ Has minor children, in client's custody
- ☐ Has minor children, NOT in client's custody
- ☐ Expectant parent
- ☐ Unknown

13. Was Client Homeless in Shelter or on Street at any time within the past 6 months?

❍ No ❍ Yes ❍ Unknown

14. County of Residence **15. Residence Zip Code**

(Inpatient programs and Residential Treatment Facilities should report residence before admission)

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Sheet Number:	_____	Client's Name:	_____

16. Preferred Language

- ❍ English
- ❍ Spanish/Spanish Creole
- ❍ Russian
- ❍ Mandarin
- ❍ Cantonese
- ❍ Fujianese
- ❍ Other Chinese
- ❍ French
- ❍ French/Haitian Creole
- ❍ Portuguese/Creole
- ❍ Italian
- ❍ Polish
- ❍ Yiddish
- ❍ Hebrew
- ❍ Arabic
- ❍ Hindi
- ❍ Urdu
- ❍ Other Indic (e.g., Sindhi)
- ❍ Other Indo-European
- ❍ African Languages
- ❍ Tagalog
- ❍ Korean
- ❍ Vietnamese
- ❍ Other Asian
- ❍ Sign Language
- ❍ Other
- ❍ Unknown

17. Prior or current active U.S. military service?

❍ No ❍ Yes ❍ Unknown

18. Employment Status *(Select the first outcome that applies)*

- ❍ Competitive and integrated employment
- ❍ Other employment
- ❍ Non-paid work position (volunteer)
- ❍ Unemployed and looking for work
- ❍ Not In Labor Force: unemployed but not looking for work, retired, homemaker, student, incarcerated, or psychiatric inpatient
- ❍ Unknown

19. Usual hours worked per week

- ❍ Not Applicable
- ❍ 1-14 hours
- ❍ 15-34 hours
- ❍ 35 hours or more
- ❍ Unknown

20. Client has attended school, home tutoring or received education instruction at any time in the past three months.

❍ No ❍ Yes ❍ Unknown

21. Education Level

- ❍ No formal education
- ❍ Pre-Kindergarten
- ❍ Kindergarten
- ❍ First grade
- ❍ Second grade
- ❍ Third grade
- ❍ Fourth grade
- ❍ Fifth grade
- ❍ Sixth grade
- ❍ Seventh grade
- ❍ Eighth grade
- ❍ Ninth grade
- ❍ 10^{th} grade
- ❍ 11^{th} grade
- ❍ 12^{th} grade, no diploma
- ❍ High school diploma or GED
- ❍ Business, technical training
- ❍ Some college, no degree
- ❍ Associate's degree
- ❍ Bachelor's degree
- ❍ Graduate degree
- ❍ Other
- ❍ Unknown

22. Special education services?

❍ Not applicable ❍ Yes ❍ No ❍ Unknown

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Sheet Number:	_____	Client's Name:	_____

23. Disability or Disorder

a. Mental Illness or Emotional Disturbance	❍ No	❍ Yes	❍ Unknown
b. Intellectual Disability/Mental Retardation	❍ No	❍ Yes	❍ Unknown
c. Autism Spectrum	❍ No	❍ Yes	❍ Unknown
d. Other Developmental Disability (Epilepsy, Cerebral Palsy, Neurological Impairment)	❍ No	❍ Yes	❍ Unknown
e. Alcohol Related Disorder	❍ No	❍ Yes	❍ Unknown
f. Drug/Substance Related Disorder	❍ No	❍ Yes	❍ Unknown
g. Mobility Impairment	❍ No	❍ Yes	❍ Unknown
h. Hearing or Visual Impairment	❍ No	❍ Yes	❍ Unknown

