

This form is for internal use. All data are submitted electronically.



Patient Characteristics Survey for the week ending 10/29/2023

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. Sex on Birth Certificate (check one)

- Male Female X (Non-Binary) Intersex Unknown

6. Gender (check one)

- Cisgender
 Transgender Woman
 Transgender Man
 Non-Binary
 Gender Non-Conforming
 Client didn't answer
 Unknown

7. Sexual Orientation (check one)

- Straight Bisexual Client didn't answer
 Lesbian or gay Other Unknown

8a. Hispanic Ethnicity (check one)

- No, not Hispanic/Latino Yes Unknown

8b. If Yes to Question 8a, select one of the following (check one)

- Cuban Puerto Rican Ecuadorian Unknown
 Mexican Dominican Other Not Applicable

9. Race (select all that apply)

- a. White d. American Indian/Alaska Native g. Unknown
 b. Black/African American e. Native Hawaiian/Other Pacific Islander
 c. Asian f. Other

9h. If 9b. Black/African American is selected, select one of the following (check one)

- African American African Continent Unknown
 Afro-Caribbean Other Black Not Applicable

9i. If 9c. Asian or 9e. Hawaiian/Pacific Islander is selected, select one of the following (check one)

- Chinese Asian Indian Indonesian Nepalese Guamanian
 Japanese Laotian Malaysian Burmese Samoan
 Filipino Cambodian Pakistani Tibetan Fijian and Tongan
 Korean Bangladeshi Sri Lankan Thai Other Asian or Pacific Islander
 Vietnamese Hmong Taiwanese Hawaiian Unknown
 Not Applicable

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Sheet Number: _____	Client's Name: _____
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10. Living Situation (check one)

(Inpatient programs and Crisis Resident (CR) should report residence **before** admission, and short-term inpatient setting)

- 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 (RTC) / Qualified Residential Treatment Program (QRTP)
- Youth community-based residence (OCFS, DSS/ACS)
- Nursing or health-related facility (nursing home, skilled nursing facility)
- Homeless (Economic hardship "doubled-up", Shelter, Hotel or Motel, Car, Park, Bus Station, Train Station, Campsite, Transitional Housing, or other temporary living situation)
- Incarcerated
- Other (e.g., non-OMH residential care such as group home or halfway house) Individualized Residential Alternative (IRA)
- Unknown

11. If living in private residence, what is the household composition (select all that apply – Inpatient programs and Residential Treatment Facilities should report household composition **before** admission)

- | | |
|--|--|
| <input type="checkbox"/> Client lives alone | <input type="checkbox"/> Other relatives of client not specified above |
| <input type="checkbox"/> Client's child, stepchild, foster child, grandchild | <input type="checkbox"/> Foster parent |
| <input type="checkbox"/> Client's parent (biological, adoptive, stepparent) | <input type="checkbox"/> Other people unrelated to client |
| <input type="checkbox"/> Client's sibling(s) | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Client's spouse or domestic partner | <input type="checkbox"/> Not Applicable |

12. Parental Status (select all that apply)

- | | |
|--|--|
| <input type="checkbox"/> No children | <input type="checkbox"/> Has minor children, NOT in client's custody |
| <input type="checkbox"/> Has children over 18 years old | <input type="checkbox"/> Expectant parent |
| <input type="checkbox"/> Has minor children, in client's custody | <input type="checkbox"/> Unknown |

13. Was client homeless in shelter or on the street at any time within the past 6 months (Economic hardship "doubled-up", Shelter, Hotel or Motel, Car, Park, Bus Station, Train Station, Campsite, Transitional Housing, or other temporary living situation)?

- 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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16. Preferred Language (*check one*)

- | | | |
|--|---|---|
| <input type="radio"/> English | <input type="radio"/> Portuguese/Creole | <input type="radio"/> Other Indo-European |
| <input type="radio"/> Spanish/Spanish Creole | <input type="radio"/> Italian | <input type="radio"/> African Languages |
| <input type="radio"/> Russian | <input type="radio"/> Polish | <input type="radio"/> Tagalog |
| <input type="radio"/> Mandarin | <input type="radio"/> Yiddish, Pennsylvania Dutch/
other West Germanic | <input type="radio"/> Korean |
| <input type="radio"/> Cantonese | <input type="radio"/> Hebrew | <input type="radio"/> Vietnamese |
| <input type="radio"/> Fujianese | <input type="radio"/> Arabic | <input type="radio"/> Other Asian |
| <input type="radio"/> Other Chinese | <input type="radio"/> Hindi | <input type="radio"/> Sign Language |
| <input type="radio"/> French | <input type="radio"/> Urdu | <input type="radio"/> Other |
| <input type="radio"/> French/Haitian Creole | <input type="radio"/> Other Indic (e.g., Sindhi) | <input type="radio"/> Unknown |

