Send Referral to:
Fax Number: (330) 544-9379
Email: front.office@cadencecare.org

Service(s) Requested

- ☐ Assessment- Admission to Mental Health Treatment
- ☐ CANS- OhioRise
- ☐ Pharmacological Mgmt

Name: _____ Date: _____

Address: _____ City/Zip: _____ County of Residence: _____

DOB: _____ Age: _____ Gender: ☐ M ☐ F ☐ Undifferentiated

Social Security Number: _____ Race: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Legal Guardian Name: _____ DOB: _____

Relationship to client: _____ Gender: ☐ M ☐ F

County Custody: ☐ Yes ☐ No Permission to Leave: ☐ Voicemail ☐ Email

Email: _____ Phone #: _____

Address: _____

Guardian / Caregiver Name: _____ DOB: _____

Relationship to client ☐ Parent ☐ Foster Parent ☐ Kinship Gender: ☐ M ☐ F

Phone #: _____ Permission to leave voicemail at this #: ☐ Yes ☐ No

Client school and grade (if applicable): _____

Are you receiving mental health services elsewhere? ☐ Yes ☐ No

Are there pets in your home? ☐ Yes ☐ No If yes what kind? _____

Who referred you to Cadence Care Network? _____

What agency does the referral source work for? _____

What is your current reason for seeking services at Cadence Care Network? _____

_____

_____

Financial Information:

in household: _____ Household monthly income: _____

Primary Insurance Name: _____ Secondary Insurance Name: _____

Guarantor (Policy Holder): _____

Primary Member ID#: _____ Secondary Member ID#: _____

Guarantor DOB & SS# _____

Completed by: _____

Acknowledgment of Receipt of
Cadence Care Network Handouts

Client Name: _____ MRN#: _____

I have reviewed the following Cadence Care Network Handouts and received a copy upon my request. By signing this acknowledgement statement, I hereby confirm that I have read the documents and understand the contents, and have asked my assessment therapist any questions that I have about these documents.

	Initial	
☐	_____	Clients Rights Policy/Client Grievance
☐	_____	Client Care Philosophy
☐	_____	Attendance Policy
☐	_____	Partner Solutions Release
☐	_____	Notice of Privacy Practices Booklet
☐	_____	Payment and Billing Acknowledgment Form
☐	_____	Accessibility, Availability, Acceptability, and Appropriateness Policy

_____ _____

Signature of Client Date

_____ _____

Signature of Parent/ Guardian Date

_____ _____

Signature of Staff Reviewing Handouts Date

Consent for Mental Health Services
and Publicly Funded Services Disclosure Notice

Client Name: _____ DOB: _____

I hereby authorize Cadence Care Network to provide routine evaluation and treatment services as may be deemed necessary or advisable for the diagnosis and/or care of the above-named individual.

I acknowledge that the risks and benefits of each proposed treatment, of alternative treatment and of no treatment have been explained to me. I have also been advised of my right to refuse or withdraw consent for treatment and that the implications and potential consequences of refusing or withdrawing consent have been/will be fully explained.

This consent applies to treatment services for any and all of the services identified in which the client may be enrolled or to which they may be transferred.
I also acknowledge that to receive alcohol, drug addiction and mental health services paid for by public funds, I must provide information to the appropriate Board of Mental Health so they can:

- enroll this client in the County Behavioral Healthcare Program,
- determine if the client is eligible for publicly funded services, and
- pay the provider for services for this client through the MACSIS (Multi Agency Community Services Information System) computer system, or any future replacements to MACSIS, which connects the Board to the Ohio Department of Mental Health and Addiction Services, and the Ohio Department of Human Services.

If applicable, I recognize that Behavoiral health providers use a tool called Child and Adolescent Needs and Strengths (CANS) to collect behavioral health clinical information about clients under 21. For clients who are in ongoing treatment, a provider will regularly update the CANS at least every 90 days.
The information collected using the CANS tool helps providers to do a number of things, such as:

- decide what behavioral health services a client may need
- check over time that behavioral health services are helping clients.

The CANS will be entered into the Ohio Children's Initiative CANS information Technology (IT) System.

- Only providers whom the caregiver has given consent to will be able to view and copy the CANS record.

