|  |  |  |  |
| --- | --- | --- | --- |
|  | Massachusetts Department of Public Health Logo | **Enrollment Assessment*****Standard*** | ⯈***Enrollment Date: / /****mm dd yyyy* |
| ⯈***ESM Client ID:*** |
|  ***Provider ID:*** |
|  ***Questions (Q) marked with* ⯈ *must be completed. Boxes marked with* 🟋 *= Refer to Key at end of form***  |
|   **First Name: Middle Initial: Last Name: *Suffix:*** |
| ⯈ |  **1. Client Code:**  |  | ⯈ **2. Intake/Clinician Initials:** |   |
| ⯈ |  **3. Do you own or rent a house, apartment, or room?** Yes No  *If the answer to Q3 is Yes, skip to Q5* |
|  |  **4. Are you Chronically Homeless?***(HUD Definition in Manual)* | Yes No  | ⯈ **5. ZIP Code of Last Permanent Address:** *Do* ***Not*** *enter zip code of Program.*  |
| ⯈ |  **6. Where did you stay last night?**  |
|  | 1 Emergency shelter |  7 Jail, prison or juvenile detention facility | 13 Foster care home or foster care group hm |
|  | 2 Transitional housing for homeless persons |  8 Room, apartment, or house that you own or rent  | 14 Place not meant for habitation |
|  | 3 Permanent housing for formerly homeless  |  9 Staying or living with a family member | 15 Other |
|  | 4 Psychiatric hospital or other psych. facility  | 10 Staying or living with a friend | 88 Refused |
|  | 5 Substance abuse treatment facility or detox  | 11 Room, apartment, or house to which you  cannot return (future return can be uncertain) |  |
|  | 6 Hospital (non-psychiatric) | 12 Hotel or motel paid for without emergency shelter voucher  |
| ⯈ |  **7a. Do you consider yourself to be transgender?** Yes No Refused  |
|  |  **7b. If you answered Yes to Q7a, please specify:** Male to Female Female to Male Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ⯈ |  **8. Do you consider yourself to be:** Heterosexual Gay/Lesbian Bisexual Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Refused |
| ⯈ |  **9. Number of days between initial contact with program by client or someone on behalf of client and the first  available appointment or bed availability:**  *(unknown = 999) See Manual to help determine wait time.* |
| ⯈ |  **🟋** **10. Source of Referral:** |  |
| ⯈ |  **🟋** **11. Frequency of attendance at self-help programs (e.g. AA, NA) in 30 days prior to Enrollment:**  |  |
| ⯈ |  **12. Client Type** Primary Collateral  |  |
| ⯈ | **13. Additional Client Type:** *Answer Yes or No to a-i* |
|  | a. Student  | Yes No  | f. Probation  | Yes No  |
|  | b. Pregnant  | Yes No  | g. Parole  | Yes No  |
|  | c. Postpartum  | Yes No  | h. Federal Probation  | Yes No  |
|  | d. Veteran/ Any Military Service  | Yes No  | i. Federal Parole | Yes No  |
|  | e. Prison | Yes **☒**No  |  |  |
| ⯈ | **14. Do you have children?**  |  Yes No Refused  | *If ‘Yes’, complete 14a-14d. If No, skip to Q15* |
|  | **14a. Number Children Under 6:** |  | **14b. Number of Children 6-18:** |  | **14c. Children Over 18:** |  |
|  | **14d. Are any of the children of the** Native American **Indian race?** |  1Yes 2No  |

|  |  |  |
| --- | --- | --- |
| ⯈ | **15. Are you the primary caregiver for any children? MC900434741[1]** If yes, see manual. *If the client is the primary caregiver*  *of children you must assess what arrangements have been made for their care in your full clinical assessment.* |  Yes No Refused  |
| ⯈ | **16. Employment status at Enrollment:** |  **🟋** | ⯈**17. Number of days worked in the past 30 days?** |  |
| ⯈ | **18. Where do you usually live? (***Where has the client spent/slept most of the time over the last 12 months?)* |
|  | 1 House or apartment | 3 Institution | 5 Shelter/mission |  7 Foster Care |
|  | 2 Room/boarding or sober house | 4 Group home/treatment | 6 On the streets | 88 Refused |
| ⯈ | **19. Who do you live with? (***Check all that apply)*  |
|  |  Alone |  Child 6-18 |  Spouse/Equivalent |  Other Relative |
|  |  Child under 6 |  Child over 18 |  Parents |  Roommate/Friend |

