

1.15 Employment Status <i>Must choose between A, B, or C. D is optional.</i>			
A. Competitive Employment	Date Employed:	<input type="text"/> / <input type="text"/>	Hours worked during a typical week: <input type="text"/>
	Hourly or Monthly Wage:	Hourly Wage <input type="text"/>	Monthly Wage <input type="text"/>
B. Non-Competitive Employment	Date Employed:	<input type="text"/> / <input type="text"/>	Hours worked during a typical week: <input type="text"/>
	Type of Non-Competitive Employment		
<input type="checkbox"/> Community Based <input type="checkbox"/> Facility Based			
C. Unemployed But Available for Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If answered 'No' above, please indicate why	<input type="checkbox"/> Home maker		<input type="checkbox"/> Institutionalized
	<input type="checkbox"/> Student		<input type="checkbox"/> Disabled
	<input type="checkbox"/> Retired		<input type="checkbox"/> Inmate
			Date of Last Employment (yr): <input type="text"/>
D. Volunteer	Time during a typical week spent doing volunteer work in a community setting: <input type="text"/>		Hours <input type="text"/>
1.16 School Setting			
<input type="checkbox"/> Enrolled in Mainstream School		<input type="checkbox"/> Enrolled in Psycho-Education Center	<input type="checkbox"/> Enrolled in Home School
<input type="checkbox"/> Enrolled in Alternative School		<input type="checkbox"/> Enrolled in a Technical School	<input type="checkbox"/> Not Enrolled in School
Child and Adolescent			
Number of days absent from school in past month: <input type="text"/>			
1.17 Education			
a. Years of Education	What is the highest level of education that the consumer has completed?		<input type="text"/>
1.18 Legal Status			
a. Legal Status: <i>(Check one)</i>	<input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary		
b. Legal Custody: <i>(Check any that apply)</i>	<input type="checkbox"/> DFCS Custody <input type="checkbox"/> Other Court-Appointed Guardian		
c. Legal Involvement <i>(Check all that apply)</i>	<input type="checkbox"/> DFCS <input type="checkbox"/> Jail/Law Enforcement	<input type="checkbox"/> Juvenile Justice (See Instructions) <input type="checkbox"/> Adult Criminal Court	<input type="checkbox"/> Treatment Court (MH/AD) <input type="checkbox"/> Adult Probation
d. Agency Requiring Consumer to Obtain Services: <i>(Check all that apply)</i>	<input type="checkbox"/> DFCS <input type="checkbox"/> Jail/Law Enforcement	<input type="checkbox"/> Juvenile Justice (See Instructions) <input type="checkbox"/> Adult Criminal Court	<input type="checkbox"/> Treatment Court (MH/AD) <input type="checkbox"/> Adult Probation
e. Justice System Involvement	Has consumer been involved with criminal/juvenile justice system in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No (Includes arrests, probation, parole, commitments, adjudications, diversions, or awaiting sentencing)		
f. Arrests:	Number of arrests, regardless of nature of offense or outcome, in the past 30 days		<input type="text"/>
1.19 Addiction			
a. Type of Substance(s) Used	<input type="checkbox"/> None <input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs <input type="checkbox"/> Both		
b. Name of Substance(s) Used	Indicate the name of substances used/abused:		
	Primary Substance Used	Secondary Substance Used	Tertiary Substance Used
c. Route of Administration	<input type="checkbox"/> Oral <input type="checkbox"/> Smoking <input type="checkbox"/> Inhalation <input type="checkbox"/> Injection <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Oral <input type="checkbox"/> Smoking <input type="checkbox"/> Inhalation <input type="checkbox"/> Injection <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Oral <input type="checkbox"/> Smoking <input type="checkbox"/> Inhalation <input type="checkbox"/> Injection <input type="checkbox"/> Other <input type="checkbox"/> Unknown
d. Frequency of use	<input type="checkbox"/> Daily <input type="checkbox"/> 1-2 times in the past week <input type="checkbox"/> 3-6 times in the past week <input type="checkbox"/> 1-3 times in the past month <input type="checkbox"/> No use in the past month	<input type="checkbox"/> Daily <input type="checkbox"/> 1-2 times in the past week <input type="checkbox"/> 3-6 times in the past week <input type="checkbox"/> 1-3 times in the past month <input type="checkbox"/> No use in the past month	<input type="checkbox"/> Daily <input type="checkbox"/> 1-2 times in the past week <input type="checkbox"/> 3-6 times in the past week <input type="checkbox"/> 1-3 times in the past month <input type="checkbox"/> No use in the past month
e. Age at first use	<input type="text"/>	<input type="text"/>	<input type="text"/>
f. Prior Treatment Episodes	How many previous treatment episodes has the consumer received in any drug or alcohol program?		<input type="text"/>

1.20 MH/AD Criteria for Brief Intervention Check all that apply.	Adult	Child and Adolescent			