I agree that I am responsible for payment for services provided to my dependents or me by Cadence Care Network. I request that payment of authorized benefits be made to Cadence Care Network for mental health services furnished by Cadence Care Network. I authorize release to the indicated insurance carrier or Medicaid any medical information about me needed to determine these payments for related services. I will be fully responsible for payment for any claims my insurance or Medicaid denies and agree to pay the balance to Cadence Care Network. Cadence Care Network will notify me of any services not covered by my insurance or Medicaid or changes to coverage. Cadence Care Network will not discontinue services to any individual in a critical situation until appropriate arrangements can be made for continuation of services. If the client is not covered by Medicaid or Insurance, Cadence Care Network may allow for "out of pocket" payment using a sliding scale fee.

All information will be kept confidential. Name identifying information will be used only to pay for services provided to this client. Demographic information will be kept without the youth's name attached, and reported to the State departments and Ohio Health Care Data center. This information will not be available to any other sources or used for other purposes. Billing information will only be kept for ten years after the client has received services, and only demographic information will be kept after that time.

Please note: In accordance with section 5122.04 of the revised code, mental health services, except for the use of medication, may be provided to minors 14 years of age or older for not more than 6 sessions or thirty days, whichever occurs first without a consent for treatment form signed by the minor's parent or guardian.

A copy of my signature shall be the functional equivalent of the original. I consent to treatment and have received this information:

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Printed Name of Member (client receiving services) Client Signature

I have read and explained this information to the above named individual:

_____ _____
Agency Staff Member Signature

Consent for Mental Health Services
and Publicly Funded Services Disclosure Notice

Cadence Care Network has partnered with the CliniSync Health Information Exchange. This partnership allows Cadence Care Network to access healthcare information electronically across organizaitions across the state. Clear and strict state and federal guidelines govern how the information can be exchanged, viewed and used. The goal of the Health Information Exchange is to make the information available when and where it is needed.

The purpose of the CliniSync Health Information Exchange is giving Cadence Care Network the capability to access hospital records electronically. Cadence Care Network will be able to view test results, lab results, x-rays, medication list, and other pertinent information that is relevant to your treatment at Cadence Care Network.

All Health Information obtained by The CliniSync Health Information Exchange is kept private. The CliniSync Health Information Exchange follows U.S. and Ohio privacy laws. Only people providing care to you may view your medical records on the exchange. Anyone not involved in your care is not allowed to view your medical records on the exchange.

I understand that my treating providers have access to my medical records through the CliniSync Health Information Exchange. These medical records include test results, lab results, x-rays, medication list, and other health information that is relevant to your treatment at Cadence Care Network. I understand that my choice will not affect my ability to get medical or mental health care.

If you DO NOT want to have your records shared with Cadence Care Network, please mark the box below.

☐ I do not want to have my records shared on the CliniSync Health Information Exchange. I understand that by submitting this request for Non-Participation in CliniSync my test results and medical information will not be accessible to health care providers through CliniSync.

If you want to have your records shared with Cadence Care Network, please mark the box below.

☐ I consent to have my records shared through the Health Information Exchange.

_____ _____

Parent/Legal Guardian Signature Date

_____

Printed Name of Member (client receiving services)

_____ _____

Agency Staff Member Signature Date

* = Required Field

SmartCareMCO New Member Enrollment/ClientID Request Form

*OhioMHAS Board Consortium | ClientID No. | *Form Type

Provider Information

*Submitting Provider | *UPI | Requested Date | *Fax No. | *Phone No.

Client Information

*First Name | Middle Name | *Last Name | Suffix

*SSN | ☐ Client doesn't have an SSN. | *DOB | *Sex | *Primary Language

*Ethnicity

*Race ("X" all that apply)

☐ White ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☐ Asian ☐ Client Refused/Doesn't Know

*Marital Status

Residency and Contact Information

*Address 1 | Address 2

*City | *State | *ZIP | *County of Residence | *County of Financial Responsibility

Primary Phone No. | Secondary Phone No. | Aff. Code | Aff. Code Start Date | Aff. Code End Date

Additional Information

Gender Identity | Sexual Orientation | Amish/Hutterite/Mennonite ("X" if yes) ☐ | IDAT Funding (House Bill 131) ◯ Yes ◯ No ◯ N/A

Coverage and Financial Information

*Effective Date | *Household Size | *Adjusted Gross Monthly Income | Medicaid ID | Medicaid Managed Care Plan