**COLLATERAL CLIENTS STOP HERE**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ⯈ | **20. Use of mobility aid:** (*Check all that apply)* |  None |  Crutches |  Walker |  Manual Wheelchair |  Electric Wheelchair |
| ⯈ | **21. Vision Impairment** |  ***🟋***  |  | ⯈ | **22. Hearing Impairment**  |  ***🟋*** |   |
| ⯈ | **23. SelfCare/ADL Impairment** |  **🟋** |  | ⯈ | **24. Developmental Disability** | ***🟋*** |  |
| ⯈ | **25. Prior Mental Health Treatment**  | 0 No history  | 1 Counseling | 2 One hospitalization | 3 More than one hospitalization |
| ⯈ | **26. During the past 12 months, did you take any prescription medication that was prescribed for you to treat a mental or emotional condition?** | 1 Yes 2 No 88 Refused 99 Unknown  |
| ⯈ | **27. Number of prior admissions to each substance abuse treatment modality** *(0-5 admissions, ‘5’ = 5 or more, 99=unknown)**Do not count this tx. episode.* |
|  |   Detox |   Outpatient |   Drunk Driver |   Other |
|  |   Residential |   Opioid |   Section 35 |  |
| ⯈ | **28. Are you currently receiving Medication Assisted Treatment?** *If Yes, answer Q28a . If No, skip to Q29*  |  Yes No  |
|  | **28a. Are you receiving Methadone Treatment**  *(If Yes skip to Q29)* |  Yes No  |
|  | **28b. Are you receiving Suboxone or Vivitrol Treatment?** *Select Below* Buprenorphine (Suboxone) Extended release injectable naltrexone (Vivitrol) |  |
|  | **28c. Is your Suboxone or Vivitrol prescription for alcohol use disorder, opioid use disorder, or both?** Alcohol Use Disorder Opioid Use Disorder Both |  |
| ⯈ | **29. Currently receiving services from a state agency: (***Check all that apply) See manual for definitions* |
|  |  None |  DMH *client has* a *case mgr.* |  DTA *e.g. food stamps* |  MCDHH *services for* *Deaf and Hard of Hearing*  |
|  |  DCF *children and families*  |  DDS *developmental disabilities* |  MRC *Rehabilitation Commission* |  Other  |
|  |  DYS *youth services* |  DPH *e.g. HIV/STD; not BSAS .* |  MCB *services for the blind* |  |
| ⯈ | **30. Number of arrests in the past 30 days?**    |  | *(Section 35 is not an arrest, it is a civil commitment)* |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ⯈ | **31. History Substance Mis-use, Nicotine/Tobacco Use & Gambling***For pharmaceutical drugs prescribed for the client, only code misuse (more than the recommended dosage) or non-medical use. (Example - If the client was prescribed a benzodiazepine for a mental health disorder and used per instruction, do not list on History Table.) Note: For the safety of the client all drugs used must be recorded in the client record.(See Manual for commercial names.)* | **Have You Ever Mis-Used/Bet** | **Age of First Use/Bet** | **Last Use/Bet** | **Freq of Last Use/Bet** | **Route of Admin Code** |
|  |  | **Y** | **N** |
|  **A** | **Alcohol** *For* ***Alcohol****, enter first age of* ***intoxication*** |  |  |  |  |  |  |
|  **B** | **Cocaine** |  |  |  |  |  |  |
|  **C** | **Crack** |  |  |  |  |  |  |
|  **D** | **Marijuana / Hashish** |  |  |  |  |  |  |
|  **E** | **Heroin** |  |  |  |  |  |  |
|  **F** | **Prescribed Opiates *Misuse/non-medical use of pharmaceutical opiates which were prescribed for the client.***  |  |  |  |  |  |  |
|  **G** | **Non-prescribed Opiates*****Non-medical use*** *of pharmaceutical opiates which were not prescribed for the client* |  |  |  |  |  |  |
|  **H** | **PCP** |  |  |  |  |  |  |
|  **I** | **Other Hallucinogens** |  |  |  |  |  |  |
|  **J** | **Methamphetamine** |  |  |  |  |  |  |
|  **K** | **Other Amphetamines** |  |  |  |  |  |  |
|  **L** | **Other Stimulants** |  |  |  |  |  |  |
|  **M** | **Benzodiazepines** |  |  |  |  |  |  |
|  **N** | **Other Tranquillizers** |  |  |  |  |  |  |
|  **O** | **Barbiturates** |  |  |  |  |  |  |
|  **P** | **Other Sedatives / Hypnotics** |  |  |  |  |  |  |
|  **Q** | **Inhalants** |  |  |  |  |  |  |
|  **R** | **Over the Counter** |  |  |  |  |  |  |
|  **S** | **Club Drugs**  |  |  |  |  |  |  |
|  **U** | **Other** |  |  |  |  |  |  |
|  **V** | **Fentanyl** |  |  |  |  |  |  |
|  **X** | **Nicotine/Tobacco**  *Includes cigarettes, cigars, chewing tobacco, inhalers* |  |  |  |  |  |  |
|  **Y** | **Gambling**  *Includes any of the types listed in Q33a* |  |  |  |  |  | **N/A** |
|  **Z** | **K2/Spice or Other Synthetic Marijuana** |  |  |  |  |  |  |
|  |
|  | **32a. Number of cigarettes currently smoked per day (Indicate number of cigarettes, not number of packs: 1 pack = 20 cigarettes)** *If client uses another type of nicotine/tobacco product, mark Zero (0). Go to Q32b* *If person does not use nicotine products, skip to Q33a .*  |
|  | **32b. Interest in stopping nicotine/tobacco use at Enrollment:**  |
|  |  1No |  3Yes, Within 30 days | 88Refused  |
|  |  2Yes, Within 6 Months |  4Does Not Apply (already stopped) | 99Unknown |
|  | **33a Types of last regular gambling *(check all that apply***) *If person does not have a gambling history, skip to Q34.*  |
|  | Lottery -Scratch Tickets | Slot Machines | Sports Betting | Stock Market |
|  | Lottery - Keno  | Casino Games  | Bingo | Internet Gambling |
|  | Lottery/Numbers Games  | Card Games  | Dog/Horse Tracks, Jai Alai  |  |
|  | **33b. Have you ever thought you might have a gambling problem, or been told you might?**  Yes No Refused  |