	A. Individual's level of functioning is significantly affected by the presenting mental health and/or addictive disease issue? <input type="checkbox"/> Yes <input type="checkbox"/> No --AND one or more of the following*: B. Individual displays behaviors that are significantly disruptive to the community, to the individual's family/support system, or to the individual's ability to maintain his or her current employment/schooling, housing or personal health/safety? <input type="checkbox"/> Yes <input type="checkbox"/> No --AND/OR-- C. Individual displays behaviors that demonstrate a potential risk to self or others? <input type="checkbox"/> Yes <input type="checkbox"/> No * The individual's functioning must meet A and at least B OR C – 2 of the three criteria listed above to qualify for Brief Intervention/Stabilization Services .	A. Brief Intervention Services Individual's level of functioning must meet at least two of the following criteria: <input type="checkbox"/> 1) is affected by an emotional disturbance or substance related disorder. <input type="checkbox"/> 2) has shown early indications of behaviors that could be disruptive to the community and the family/support system if behaviors intensified. <input type="checkbox"/> 3) has shown early indications behaviors/functional problems that could cause risk of removal from the home if problems intensified. <input type="checkbox"/> 4) has shown early indications of poor school performance (poor grades, disruptive behavior, lack of motivation, suspension). <input type="checkbox"/> 5) has shown early indications of delinquent behaviors that could result in legal system involvement. <input type="checkbox"/> 6) has shown early indications of behavioral/functional problems that could result in multiple agency involvement if problems intensified. --OR-- B. Stabilization Services Individual's level of functioning must meet at least one of the following criteria: <input type="checkbox"/> 1) is significantly affected by a serious emotional disturbance or substance related disorder. <input type="checkbox"/> 2) results in behaviors that demonstrate a risk of harm to self, others, or property. <input type="checkbox"/> 3) causes a risk of removal from the home. <input type="checkbox"/> 4) results in school problems such as poor grades, school failure, disruptive behavior, lack of motivation, drop out, suspension or expulsion. <input type="checkbox"/> 5) results in legal system involvement;. <input type="checkbox"/> 6) indicates the need for detoxification services. <input type="checkbox"/> 7) is significantly disruptive to the community or the family/support system.			
1.21 Disposition of Screen If not referred for evaluation, form is complete. Check all that apply.	<input type="checkbox"/> Referred for crisis intervention <input type="checkbox"/> Referred for brief intervention and stabilization services <input type="checkbox"/> Referred for ongoing support and recovery services <input type="checkbox"/> Referred for inpatient services <input type="checkbox"/> Referred other _____ <input type="checkbox"/> Not referred		1.22 Diagnostic Category		
	DD Only <input type="checkbox"/> On Short Term Planning List <input type="checkbox"/> Receiving Waiver Services <input type="checkbox"/> Receiving State Contracted Services		Primary (Required) <input type="checkbox"/> AMH <input type="checkbox"/> CAMH <input type="checkbox"/> ASA <input type="checkbox"/> CASA <input type="checkbox"/> ADD <input type="checkbox"/> CADD	Secondary/Dual (Required) <input type="checkbox"/> None <input type="checkbox"/> MH/SA <input type="checkbox"/> MH/DD <input type="checkbox"/> SA/MH <input type="checkbox"/> MH/DD <input type="checkbox"/> SA/MH <input type="checkbox"/> SA/DD <input type="checkbox"/> DD/SA <input type="checkbox"/> DD/MH <input type="checkbox"/> DD/SA <input type="checkbox"/> DD/MH	
1.23 Referral Information: Complete only for those continuing in services.	Agency Referred to: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Appointment Date and Time: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> : <input type="text"/>		
Additional Information for DD Consumers ONLY					
1.24 Region of Residence	Regional Intake Team & Phone Number:		1.25 ICD-9 Code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>		
1.26 Special Categories	<input type="checkbox"/> DCH Slot <input type="checkbox"/> State Converted Dollars	<input type="checkbox"/> LOC <input type="checkbox"/> Emergency Slot MHDDAD	<input type="checkbox"/> HUD Placement <input type="checkbox"/> State Facilities Services	<input type="checkbox"/> DFCS Guardian <input type="checkbox"/> Other	
1.27 Prior Placement	<input type="checkbox"/> Own Home <input type="checkbox"/> Group Home <input type="checkbox"/> Out of State <input type="checkbox"/> Nursing Home	<input type="checkbox"/> Homeless <input type="checkbox"/> Surrogate Home <input type="checkbox"/> DFCS Custody <input type="checkbox"/> Incarcerated	<input type="checkbox"/> Other Service/ Program Options <input type="checkbox"/> GRH - Augusta <input type="checkbox"/> West Central Regional <input type="checkbox"/> Central State	<input type="checkbox"/> SWSH <input type="checkbox"/> GRH - Atlanta <input type="checkbox"/> Rome Regional <input type="checkbox"/> GRH -Savannah	<input type="checkbox"/> Gracewood <input type="checkbox"/> Bainbridge - <i>Historical</i> <input type="checkbox"/> Brook Run - <i>Historical</i> <input type="checkbox"/> Rivers Crossing - <i>Historical</i> <input type="checkbox"/> Community <input type="checkbox"/> Other