Verifications

1.) *Disclosure of enrollment? ◯ Yes ◯ No

2.) *All applicable authorizations for billing as required by Federal and State laws have been received? ◯ Yes ◯ No

3.) *In crisis at enrollment? ◯ Yes ◯ No

4.) Client is potentially SPMI/SED? ◯ Yes ◯ No ◯ N/A

5.) Residency verification form signed? ◯ Yes ◯ No ◯ N/A

6.) Proof of household income? ◯ Yes ◯ No ◯ N/A

7.) Proof of identity? ◯ Yes ◯ No ◯ N/A

Prohibition on Redisclosure:
42 CFR Part 2 prohibits unauthorized disclosure of these records.

Items Completed by Enrollment Staff

Client Copay | Client Plan | Staff Entering Data | Date Entered

Version 1.3

Verification of Guardianship

I, _____, attest that I am the legal guardian of
Printed Name

_____.
Printed Name of Client

Please indicate Relationship to Client _____

_____ _____

Guardian Signature Date

_____ _____

Cadence Care Network Staff / Witness Signature Date

RELEASE OF INFORMATION
FOR
PARTNERSOLUTIONS HEALTH INFORMATICS CONSORTIUM (PSHIC)

*I,*_____*authorize* _____
(Name of Client) ***(Agency Name)***
*and the other members of the PartnerSolutions Health Informatics Consortium**, as listed on the back of this form,** to communicate with and disclose to one another the following information about me:*

- *My name, contact information and other personal identifying information*
- *My status as a services recipient*
- *Initial and subsequent evaluations of my service needs*
- *Medications and allergies*
- *My treatment history, including mental health and alcohol/drug services*
- *Discharge plans and outcomes*
- *Enrollment, eligibility and payment information*

The purposes of this exchange of information is to enable the members of PSHIC to better evaluate my need for services, to enable the coordination of services provided to me, to allow for billing and payment of those services and to enhance the care that I receive. All disclosures will be limited to the information necessary to fulfill these purposes.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), CFR Parts 160 & 164, and cannot be re-disclosed to a third party without my written authorization unless permitted by the regulations. I also understand that my mental health treatment records are protected by HIPAA but if the recipient of my information is not subject to HIPAA, they may no longer be protected by state or federal law and therefore subject to re-disclosure by a third party.

I understand that this release takes effect upon signature and that I may revoke this authorization at any time, except to the extent that the entity(ies) authorization to make the disclosure has taken action in reliance on it. In any event this authorization expires automatically when I am no longer receiving services from any member of PSHIC and no longer have an active case record.

I understand that I may refuse to sign this authorization, if it is for purposes other than alcohol and/or drug treatment and payment for that treatment, and that my refusal to sign it for other purposes will not otherwise affect my ability to obtain treatment, my eligibility for benefits, or the payment provided for those services. I understand that refusing to sign this form does not prohibit disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.

_____ _____ _____
Signature of Client/Legal Representative *Date* *Client Date of Birth*

_____
Printed Name and Authority of Person Signing on Behalf of Client (if applicable)

NOTICE TO RECIPIENTS OF ALCOHOL AND/OR DRUG TREATMENT INFORMATION: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2).

MEMBERS OF THE PARTNERSOLUTIONS HEALTH INFORMATICS CONSORTIUM

ASHTABULA COUNTY:

- **Ashtabula County Mental Health and Recovery Services Board -** 4817 State Road, Suite 203, Ashtabula, Ohio 44004
- **Lake Area Recovery Center-** 2801 C Court, Ashtabula, Ohio 44004

FRANKLIN COUNTY:

- **Chrysalis Health Ohio** - 5250 Strawberry Farms Blvd, Columbus, Ohio 43230

JEFFERSON COUNTY:

- **Chrysalis Health Ohio -** 1 Ross Park Blvd - Suite 201 Steubenville, Ohio 43952

MONTGOMERY COUNTY:

- **ADAMHS Board for Montgomery County -** 409 E. Monument Avenue, Suite 102, Dayton, OH 45402
- **Nova Behavioral Health, Inc. -** 732 Beckman Street, Dayton, Ohio 45410
- **PLACES Inc. -** 11 West Monument Ave, 7th Floor, Dayton, OH 45402