|  |  |
| --- | --- |
|  | ***Clients must be asked if they have a secondary and/or tertiary drug of choice. Clinicians may rank substances based on their clinical opinion after review of the substance use history and not necessarily client report.****(Nicotine/Tobacco and Gambling CANNOT be marked as a primary/secondary/or tertiary drug)* |
|  | **34. Rank substances by entering corresponding letter for substances listed above in Question 31.** (*If no secondary or tertiary substance, leave blank)* |
|  | ⯈ **Primary Substance**  |  |  **Secondary Substance**  |  | **Tertiary Substance** |  |
| ⯈ | **35. Needle Use?**  | 0 Never  |  | 2 3 to 11 months ago  |  | 4 Past 30 days  |  |
|  | 1 12 or more months ago  |  | 3 1 to 2 months ago |  | 5 Last week |  |
| ⯈ | **36 Have you had any overdoses in your lifetime?\*** Yes No *(If No, Assessment is complete)* |
|  |  **36a. How many overdoses have you had in your lifetime?** *(1-99)* |  | **36b. How many overdoses have you had in past year?** *(0-99)* |  |

|  |
| --- |
| **🟋Q10. Source of Referral at Enrollment** |
| **Code** |  | **Code** | **Code** |
| 01 | Self, Family, Non-medical Professional | 20 | Health Care Professional, Hospital | 67 | Department of Corrections |
| 02 | BMC Central Intake/Room 5 | 21 | Emergency Room | 68 | Office of the Commissioner of Probation |
| 03 | ATS/Detox | 22 | HIV/AIDS Programs | 69 | Massachusetts Parole Board |
| 04 | Transitional Support Services/TSS | 23 | Needle Exchange Programs | 70 | Dept. of Youth Services |
| 05 | Clinical Stabilization Services/CSS-CMID |  | *24 through 25 Discontinued* | 71 | Dept. of Children and Families |
| 06 | Residential Treatment | 26 | Mental Health Care Professional | 72 | Dept. of Mental Health |
| 07 | Outpatient SA Counseling | 30 | School Personnel, School System/Colleges | 73 | Dept. of Developmental Services |
| 08 | **Medication Assisted Treatment** | 31 | *Recovery High School* |  | *74 through 76 Discontinued* |
| 09 | Drunk Driving Program |  | *32 through 39 Discontinued* | 77 | Mass. Rehab. Commission |
| 10 | Acupuncture | 40 | Supervisor/Employee Counselor | 78 | Mass. Commission for the Blind |
| 11 | Gambling Program |  | *41 through 49 Discontinued* | 79 | Mass. Comm. For Deaf & Hard of Hearing |
|  | *Note: Sec 35 Options are grouped although numbers are not in sequence. Select correct #* | 50 | Shelter | 80 | Other State Agency |
| 12 | Sec 35 (WATC & MATC) | 51 | Community or Religious Organization |  | *81 Discontinued* |
| 24 | Sec 35 Bridgewater MASAC |  | *52 through 58 Discontinued* | 99 | Unknown |
| 25 | Sec 35 Framingham MCI | 59 | Drug Court |  |  |
|  | *13 Discontinued* | 60 | Court - Section 35 |  |  |
| 14 | Sober House | 63 | Court - Other |  |  |
| 15 | Information and Referral | 64 | Prerelease, Legal Aid, Police |  |  |
| 17 | Second Offender Aftercare | 65 | County House of Corrections/Jail |  |  |
| 16 | *New* Recovery Support Centers | 66 | Office of Community Corrections |  |  |
| 18 | Family Intervention Program |  |  |  |  |
| 19 | Other Substance Abuse Treatment |  |  |  |  |