17a. What best describes the client's religious and spiritual preferences? (*Check one*)

- | | | | |
|--|---|--|-------------------------------|
| <input type="radio"/> Client belongs to a formal religious group | <input type="radio"/> Client does not have a formal religion, nor am I a spiritual person | <input type="radio"/> Client considers themselves spiritual, but not religious | <input type="radio"/> Unknown |
|--|---|--|-------------------------------|

17b. If the client belongs to a formal religious group in Question 17a, select one of the following (*check one*)

- | | | | |
|--|--|-----------------------------------|--------------------------------------|
| <input type="radio"/> Protestant (Baptist, Methodist, Non-denominational, Lutheran, Presbyterian, Pentecostal, Episcopalian, Reformed, Church of Christ, etc.) | <input type="radio"/> Other Christian | <input type="radio"/> Hinduism | <input type="radio"/> Unknown |
| <input type="radio"/> Roman Catholic (Catholic) | <input type="radio"/> Judaism (Jewish) | <input type="radio"/> Agnosticism | <input type="radio"/> Not Applicable |
| <input type="radio"/> Orthodox (Greek, Russian, or some other orthodox church) | <input type="radio"/> Islam (Muslim) | <input type="radio"/> Atheism | |
| <input type="radio"/> Mormon (Church of Jesus Christ of Latter-day Saints/LDS) | <input type="radio"/> Buddhism | <input type="radio"/> Other | |

18. Does client have prior or current active U.S. military service?

- | | | |
|--------------------------|---------------------------|-------------------------------|
| <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown |
|--------------------------|---------------------------|-------------------------------|

19. Employment Status (*check one - select the first outcome that applies*)—

- Employed (Competitive or Self-employed)
- Other employment (internship, OMH funded employment, etc.)
- 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, underage of employment/ below working age
- Unknown

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20. If employed, what are the client's usual hours worked per week? (check one)

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

21. Has client attended school (in person or virtual), home tutoring, or received education instruction at any time in the past three months?

- No Yes Unknown

22. Education Level (check one)

- | | | |
|---|--|--|
| <input type="radio"/> No formal education | <input type="radio"/> Sixth grade | <input type="radio"/> Vocational and/or trade school |
| <input type="radio"/> Pre-Kindergarten | <input type="radio"/> Seventh grade | <input type="radio"/> Some college, no degree |
| <input type="radio"/> Kindergarten | <input type="radio"/> Eighth grade | <input type="radio"/> Associate's degree |
| <input type="radio"/> First grade | <input type="radio"/> Ninth grade | <input type="radio"/> Bachelor's degree |
| <input type="radio"/> Second grade | <input type="radio"/> 10 th grade | <input type="radio"/> Graduate degree |
| <input type="radio"/> Third grade | <input type="radio"/> 11 th grade | <input type="radio"/> Other |
| <input type="radio"/> Fourth grade | <input type="radio"/> 12 th grade, no diploma | <input type="radio"/> Unknown |
| <input type="radio"/> Fifth grade | <input type="radio"/> High school diploma or GED | |

23. Does the child have an IEP for special education services through the school district's Committee on Special Education?

- No Yes Unknown Not applicable

24. Disability or Disorder

- | | | | |
|---|--------------------------|---------------------------|-------------------------------|
| a. Mental Illness or Emotional Disturbance | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown |
| b. Intellectual and Developmental Disability | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown |
| c. Autism Spectrum Disorder | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown |
| d. Other Developmental Disability (Epilepsy, Cerebral Palsy, Neurological Impairment) | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown |
| e. Alcohol Use Disorder | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown |
| f. Drug/Substance Related Disorder | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown |
| g. Tobacco Use Disorder | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown |
| h. Opioid Use Disorder | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown |
| i. Other Substance Use Disorders | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown |
| j. Mobility Impairment | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown |
| k. Hearing Impairment | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown |
| l. Visual Impairment | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown |
| m. Speech Impairment | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown |
| n. Major Neurocognitive Disorder (dementia) of any subtype | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown |

25. COVID-19 Related

- | | | | |
|--|--------------------------|---------------------------|-------------------------------|
| a. Has the client ever had a positive COVID-19 virus test? | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown |
| b. Has the client been hospitalized for COVID-19 illness? | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown |
| c. Has the client received a COVID-19 vaccination? | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown |
| d. Has the client received a COVID-19 booster in the last 12 months? | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown |

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26. Chronic Medical Condition