PORTAGE COUNTY:

- **Mental Health & Recovery Board of Portage County -** 155 E. Main Street, PO Box 743, Kent, Ohio 44240
- **Children's Advantage -** 520 North Chestnut Street, Ravenna, Ohio 44266
- **Townhall II -** 155 N Water St, Kent, Ohio 44240

STARK COUNTY:

- **Stark County Mental Health & Addiction Recovery -** 121 Cleveland Avenue SW, Canton, Ohio 44702
- **Child and Adolescent Behavioral Health -** 919 Second Street NE, Canton, Ohio 44704
- **CommQuest Services, Inc. -** 625 Cleveland Avenue NW, Canton, Ohio 44702
- **Stark County TASC -** 1375 Raff Road SW, Canton, Ohio 44710

TRUMBULL:

- **Trumbull County Mental Health and Recovery Board -** 4076 Youngstown Road SE, Suite 201, Warren, Ohio 44484
- **Cadence Care Network -** 165 E. Park Avenue, Niles, Ohio 44446

WAYNE/HOLMES COUNTIES:

- **Mental Health & Recovery Board of Wayne & Holmes Counties -** 1985 Eagle Pass Drive, Wooster, Ohio 44691
- **Anazao Community Partners -** 2587 Back Orrville Road, Wooster, Ohio 44691

Consent for Telehealth Mental Health Services at Cadence Care Network

Telehealth is the provision of treatment services using telecommunication and electronic technologies in which the client and the treatment clinician and/or prescriber are physically located in two different locations. You and the clinician and/or prescriber will conduct the treatment appointment via a pre-determined agency approved form of audio-visual technology.

Telehealth services at Cadence Care Network were developed to reduce barriers to accessing mental health services and pharmacological management. Telehealth can be beneficial to clients who are unable to come to a physical office on a regular basis or during times of weather or health emergencies that make it a challenge for clinicians and/or prescribers to safely conduct treatment services in the client's home or office setting.

Telehealth offered by Cadence Care Network is voluntary and may be ended by you at any time. Confidentiality is extremely important to us. Information that you reveal during treatment will be kept strictly confidential. The laws that protect the confidentiality of your personal information, such as HIPAA, also apply to telehealth at Cadence Care Network. There are exceptions to confidentiality, including the following:

- If you disclose your intention to inflict physical harm to yourself or another person
- If you disclose that physical or sexual abuse or serious neglect of a minor child has occurred
- If you disclose that neglect or physical abuse of an animal has occurred
- If we receive a signed, valid court order requesting records

There are risks of telehealth including, but not limited to, the possibility that despite reasonable efforts on the part of Cadence Care Network that: the transmission of your information could be disrupted or distorted by technical failures; the transmission of your information could be interrupted by unauthorized persons; and/or the electronic storage of your medical information could be accessed by unauthorized persons. If the session is disrupted by a technology issue, please be aware that your clinician and/or prescriber will attempt to reach out to you to resume the session. If they are unable to reconnect within 10 minutes, the clinician and/or prescriber will send you communication via email or text or call (with your prior consent) to review the session and schedule the next session.

At times, telehealth might not be as effective as face-to-face services. If a Cadence Care Network clinician or prescriber believes you would be better served by face-to-face services, the clinician or prescriber will discuss a plan with you to best meet your treatment needs.

Telehealth sessions are a lot like in-person sessions. Your clinician or prescriber will conduct themselves in a professional manner. They will be on time and conduct the session from a secure and private location. We kindly request that you also be on time for your appointment and actively participate in the session. We also ask that you conduct the session in a quiet setting with a secure internet connection and where you have privacy and confidentiality. If needed, you agree to any safety planning the clinician and/or prescriber may need to utilize during the session and that you will cooperate with any directives given by your clinician or prescriber should the need arise.

My signature below represents that I have read this consent form, been given the opportunity to ask questions about the form, telehealth, and that I consent to telehealth services at Cadence Care Network.

Client Name: _____

Client/Guardian Signature: _____ **Date:** _____

Payment and Billing Acknowledgement Form

We are committed to providing you with quality and affordable health care. Please read below, ask us any questions you may have, and sign in the space provided. A copy will be provided to you **upon request**.

1. **Insurance.** We participate in most insurance plans. **Please contact your insurance company with any questions you may have regarding your coverage**.

