Patient Characteristics Survey for the week ending 03/27/2022

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  ○ X (Non-Binary)  ○ Unknown

6. Does client self-identify as transgender? (check one)
   ○ No
   ○ Yes, transgender female to male
   ○ Yes, transgender male to female
   ○ Yes, transgender, gender non-conforming
   ○ 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 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
   ○ b. Black/African American
   ○ c. Asian
   ○ d. American Indian/Alaska Native
   ○ e. Native Hawaiian/Other Pacific Islander
   ○ 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
10. Living Situation (check one)  
*(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 *(shelter, street, transitional living center)* 
- Incarcerated 
- Other *(e.g., non-OMH residential care such as group home or halfway house)* 
- 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) 
- 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 
- Not Applicable 

12. Parental Status (select all that apply) 
- No children 
- Has children over 18 years 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 the 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)*
16. Preferred Language (check one)
- English
- Spanish/Spanish Creole
- Russian
- Mandarin
- Cantonese
- Fujianese
- Other Chinese
- French
- French/Haitian Creole
- Portuguese/Creole
- Italian
- Polish
- Yiddish, Pennsylvania Dutch/other West Germanic
- Hebrew
- Arabic
- Hindi
- Urdu
- Other Indic (e.g., Sindhi)
- Vietnamese
- Other Asian
- Sign Language
- Other
- Korean
- Other
- Hindi
- Yiddish, Pennsylvania Dutch/other West Germanic
- African Languages
- Tagalog
- Russian
- Polish
- French
- Urdu
- Sign Language
- Other
- Korean
- Other
- Hindi
- Yiddish, Pennsylvania Dutch/other West Germanic
- African Languages
- Tagalog
- Russian
- Polish
- French
- Urdu
- Sign Language
- Other
- Korean
- Other
- Hindi
- Yiddish, Pennsylvania Dutch/other West Germanic
- African Languages
- Tagalog
- Russian
- Polish
- French
- Urdu
- Sign Language
- Other
- Korean
- Other
- Hindi

17a. What best describes the client's religious preferences? (check one)
- I belong to a formal religious group
- I do not have a formal religion, nor am I a spiritual person
- I consider myself spiritual, but not religious
- Data not available

17b. If the client belongs to a formal religious group in Question 17a, select one of the following (check one)
- Protestant (Baptist, Methodist, Non-denominational, Lutheran, Presbyterian, Pentecostal, Episcopalian, Reformed, Church of Christ, etc.)
- Roman Catholic (Catholic)
- Orthodox (Greek, Russian, or some other orthodox church)
- Mormon (Church of Jesus Christ of Latter-day Saints/LDS)
- Other Christian
- Judaism (Jewish)
- Islam (Muslim)
- Buddhism
- Hinduism
- Agnosticism
- Atheism
- Other
- Unknown
- Not Applicable

18. Does client have prior or current active U.S. military service?
- No
- Yes
- Unknown

19. Employment Status (check one - 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

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**Sheet Number:** ___________  |  **Client’s Name:** ___________________________________

**20. If employed, what are the client’s usual hours worked per week?** *(check one)*
- O 1-14 hours
- O 15-34 hours
- O 35 hours or more
- O Not Applicable

**21. Has client attended school, home tutoring, or received education instruction at any time in the past three months?**
- O No
- O Yes
- O Unknown

**22. Education Level** *(check one)*
- O No formal education
- O Pre-Kindergarten
- O Kindergarten
- O First grade
- O Second grade
- O Third grade
- O Fourth grade
- O Fifth grade
- O Sixth grade
- O Seventh grade
- O Eighth grade
- O Ninth grade
- O 10th grade
- O 11th grade
- O 12th grade, no diploma
- O High school diploma or GED
- O Vocational and/or trade school
- O Some college, no degree
- O Associate’s degree
- O Bachelor’s degree
- O Graduate degree
- O Other
- O Unknown

**23. Does the child have an IEP for special education services through the school district’s Committee on Special Education?**
- O No
- O Yes
- O Unknown
- O Not appliable

