



DELAWARE DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH
Annual Consumer Reporting Form

(SELECT MODALITY)

- [] MH MENTAL HEALTH
[] AD ALCOHOL /DRUG (ONLY ONE)
[] DU CO - OCCURRING (MH & AD)
[] GA GAMBLING

Last Name _____

First Name _____ M.I. _____

Treatment Unit Name _____

STREET (Optional) _____

CITY (Optional) _____ STATE (Optional) _____

ZIP (Optional) _____ COUNTY (Optional) _____

Treatment Unit ID # _____

HOME TELEPHONE (Optional) (____) _____

MCI # 0 0 0 _____

Residential Arrangement

- [] PU Private Residence - Unsupervised
[] PS Private Residence - Supervised
[] FC Licensed Adult Foster Care
[] UF Unlicensed Adult Foster Care
[] BH Boarding Home
[] GU Group Home Setting - Unsupervised
[] GS Group Home Setting- Supervised
[] NH Nursing Home, ICF - SNF
[] CJ Corrections Facility- Jail
[] PH Psychiatric Hospital > 180 days
[] PW Psychiatric Ward- General Hospital > 180 Days .
[] I Other Institution
[] N No Domicile - Homeless
[] EH Emergency Housing, Shelter < 30 Days
[] TH Transitional Housing ≥30 Days
[] CR Crisis Residence
[] O Other
[] U Unknown

Primary Employment (During the Past 30 Days)

- [] F Full Time
[] P Part Time
[] M Military Armed Forces
[] L Unemployed - Looking for Work
[] N Unemployed - Not Looking
[] D Disabled - Unable to Work
[] H Homemaker
[] S Student
[] R Retired
[] I Inmate-or Resident of Institution
[] V Volunteer
[] O Other
[] U Unknown

Receiving EBP's

- [] SH Supported Housing
[] SE Supported Employment
[] AC Assertive Community Treatment
[] FP Family Psychoeducation
[] IT Integrated Treatment for Co-Occurring Disorders
[] IM Illness Management & Recovery
[] NA None of the Above

Consumer's Primary Source Of Income

- [] SS Social Security
[] SI SSI
[] SD SSDI
[] VD VA - Disability
[] VR VA - Retirement
[] UI Unemployment Insurance
[] IL Illegal
[] E Employment
[] S Spouse
[] F Family -Friends
[] A TANF
[] G General Assistance
[] P Pension-Retirement (IRA, EOGH, SEP)
[] W Workers' Compensation
[] D Private Disability Insurance
[] I Investments-Savings
[] O Other
[] N None
[] U Unknown

Homeless At Any Time During The Past 12 Months?

- [] Y Yes
[] N No
[] U Unknown

Veteran Status

- [] VP VETERAN/PREVIOUS MILITARY SERVICE (See Instructions)
[] AD ACTIVE DUTY
[] FM IMMEDIATE FAMILY MEMBER of MILITARY or VETERAN (See Instructions)
[] NA NONE OF THE ABOVE
[] U UNKNOWN

Primary Health Insurance

- [] M Medicare
[] A Medicaid
[] E Medicaid MCO
[] C Champus
[] B Blue Cross/ Blue Shield
[] V VA
[] H HMO
[] G Other Government Funds for Care
[] P Other Private Commercial
[] O Other
[] N None
[] U Unknown

Consumer's Gross Income Per Year

\$ _____

Number Dependent On Consumer's Income Write In Number (01 - 20)

97 Unknown

Housing Subsidy

- [] FH State/Federal Subsidized Housing
[] SA Subsidized with Client Assistance Funds
[] NS No Rental Subsidy

Consumer's Primary Paid Employment Type: Select one.

- [] SD Sheltered
[] CN Competitive/Not Supported
[] CS Competitive/ Supported
[] N Not working

Education Write In Highest Grade Completed

- 01-12 Elementary/ High School
13-16 College/ Post Secondary
17 Masters
18 PHD/MD
19 Post Doctoral
96 Never Completed any grade /Only Kindergarten
97 Unknow

Regular Place to Live

- [] Y Yes
[] N No
[] U Unknown

On average how many hours per week has the consumer spent on his/her primary activity during the past 90 days?

_____ (Max. 168 Hrs)

How many places has the consumer lived in the past 90 days?

- [] 1 [] 2 [] 3 [] 4 [] 5
[] 6 [] 7 [] 8 [] >=9

Number Of Arrests Past 30 Days



MCI # 0 0 0

TREATMENT UNIT ID #

Main reporting form with sections: Current Legal Involvement, Expected Source Of Payment, Alcohol & Drug Use Matrix, Substance Type Codes, Route Of Administration, CSI - Completed (Co-Occurring Screening Instrument)

Print Name - Person Completing Form

Staff ID

DATE

Staff ID

DATE

Signature



DELAWARE DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH
Annual Consumer Reporting Form

Consumer's Name _____
Last First M.I.

MCI # 0 0 0

TREATMENT UNIT ID #

Axis I: Clinical Disorders

Check One (Axis I or II) to Indicate PRIMARY DIAGNOSIS

Code [] _____
Code [] _____
Code [] _____

Axis II: Personality Disorders/Mental Retardation

Code [] _____
Code [] _____
Code [] _____

Axis III: General Medical Conditions

ICD-9-CM Name

Code _____
Code _____
Code _____
Code _____
Code _____

Axis IV: Psychosocial and Environmental Problems

Check:

- Problems with primary support group (Specify) _____
- Problems related to the social environment (Specify) _____
- Educational problems (Specify) _____
- Occupational problems (Specify) _____
- Housing problems (Specify) _____
- Economic problems (Specify) _____
- Problems with access to health care services (Specify) _____
- Problems related to interaction with the legal system/crime (Specify) _____
- Other psychosocial and environmental problems (Specify) _____

Axis V: Global Assessment of Functioning Scale

Score

Time Frame (Circle One: Current Last Month Last Quarter Last Year Other _____)

Print Name - Physician Formulating/Confirming Diagnosis

Physician ID

DATE

Signature