2. **Co-payments and deductibles.** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Proof of insurance.** We must obtain a copy of your current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

4. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 30 days, the balance will automatically be billed to you.

5. **Nonpayment**. If your account has been sent up to two billing statements without payment, you will receive a phone call from our billing department stating you have an overdue balance. We will give you the option to make your payment in full or set up a monthly payment plan. If you choose not to pay in full or set up a payment plan you will receive a 10-day letter stating, you have 10 days to pay your outstanding balance. You will also be given the names of other local agencies to seek medical care. If payment is not received within 10 business days, we will refer your account to a collection agency and you, or your child will be immediately discharged.

6. **Uninsured patients.** This agency serves all patients regardless of ability to pay. Discounts for essential services are offered based on family size and income. For more information, ask the front desk about our sliding scale fee schedule.

7. **Usual Customary Charge.**
   Mental Health Assessment: $150.00
   Psychotherapy (Individual, Family, or Crisis): $72.41-$190.00
   Group Psychotherapy: $29.20
   Community Psychiatric Supportive Treatment Group: $35.96/hour
   Intensive Home-Based Treatment: $133.04/hour
   Therapeutic Behavioral Services: $107.80-$154.40/hour
   Therapeutic Behavioral Services Group: $26.96-$29.48/hour
   Community Psychiatric Supportive Treatment: $78.16/hour
   Child and Adolescent Needs and Strengths Assessment (CANS): $98.31-$112.86
   Behavioral Health Respite: $21.45/1-3 hours $257.50/3+ hours
   New Patient Office Visit (Pharmacological Management) 99202-99205: $124.71 to $348.96
   Established Patient Office Visit (Pharmacological Management) 99211-99215: $32.86 to $243.26

8. **Discharge from the agency**: **We have the right to discharge a client for consistent missed, no show or late appointments; delayed or no payment to an account; an account in collections and/or noncompliance.**

Our prices are representative of the usual and customary charges for our area. Please let us know if you have any questions or concerns.

I have read, understand, and agree to make the appropriate co-payment prior to services rendered. In the case that my insurance coverage is inadequate or inactive at the time of service, I understand that I am personally responsible for any balance due as a result of services I have received.

_____	_____	_____
Client name	**Signature of patient or guardian**	**Date**

Ohio Mental Health Consumer Outcomes System
Ohio Youth Problem, Functioning, and Satisfaction Scales

P

Parent Rating – Short Form

Child's Name: _____ Date: _____ Child's Grade: ____ ID#: _____ Completed by Agency

Child's Date of Birth: _____ Child's Sex: ❑ Male ❑ Female Child's Race: _____

Form Completed By: ❑ Mother ❑ Father ❑ Step-mother ❑ Step-father ❑ Other: _____

Instructions: Please rate the degree to which your child has experienced the following problems in the past 30 days.	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

(Add ratings together) Total _____

Instructions: Please circle your response to each question.

1. Overall, how satisfied are you with your relationship with your child right now?
    1. Extremely satisfied
    2. Moderately satisfied
    3. Somewhat satisfied
    4. Somewhat dissatisfied
    5. Moderately dissatisfied
    6. Extremely dissatisfied
2. How capable of dealing with your child's problems do you feel right now?
    1. Extremely capable
    2. Moderately capable
    3. Somewhat capable
    4. Somewhat incapable
    5. Moderately incapable
    6. Extremely incapable
3. How much stress or pressure is in your life right now?
    1. Very little
    2. Some
    3. Quite a bit
    4. A moderate amount
    5. A great deal
    6. Unbearable amounts
4. How optimistic are you about your child's future right now?
    1. The future looks very bright
    2. The future looks somewhat bright
    3. The future looks OK
    4. The future looks both good and bad
    5. The future looks bad
    6. The future looks very bad

Total: _____

Instructions: Please circle your response to each question.

