Name: _____ Date: _____

Address: _____ City/Zip: _____

DOB: _____ Age: _____ Gender: ☐ M ☐ F

Social Security Number: _____ Race: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Parent /Guardian Name: _____ DOB: _____

Relationship to client _____ Gender: ☐ M ☐ F

Email: _____

Other Parent /Guardian Name: _____ DOB: _____

Relationship to client _____ Gender: ☐ M ☐ F

Home Phone: _____ Permission to contact/confirm at this #: ☐ Yes ☐ No

Cell Phone: _____ Permission to contact/confirm at this #: ☐ Yes ☐ No

Client school and grade (if applicable): _____ Medical Dr _____

Previous Mental Health Provider and diagnosis (if known): _____

Currently on probation ☐ Yes ☐ No If yes, Name of P.O. _____

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: _____

Medicaid MMIS # (if applicable): _____

Additional Insurance Name: _____

Guarantor (Policy Holder): _____

Guarantor DOB & SS# _____

Acknowledgment of Receipt of Cadence Care Network Handouts

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
☐	_____	Trumbull County Privacy Notice (pertains only to Trumbull County Residents)

_____ _____

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.

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 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

PartnerSolutions
Health Informatics

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 his 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: 42 CFR part 2 prohibits unauthorized disclosure of these records.

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, Ohio 45402
- **Addiction Services -** 1 Elizabeth Place SE 3rd Floor, Dayton, Ohio 45417
- **Nova Behavioral Health, Inc. -** 732 Beckman Street, Dayton, Ohio 45410
- **PLACES Inc. -** 11 West Monument Ave, 7th Floor, Dayton, Ohio 45402
- **Project Cure, Inc. -** 200 Daruma Parkway, Moraine, Ohio 45439

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 -** 624 Market Ave North, 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 are physically located in two different locations. You and the clinician 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. 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 to safely conduct treatment services in the client's home.

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 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 will attempt to reach out to you to resume the session. If they are unable to reconnect within 10 minutes, the clinician 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 believes you would be better served by face-to-face services, the clinician will discuss a plan with you to best meet your treatment needs.

Telehealth sessions are a lot like in-person sessions. Your clinician 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 may need to utilize during the session and that you will cooperate with any directives given by your clinician 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

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**

Client Name: _____ MRN: _____ Date: _____

Client Age at time of questionnaire: _____

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**…Swear at you, insult you, put you down, or humiliate you? **Or** Act in a way that made you afraid that you might be physically hurt?
Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often or very often**…Push, grab, slap, or throw something at you? **Or Ever** hit you so hard that you had marks or were injured?
Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…Touch or fondle you or have you touch their body in a sexual way? **Or** Attempt or actually have oral, anal, or vaginal intercourse with you?
Yes No If yes enter 1 _____

4. Did you **often or very often** feel that … No one in your family loved you or thought you were important or special? **Or** Your family didn't look out for each other, feel close to each other, or support each other?
Yes No If yes enter 1 _____

5. Did you **often or very often** feel that …You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **Or** Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced? Yes No If yes enter 1 _____

7. Was your mother or stepmother: **Often or very often** pushed, grabbed, slapped, or had something thrown at her? **Or Sometimes, often, or very often** kicked, bitten, hit with a fist, or hit with something hard? **Or Ever** repeatedly hit at least a few minutes or threatened with a gun or knife?
Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
Yes No If yes enter 1 _____

10. Did a household member go to prison?
Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

The Centers for Disease Control and Prevention (CDC) hosts the official website for information about the ACE Study, including the original ACE Study questionnaires and articles resulting from the Study. In 2007, responding to popular demand for a condensed version of the original questionnaires, Dr. Anda created an ACE Score Calculator 10-qacecalc.pdf which allows individuals to calculate their own ACE Scores, based on the original scoring criteria of the ACE Study. To use this survey, add up all of the YES responses. The sum is the ACE Score. The ACE Score can range from "0", meaning no exposure to the ten categories of child abuse and trauma investigated by the Study, to "10", meaning exposure to all ten categories. The Study found the higher the ACE Score, the greater the risk of experiencing poor physical and mental health, and negative social consequences later in life. NOTE: Sometimes people take exception to the phrasing of questions 3, 6, and 7, arguing that sexual assault by anyone of any age is traumatic, that the death of a parent should be included, and that both males and females can be victims of domestic violence. If, when taking the survey, you prefer to modify the questions to allow for these factors, feel free to do so. Cadence Care Network is gathering this information to help better inform your mental health treatment.

Ohio Mental Health Consumer Outcomes System
Adult Consumer Form A

A

Today's Date ___ ___/___ ___/___ ___ ___ ___

Name _____

Date of Birth ___ ___/___ ___/___ ___ ___ ___

Gender (check one): Male ☐ Female ☐

Agency Use Only

Client's Medical Record Number:

_____

We are very interested in how you are doing, and how our services may or may not be helping you. Please answer all of the questions below, then give the questionnaire to your case manager or another staff person at the mental health agency.

Part 1

Below are some questions about how satisfied you are with various aspects of your life in ***the past 6 months***. For each question, checkmark ☑ the answer that best describes how you feel.

