Print Form

DELAWARE DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

Annual Consumer Reporting Form

(SELECT MODALITY)

[ ] **MH** MENTAL HEALTH
[ ] **DU** CO - OCCURRING (MH & AD)

Last Name _____

First Name _____ M.I. _____

STREET *(Optional)* _____

CITY *(Optional)* _____ STATE *(Optional)* _____

ZIP (Optional) [ ][ ][ ][ ][ ] - [ ][ ][ ][ ]

COUNTY *(Optional)* [ ]

HOME TELEPHONE (Optional) ([ ][ ][ ]) [ ][ ][ ] - [ ][ ][ ][ ]

Treatment Unit Name _____

Treatment Unit ID # [ ][ ][ ][ ][ ][ ] - [ ][ ]

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

Homeless At Any Time During The Past 12 Months?

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

Housing Subsidy

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

Regular Place to Live

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

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

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

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

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

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

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 Commericial
[ ] **O** Other
[ ] **N** None
[ ] **U** Unknown

Consumer's Primary Paid Employment Type: Select one.

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

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

[ ][ ][ ] **(Max. 168 Hrs)**

Number Of Arrests Past 30 Days

[ ][ ]

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

Conusmer's Gross Income Per Year

$ [ ][ ][ ] , [ ][ ][ ]

Number Dependent On Consumer's Income Write In Number (00 - 20)

[ ][ ] **97** Unknown

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 Unknown

DELAWARE DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

Annual Consumer Reporting Form

MCI # 0 0 0

TREATMENT UNIT ID # -

Currently Pregnant

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

Injection Drug Use Ever

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

Current Legal Involvement

[ ] **CP** Charges Pending
[ ] **SP** Convicted - Sentence Pending
[ ] **UP** Sentenced - Unsupervised Probation (SENTAC I)
[ ] **FS** Sentenced - Field Supervision (SENTAC II)
[ ] **IS** Sentenced - Intense Supervision (SENTAC III)
[ ] **QI** Sentenced - QUASI-Incarceration (SENTAC IV)
[ ] **CJ** Sentenced - Prison-Corrections-Jail (SENTAC V)
[ ] **HX** History Of Legal Involvement But Not Current
[ ] **N** No Current Involvement Or History
[ ] **U** Unknown

SUBSTANCE ABUSE DRUG CODES
(*Select all that apply*)

[ ] CODEINE
[ ] PROPOXYPHENE (DARVON)
[ ] OXYCODONE (OXYCONTIN)
[ ] MEPHRIDINE (DEMEROL)
[ ] HYDROMORPHONE (DILAUDID)
[ ] BUTORPHANOL (STADOL)
[ ] PENTAZOCINE (TALWIN)
[ ] HYDROCODONE (VICODIN)
[ ] TRAMADOL (ULTRAM)
[ ] BUPRENOPHINE (SUBUTEX, SUBOXON

Alcohol & Drug Use Matrix	Primary	Secondary	Tertiary
Substance Type			
Frequency Of Use			
Route Of Administration			
Age Of First Use			

Frequency Of Use

N No Use In Past Month
I Infrequent (1-3 Times Past Month)
O Often (1-2 TIimes Per Week)
F Frequently (3-6 Times Per Week)
D Daily
M More Than Twice Daily
U Unknown

Substance Type Codes To Use In Box Above

AL Alcohol
CO Cocaine
CR Crack
ME Methamphethamines
AM Other Amphetamines
OS Other Stimulants
HE Heroin
OP Other Opiates & Synthetics
MD Non-Prescription Methadone
BA Barbiturates
SE Other Sedatives Or Hypnotics
BE Benzodiazepines
TR Major Tranquilizers
CS Cough Syrups And Mixtures
MA Marijuana-Hashish
PC PCP
LS LSD
HA Other Hallucinogens
IN Inhalants
ST Steroids
OC Over-The-Counter Drugs
O Other
N None
U Unknown

Route Of Administration

M By Mouth (Swallow)
S Smoke
B Breath-Inhale-Snort
V Intravenous
I Other Injection
O Other
N None
U Unknown

CSI - Completed (Co-Occurring Screening Instrument)

[ ] **Y** Yes
[ ] **N** No
[ ] **NT** Not Applicable

Screened positive for Co-occurring Disorders

[ ] **Y** Yes
[ ] **N** No
[ ] **NT** Not Applicable

Signature

/ /

DATE

DIAGNOSIS

Consumer's Name _____ Last _____ First _____ M.I.

MCI # 0 0 0

TREATMENT UNIT ID # -

DIAGNOSTIC CODE

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Physician Formulating/Confirming Diagnosis

_____
Print Full Name

Physician Identification Number

_____
Signature

/ /
M M D D Y Y