1. How satisfied are you with the mental health services your child has received so far?
    1. Extremely satisfied
    2. Moderately satisfied
    3. Somewhat satisfied
    4. Somewhat dissatisfied
    5. Moderately dissatisfied
    6. Extremely dissatisfied
2. To what degree have you been included in the treatment planning process for your child?
    1. A great deal
    2. Moderately
    3. Quite a bit
    4. Somewhat
    5. A little
    6. Not at all
3. Mental health workers involved in my case listen to and value my ideas about treatment planning for my child.
    1. A great deal
    2. Moderately
    3. Quite a bit
    4. Somewhat
    5. A little
    6. Not at all
4. To what extent does your child's treatment plan include your ideas about your child's treatment needs?
    1. A great deal
    2. Moderately
    3. Quite a bit
    4. Somewhat
    5. A little
    6. Not at all

Total: _____

Instructions: Please rate the degree to which your child's problems affect his or her current ability in everyday activities. Consider your child's current level of functioning.	Extreme Troubles	Quite a Few Troubles	Some Troubles	OK	Doing Very Well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

 January 2000 (Parent-2)

(Add ratings together) Total _____

Ohio Mental Health Consumer Outcomes System
Ohio Youth Problem, Functioning, and Satisfaction Scales

Y

Youth Rating – Short Form (Ages 12-18)

Name: _____ Date: _____ Grade: _____ ID#: _____
Completed by Agency

Date of Birth: _____ Sex: ❑ Male ❑ Female Race: _____

Instructions: Please rate the degree to which you have experienced the following problems in the past 30 days.	**Not at All**	**Once or Twice**	**Several Times**	**Often**	**Most of the Time**	**All of the Time**
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

(Add ratings together) Total _____

Instructions: Please circle your response to each question.

1. Overall, how satisfied are you with your life right now?
    1. Extremely satisfied
    2. Moderately satisfied
    3. Somewhat satisfied
    4. Somewhat dissatisfied
    5. Moderately dissatisfied
    6. Extremely dissatisfied
2. How energetic and healthy do you feel right now?
    1. Extremely healthy
    2. Moderately healthy
    3. Somewhat healthy
    4. Somewhat unhealthy
    5. Moderately unhealthy
    6. Extremely unhealthy
3. How much stress or pressure is in your life right now?
    1. Very little stress
    2. Some stress
    3. Quite a bit of stress
    4. A moderate amount of stress
    5. A great deal of stress
    6. Unbearable amounts of stress
4. How optimistic are you about the future?
    1. The future looks very bright
    2. The future looks somewhat bright
    3. The future looks OK
    4. The future looks both good and bad
    5. The future looks bad
    6. The future looks very bad

Total: _____

Instructions: Please circle your response to each question.

1. How satisfied are you with the mental health services you have received so far?
    1. Extremely satisfied
    2. Moderately satisfied
    3. Somewhat satisfied
    4. Somewhat dissatisfied
    5. Moderately dissatisfied
    6. Extremely dissatisfied
2. How much are you included in deciding your treatment?
    1. A great deal
    2. Moderately
    3. Quite a bit
    4. Somewhat
    5. A little
    6. Not at all
3. Mental health workers involved in my case listen to me and know what I want.
    1. A great deal
    2. Moderately
    3. Quite a bit
    4. Somewhat
    5. A little
    6. Not at all
4. I have a lot of say about what happens in my treatment.
    1. A great deal
    2. Moderately
    3. Quite a bit
    4. Somewhat
    5. A little
    6. Not at all

Total: _____

Instructions: Below are some ways your problems might get in the way of your ability to do everyday activities. Read each item and circle the number that best describes your current situation.	**Extreme Troubles**	**Quite a Few Troubles**	**Some Troubles**	**OK**	**Doing Very Well**
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

(Add ratings together) Total _____

CLIENT NAME: **MRN:**
COMPLETED BY: **DATE:**

TRANSITIONAL AGED YOUTH OUTCOME MEASUREMENT (Ages: 14-24)

5 = Functioning very well. 4 = Functioning well. 3= Neither functioning well nor poorly.
2 = Functioning poorly. 1= Functioning very poorly