- a. Hyperlipidemia (High blood fat/High cholesterol) No Yes Unknown
- b. High Blood Pressure No Yes Unknown
- c. Diabetes No Yes Unknown
- d. Obesity [based on BMI* or unknown] No Yes Unknown
- e. Coronary Vascular Disease No Yes Unknown
- f. Cerebrovascular Disease No Yes Unknown
- g. Other Cardiac Condition No Yes Unknown
- h. Pulmonary (Chronic Obstructive Pulmonary Disease (Emphysema), Asthma) No Yes Unknown
- i. Major Neurocognitive Disorder (Alzheimer's Disease or dementia) of any subtype No Yes Unknown
- j. Kidney Disease (dialysis, chronic renal failure, kidney stones) No Yes Unknown
- k. Liver Disease (Cirrhosis, Hepatitis A/B/C, alcohol-related liver injury) No Yes Unknown
- l. Endocrine Condition (e.g., hyper- or hypothyroidism; adrenal insufficiency or hypercortisolism; or hyperprolactinemia) No Yes Unknown
- m. Progressive neurological condition (Multiple Sclerosis, Cerebral palsy, Amyotrophic lateral sclerosis (ALS)) No Yes Unknown
- n. Traumatic Brain Injury No Yes Unknown
- o. Joint and connective tissue disease (Lupus, Rheumatoid arthritis, Osteoporosis, Osteoarthritis) No Yes Unknown
- p. Cancer No Yes Unknown
- q. Long COVID-19 No Yes Unknown
- r. Other chronic medical condition (s) not listed above No Yes Unknown

27. In the last 12 months, did client use cannabis (marijuana, weed, pot or hashish) obtained without a recommendation from a medical-cannabis-certified practitioner

- No Yes Unknown

28. Has the client received a recommendation to use cannabis (marijuana, weed, pot or hashish) for medical purposes from a medical-cannabis-certified practitioner within the last 12 months?

- No Yes Unknown

29. In the last 12 months, has the program assessed the client's stage of change?

- Pre-contemplative Preparation Maintenance Not Applicable
 Contemplative Action Unknown

30a. In the last 12 months, did client smoke cigarettes, vape or use tobacco products?

- No Yes Unknown

30b. Did client receive a medication for treatment of tobacco use disorder (e.g. varenicline, bupropion, nicotine replacement therapy) from this program in the past year?

- No Yes Unknown

30c. Did client receive counseling or psychotherapy for treatment of tobacco use disorder from this program in the past year?

- No Yes Unknown

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31a. In the last 12 months, did client receive any medications for Alcohol Use Disorder (e.g., naltrexone, acamprosate, disulfiram) from this program?

- No Yes Unknown

31b. In the last 12 months, did the client receive any psychotherapy or counseling for alcohol use disorder from this program?

- No Yes Unknown

32a. In the last 12 months, did client receive any medications for opioid use disorder (e.g., long-acting naltrexone, buprenorphine) from this program?

- No Yes Unknown

32b. In the last 12 months, did the client receive any counseling or psychotherapy for opioid use disorder from this program?

- No Yes Unknown

33. In the last 12 months, did client receive any treatment for any other Addiction Disorder from this program?

- No Yes Unknown

34. In the last 12 months, was the client screened for Hepatitis C?

- No Yes Unknown

35. In the past 12 months, did the client have any thoughts of killing themselves?

- No Yes Unknown

36. In the past 12 months, did the client have a suicide attempt?

- No Yes Unknown

37. Does client have a Serious Mental Illness/Serious Emotional Disturbance?

- No Yes Unknown

38. Primary Psychiatric Diagnosis

39. Additional Diagnosis

40. Cash Assistance Benefits

- | | | | |
|--|--------------------------|---------------------------|-------------------------------|
| a. SSI (Supplemental Security Income) | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown |
| b. SSDI (Social Security Disability Insurance) | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown |
| c. Veteran's disability benefits | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown |
| d. Veteran's Cash Assistance | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown |
| e. Public Assistance Cash Program (TANF, Safety Net, etc.) | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown |
| f. Other cash benefits (pension, SSA retirement, other) | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown |

41. Health Insurance Coverage

- | | | | | |
|--|--------------------------|---------------------------|-------------------------------|--------------------------------------|
| a. Medicaid | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown | |
| b. If Yes to 41a, is it Managed Care? | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown | <input type="radio"/> Not applicable |
| c. Medicare | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown | |
| d. Private Insurance | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown | |
| e. Child Health Plus | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown | |
| f. Other Health Insurance | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unknown | |

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42. Admission Date, Current Episode (If the program does not have an admission date, then Date of Intake is acceptable) (MMDDYYYY format)

Date:

- Check here if program **does not do** formal admission paperwork.
- Check here if **unknown** admission date.

43. Criminal Justice or Juvenile Justice Status (check one - select the *current status* 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, Drug Court Treatment
- Other criminal justice status
- Unknown whether or not client has a criminal justice or juvenile justice status

44. Date Last Served Before 10/23/2023 by this Program (MMDDYYYY format)

Date:

- Check here if client was **never** before served by this program.
- Check here if client's date last served is **unknown**.

45. Date of Client Service (select all that apply)

- Oct 23 Oct 24 Oct 25 Oct 26 Oct 27 Oct 28 Oct 29