**24. Disability or Disorder**
- a. Mental Illness or Emotional Disturbance
- b. Intellectual Disability
- c. Autism Spectrum
- d. Other Developmental Disability (Epilepsy, Cerebral Palsy, Neurological Impairment)
- e. Alcohol Related Disorder
- f. Drug/Substance Related Disorder
- g. Opioid Related Disorder
- h. Mobility Impairment
- i. Hearing Impairment
- j. Visual Impairment
- k. Speech Impairment
- O No
- O Yes
- O Unknown

**25. COVID-19 Related**
- a. Has the client ever had a COVID-19 virus test?
- b. Has the client ever had a positive COVID-19 virus test?
- c. Has the client had COVID-19 illness (i.e., COVID-19 symptoms)?
- d. Has the client been hospitalized for COVID-19 illness?
- e. Has the client received a COVID-19 vaccination?
- O No
- O Yes
- O Unknown

This form is for internal use. All data are submitted electronically.
### 26. Chronic Medical Condition

<table>
<thead>
<tr>
<th>Condition</th>
<th>No</th>
<th>Yes</th>
<th>Unknown</th>
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</thead>
<tbody>
<tr>
<td>a. Hyperlipidemia (High blood fat/High cholesterol)</td>
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<td>b. High Blood Pressure</td>
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<td>c. Diabetes</td>
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<td>d. Obesity [based on BMI*, if not then subjective judgment]</td>
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<td>e. Heart attack</td>
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<td>f. Stroke</td>
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<td>g. Other Cardiac Condition</td>
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<td>h. Pulmonary (Emphysema, Chronic Obstructive Pulmonary Disease, Asthma)</td>
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<td>i. Alzheimer's Disease or Dementia</td>
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<td>j. Kidney Disease</td>
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<td>k. Liver Disease (Cirrhosis, Hepatitis A/B/C)</td>
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<td>l. Endocrine Condition (High or Low thyroid, Pituitary disease, Adrenal disease)</td>
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<td>m. Progressive neurological condition (Multiple Sclerosis, Cerebral palsy, Amyotrophic lateral sclerosis (ALS))</td>
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<td>n. Traumatic Brain Injury</td>
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<td>o. Joint and connective tissue disease (Lupus, Rheumatoid arthritis, Osteoporosis, Osteoarthritis)</td>
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<td>p. Cancer</td>
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<tr>
<td>q. COVID-19</td>
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<tr>
<td>r. Other Chronic Medical Condition(s) not listed above</td>
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</tbody>
</table>

### 27. In the last 12 months, did client use cannabis (marijuana, weed, pot or hashish) for recreational purposes (not prescribed)?
- No
- Yes
- Unknown

### 28. In the last 12 months, did client use cannabis (marijuana, weed, pot or hashish) for medical purposes?
- No
- Yes
- Unknown

### 29a. In the last 12 months, did client smoke cigarettes, vape or use tobacco products?
- No
- Yes
- Unknown

### 29b. Did client receive a medication or a prescription for medication for smoking cessation from this program in the past year?
- No
- Yes
- Unknown

### 29c. Did client receive counseling for smoking cessation from this program in the past year?
- No
- Yes
- Unknown
30. In the last 12 months, did client receive any treatment, counseling or medication for Alcohol Use from this program?
   - No  - Yes  - Unknown

31. In the last 12 months, did client receive any treatment, counseling or medication for any Opiate Related use from this program?
   - No  - Yes  - Unknown

32. In the last 12 months, did client receive any treatment, counseling or medication for any other Drug/Substance Use from this program?
   - No  - Yes  - Unknown

33. Does client have a Serious Mental Illness/Serious Emotional Disturbance?
   - No  - Yes  - Unknown

34. Primary Psychiatric Diagnosis

35. Additional Diagnosis

36. 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

37. Health Insurance Coverage
   a. Medicaid  - No  - Yes  - Unknown
   b. If Yes to 37a, is it Managed Care?  - 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

38. 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.
39. 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

40. Date Last Served Before 03/21/2022 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.

41. Date of Client Service (select all that apply)
- Mar 21
- Mar 22
- Mar 23
- Mar 24
- Mar 25
- Mar 26
- Mar 27

42. Number of days you have served this client in the past 12 months? ________