24. Chronic Medical Condition *(Select all that apply)*

☐ Hyperlipidemia (High blood fat/High cholesterol)
☐ High Blood Pressure
☐ Diabetes
☐ Obesity [based on BMI*, if not then subjective judgment]
☐ Heart attack
☐ Stroke
☐ Other Cardiac Condition
☐ Pulmonary (Emphysema (Chronic Obstructive Pulmonary Disease, Asthma)
☐ Alzheimer's Disease or Dementia
☐ Kidney Disease
☐ Liver Disease (Cirrhosis, Hepatitis A/B/C)
☐ Endocrine Condition (High or Low thyroid, Pituitary disease, Adrenal disease)
☐ Progressive neurological condition (Multiple Sclerosis, Cerebral palsy, Amyotrophic lateral sclerosis (ALS))
☐ Traumatic Brain Injury
☐ Joint and connective tissue disease (Lupus, Rheumatoid arthritis, Osteoporosis, Osteoarthritis)
☐ Cancer
☐ Other
☐ None
☐ Unknown whether client has any of the above chronic medical conditions

25. Smokes cigarettes or uses tobacco products?

❍ No ❍ Yes ❍ Unknown

26. Received a medication or a prescription for medication for smoking cessation from this program in the past year?

❍ No ❍ Yes ❍ Unknown

27. Received counseling for smoking cessation from this program in the past year?

❍ No ❍ Yes ❍ Unknown

28. Serious Mental Illness/Serious Emotional Disturbance

❍ No ❍ Yes ❍ Unknown

29. Diagnostic System used for primary psychiatric diagnosis

❍ DSM-IV or ICD-9 ❍ DSM-5 or ICD-10

30. Primary Psychiatric Diagnosis

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Sheet Number:	_____	Client's Name:	_____

31. Diagnostic System used for additional diagnosis
❍ DSM-IV or ICD-9 ❍ DSM-5 or ICD-10

32. Additional Diagnosis

33. Cash Assistance Benefits

a. SSI? (Supplemental Security Income)	❍ No	❍ Yes	❍ Unknown
b. SSDI? (Social Security Disability Insurance)	❍ No	❍ Yes	❍ Unknown
c. Veteran's disability benefits?	❍ No	❍ Yes	❍ Unknown
d. Veteran's Cash Assistance?	❍ No	❍ Yes	❍ Unknown
e. Public Assistance Cash Program? (TANF, Safety Net, etc.)	❍ No	❍ Yes	❍ Unknown
f. Other cash benefits? (pension, SSA retirement, other)	❍ No	❍ Yes	❍ Unknown

34. Health Insurance Coverage

a. Medicaid?	❍ No	❍ Yes	❍ Unknown
b. If "Yes," is it Managed Care? ❍ Not Applicable	❍ No	❍ Yes	❍ Unknown
c. Medicare?	❍ No	❍ Yes	❍ Unknown
d. Private Insurance?	❍ No	❍ Yes	❍ Unknown
e. Child Health Plus?	❍ No	❍ Yes	❍ Unknown
f. Other Health Insurance?	❍ No	❍ Yes	❍ Unknown

35. Admission Date, Current Episode *(MMDDYYYY format)*
Date: ☐
If program **does not do** formal admission paperwork, ❍ Check here
If **Unknown** admission date, ❍ Check here

36. Criminal Justice or Juvenile Justice Status *(Select the first outcome that applies).*
❍ None
❍ Criminal Procedure Law (CPL) 330.20
❍ Article 10-Sex Offender Management & Treatment (SOMTA)
❍ NYS Dept. of Correctional Services Prisoner
❍ County/City Jail, Court Detention or Police lockup Prisoner (including CPL 730 and CL 508 referrals)
❍ Parolee (adults)
❍ Probationer (adults)
❍ PINS (Person in Need of Supervision)
❍ Adjudicated Juvenile Delinquent or Offender
❍ Alternative to Incarceration (ATI) status, Mental Health Court, Court Diversion
❍ Other criminal justice status
❍ Unknown whether or not client has a criminal justice or juvenile justice status

37. Date Last Served Before 10/19/2015 by *this* Program *(MMDDYYYY format)*
Date: ☐
If **Never** served by this program, ❍ Check here
If **Unknown** date last served, ❍ Check here

38. Date of Client Service *(Select all that apply)*
☐ Oct 19 ☐ Oct 20 ☐ Oct 21 ☐ Oct 22 ☐ Oct 23 ☐ Oct 24 ☐ Oct 25

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