|  |  |
| --- | --- |
|  | **🟋Q 11 Frequency of Attendance at Self-Help Programs** |
| **Code** |  | **Code** |  |
| 01 | No attendance in the past month | 05 | 16-30 times in past month (4 or more times per week) |
| 02 | 1-3 times in past month (less than once per week) | 06 | Some attendance, but frequency unknown |
| 03 | 4-7 times in past month (about once per week) | 99 | Unknown |
| 04 | 8-15 times in past month (2 or 3 times per week) |  |  |

|  |
| --- |
| **🟋Q 16 Employment Status at Enrollment** |
| **Code** |  | **Code** |  | **Code** |  |
| 1 | Working Full Time | 6 | Not in Labor Force - Retired | 11 | Volunteer  |
| 2 | Working Part time | 7 | Not in Labor Force - Disabled | 12 | Other |
| 3 | Unemployed - looking | 8 | Not in labor force - Homemaker | 13 | Maternity/Family Leave |
| 4 | Unemployed – Not Looking | 9 | Not in labor force - Other | 99 | Unknown |
| 5 | Not in labor force – Student | 10 | Not in labor force - Incarcerated |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| **Code** | **🟋Q. 21 Vision Impairment** |  | **Code** | **🟋Q. 22 Hearing Impairment** |
| 0 | None: Normal Vision |  | 0 | None: Normal hearing requiring no correction |
| 1 | Slight: vision can be or is corrected with glasses/lenses |  | 1 | Slight: Hearing is or can be adequately corrected with amplification (eg hearing aid) |
| 2 | Moderate: “Legally blind” but having some minimal vision |  | 2 | Moderate: Hard of hearing, even with amplification |
| 3 | Severe: No usable vision |  | 3 | Severe: Profound deafness |
|  |  |  |  |
| **Code** |  **🟋Q 23 Self Care/ADL Impairment** |  | **Code** | **🟋Q. 24 Developmental Disability** |
| 0 | None: No problem accomplishing ADL skills such as bathing, dressing and other self-care |  | 0 | None |
| 1 | Slight: Uses adaptive device(s) and/or takes additional time to accomplish ADL but does not require attendant |  | 1 | Slight Developmental Disability |
| 2 | Moderate: Needs personal attendant up to 20 hours a week for ADL |  | 2 | Moderate Developmental Disability |
| 3 | Severe: Requires personal attendant for over 20 hours a week for ADL |  | 3 | Severe Developmental Disability |

🟋Q 30: SUBSTANCE MIS-USE / NICOTINE/TOBACCO / GAMBLING HISTORY

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Code** | **Last Use Substances** |  | **Code** | **Frequency of Last Use/bet** |  | **Code** | **Route of Administration** |
| 1 | 12 or more months ago |  | 1 | Less than once a month |  | 1 | Oral (swallow and/or chewing) |
| 2 | 3-11 months ago |  | 2 | 1-3 times a month |  | 2 | Smoking |
| 3 | 1-2 months ago |  | 3 | 1-2 times a week |  | 3 | Inhalation |
| 4 | Past 30 days |  | 4 | 3-6 times a week |  | 4 | Injection |
| 5 | Used in last week |  | 5 | Daily |  | 5 | Other |
|  |  |  | 99 | Unknown |  | **6** | **Electronic Devices/Vaping** |