How do you feel about:

1. The amount of friendship in your life?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased

2. The amount of money you get?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased

3. How comfortable and well-off you are financially?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased

4. How much money you have to spend for fun?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased

5. The amount of meaningful activity in your life (such as work, school, volunteer activity, leisure activity)?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased

6. The amount of freedom you have?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased

7. The way you and your family act toward each other?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased
- ☐ Does not apply

Please turn to the next page ⟶

8. Your personal safety?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased

9. The neighborhood in which you live?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased

10. Your housing/living arrangements?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased

11. Your health in general?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased

12. How often do you have the opportunity to spend time with people you really like?

- ☐ Never
- ☐ Seldom/rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

Part 2

These next few items ask you about your health and medications ***within the past 6 months***.

13. How often does your physical condition interfere with your day-to-day functioning?

- ☐ Never
- ☐ Seldom/rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

14. Concerns about my medications (such as side effects, dosage, type of medication) are addressed:

- ☐ Never
- ☐ Seldom/rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always
- ☐ Not applicable/no medications

The next two items deal with how you have been treated by other people.

---

15. I have been treated with dignity and respect at this agency.

- ☐ Never
- ☐ Seldom/rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

16. How often do you feel threatened by people's reactions to your mental health problems?

- ☐ Never
- ☐ Seldom/rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

Part 3

The following questions ask you about how much you were distressed or bothered by some things ***during the last seven days.*** Please mark the answer that best describes how you feel.

During the past 7 days, about how much were you distressed or bothered by:

17. Nervousness or shakiness inside

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

18. Being suddenly scared for no reason

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

19. Feeling fearful

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

20. Feeling tense or keyed up

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

21. Spells of terror or panic

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

22. Feeling so restless you couldn't sit still

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

23. Heavy feelings in arms or legs

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

24. Feeling afraid to go out of your home alone

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

25. Feeling of worthlessness

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

26. Feeling lonely even when you are with people

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

27. Feeling weak in parts of your body

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

28. Feeling blue

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

29. Feeling lonely

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

30. Feeling no interest in things

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

31. Feeling afraid in open spaces or on the streets

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

32. How often can you tell when mental or emotional problems are about to occur?

- ☐ Never
- ☐ Seldom/rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

33. When you can tell, how often can you take care of the problems before they become worse?

- ☐ Never
- ☐ Seldom/rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

Part 4

Below are several statements relating to one's view about life and having to make decisions. Please check the response that is closest to how you feel about the statement. Check the word or words that best describes how you feel now.

34. I can pretty much determine what will happen in my life.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

35. People are limited only by what they think is possible.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

36. People have more power if they join together as a group.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

37. Getting angry about something never helps.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

38. I have a positive attitude toward myself.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

39. I am usually confident about the decisions I make.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

40. People have no right to get angry just because they don't like something.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

41. Most of the misfortunes in my life were due to bad luck.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

42. I see myself as a capable person.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

43. Making waves never gets you anywhere.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

44. People working together can have an effect on their community.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

45. I am often able to overcome barriers.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

46. I am generally optimistic about the future.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

47. When I make plans, I am almost certain to make them work.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

48. Getting angry about something is often the first step toward changing it.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

49. Usually I feel alone.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

50. Experts are in the best position to decide what people should do or learn.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

51. I am able to do things as well as most other people.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

52. I generally accomplish what I set out to do.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

53. People should try to live their lives the way they want to.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

54. You can't fight city hall (authority).

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

55. I feel powerless most of the time.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

56. When I am unsure about something, I usually go along with the rest of the group.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

57. I feel I am a person of worth, at least on an equal basis with others.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

58. People have a right to make their own decisions, even if they are bad ones.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

59. I feel I have a number of good qualities.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

60. Very often a problem can be solved by taking action.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

61. Working with others in my community can help to change things for the better.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

Part 5

Please tell us some things about yourself.

62. What was the last school grade you completed?

- ☐ Less than 1st grade
- ☐ 1st grade
- ☐ 2nd grade
- ☐ 3rd grade
- ☐ 4th grade
- ☐ 5th grade
- ☐ 6th grade
- ☐ 7th grade
- ☐ 8th grade
- ☐ 9th grade
- ☐ 10th grade
- ☐ 11th grade
- ☐ High school diploma/GED
- ☐ Trade/Tech school
- ☐ Some college
- ☐ 2 yr college/Associate degree
- ☐ 4 yr college/Undergraduate degree
- ☐ Graduate school courses
- ☐ Graduate degree
- ☐ Post-graduate studies
- ☐ Further special studies

63. Race (check all that apply):

- ☐ White
- ☐ Native American/Pacific Islander
- ☐ Black/African-American
- ☐ Hispanic/Latino
- ☐ Asian
- ☐ Other_____

64. What is your marital status?

- ☐ Never married
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Living together

65. What is your current living situation?

- ☐ Your own house/apartment
- ☐ Friend's home
- ☐ Relative's home
- ☐ Supervised group living
- ☐ Supervised apartment
- ☐ Boarding home
- ☐ Crisis residential
- ☐ Child foster care
- ☐ Adult foster care
- ☐ Intermediate care facility
- ☐ Skilled nursing facility
- ☐ Respite care
- ☐ MR intermediate care facility
- ☐ Licensed MR facility
- ☐ State MR institution
- ☐ State MH institution
- ☐ Hospital
- ☐ Correctional facility
- ☐ Homeless
- ☐ Rest home
- ☐ Other_____

66. What is your employment status?

- ☐ Employed full time
- ☐ Employed part time
- ☐ Sheltered employment
- ☐ Unemployed
- ☐ Homemaker
- ☐ Retired
- ☐ Disabled
- ☐ Inmate of institution

67. Are you in treatment because you want to be?

- ☐ Yes
- ☐ No

Please stop here. Thanks!!