OUTCOME CATEGORY	Score
EMPLOYMENT	
Employment/ Skills Progress: Examples: makes progress in learning employment skills; Applies work skills; Considered to be a good worker; Follows instructions; Asks for clarification or guidance as needed; Completes task accurately and on-time; considered to be a good team member or leader; Recognizes others for their contributions; Received recognition for work performance.	
Employability Norms: Examples: Meets behavioral norms (e.g., arrives on time, comes in on scheduled work days, is prepared for work with appropriate materials and equipment); Meets social expectations of the work place (e.g., interacts in respectful ways with co-workers, customers, and supervisors); Takes responsibility for his/her mistakes and quality products/services.	
EDUCATION	
Academic Skills/Progress: Examples: Learns academic and/or vocational/technical skills; Applies skills in classroom and /or in relevant work/community settings; Uses good study skills; Completes assignments on time; Maintains passing grades; Makes Academic Achievement Lists; Seeks assistance with studies as needed (e.g., meets with instructor or secures tutorial services as needed; Participates in class and group activities; Advances to next grade level or course level; Passes standardized proficiency exams.	
Educational Norms: Examples: Meets behavioral norms of school setting (e.g., arrives on time, attends classes regularly); Has access to relevant supplies, books, materials, and equipment for course of study; Meets social expectations of the school setting (e.g., interacts in respectful ways with other students and instructors); Takes responsibility for his/her mistakes and quality of completed assignments or tasks.	
SHELTER/HOUSING	
Independent Living Skills/Progress: Examples: Learning how to budget effectively; Can make good choices; Applies decision making skills to real life situations; Seeks assistance from mentors or reliable adults when necessary; Participates in programs to strengthen independent living skills; Takes responsibility for his/her mistakes and quality of completed tasks.	
Housing Norms: Examples: Has stable housing arrangements; Budgets wisely for shelter needs; Takes care of housing chores on a timely basis; Has access to needed supplies; Meets social expectations of the housing setting (e.g., interacts well with others, abides by established rules for the setting), Plans for potential changes in housing.	
EMOTIONAL AND BEHAVIORAL WELL-BEING	

Emotional and Behavioral Skills/Progress: Examples: Learn skills to demonstrate appropriate emotional and behavioral regulation; Apply skills in school, home and community settings; Learn skills to make good decisions; Learn skills to resolve conflicts; Participate in programs and services that develop these skills; Seeks assistance with these skills as needed (e.g., meet with your counselor/CPST to work on these skills); Participate in group activities: Show progress over time; Use community support as necessary.	
Well-Being Norms: Examples: Demonstrates appropriate emotional responses (e.g., does not overreact or dramatize responses; Has appropriate mentors and responsible adults in place and uses their advice to help work through situations that occur (interacts appropriately in difficult situations); Makes good decisions; Maintains stability in all other dimensions; Does not abuse substances; Takes medication as prescribed; Takes responsibility for his/her mistakes.	
Healthy Lifestyle Norms: Examples: Maintains balanced diet (e.g., includes vegetables and fruit), regular exercise, and sleep; Does not smoke; Uses good dental hygiene; Recognizes when to go to the health department or seek services for medical, psychological, sight, pregnancy, hearing, or dental care; can describe to relevant personnel his/her medical/psychological/behavioral service needs as necessary.	
Medication Norms: Participates in deciding about needs for and/or use of medications including over-the-counter and prescription medications; Successfully self –manages use of prescribed medications; Uses medications as prescribed (e.g., avoid combining with alcohol); Understands and reports side-effects; Has a goal to use minimal but effective medication as negotiated with the physician.	
COMMUNITY LIFE FUNCTIONING	
Community Life/Skills Progress: Examples: Learning how to function independently; Makes good use of idle time; participates with others when needed; Developing relationship skills with family, friends, and in social settings; Participates in activities that contribute to a sense of self identity (e.g., spiritual, social, family, ethnic activities); Developing skills or a means of mobility within the community.	
Engagement in Leisure Time Activity Norms: Examples: Entertains one's self through reading, hobbies, exercise, meditation, video games, etc.; Participates with others in mutually interesting activities; Spends special holidays or birthdays with family and/or friends; Enjoys a range of leisure-time activities.	
Active Participant Norms: Examples: Participates in school clubs or community, religious, or recreational groups that seem engaging and satisfying, volunteers at school, church, or a community service organization.	
Cultural/Spiritual Identity Norms: Examples: Participates with family members, friends, or a community of others to have a sense of his/her culture/ethnic background and/or religious/spiritual orientation.	
Community Mobility Norms: Examples: Has means to get around the community (e.g., walking, bicycling, public transportation, own motor cycle, car, rides with friends, family) to access job/school, friends, interesting events, social functions, and necessary appointments or for access needed resources.	
GRAND TOTAL OF FUNCTIONING RATING:	