

Adult: 26-59 Years Partnership Assessment Form (PAF)

Partnership Information

* Date Completed (mm/dd/yyyy):	
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* County: _____

CSI County Client Number (CCN): _____

County Partner ID (optional): _____

* Partner's First Name: _____

* Partner's Last Name: _____

* Partnership Date (mm/dd/yyyy): _____

* Partner's Date of Birth (mm/dd/yyyy): _____

Who Referred the Partner? (Choose One)

- | | |
|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| <input type="radio"/> Self | <input type="radio"/> Social Services Agency |
| <input type="radio"/> Family Member (e.g. parent, guardian, sibling, aunt, uncle, grandparent) | <input type="radio"/> Substance Abuse Treatment Facility / Agency |
| <input type="radio"/> Significant Other (e.g. boyfriend / girlfriend, spouse) | <input type="radio"/> Faith-based Organization |
| <input type="radio"/> Friend / Neighbor (i.e., unrelated other) | <input type="radio"/> Other County / Community Agency |
| <input type="radio"/> School | <input type="radio"/> Homeless Shelter |
| <input type="radio"/> Primary Care/Medical Office | <input type="radio"/> Street Outreach |
| <input type="radio"/> Emergency Room | <input type="radio"/> Jail / Prison |
| <input type="radio"/> Mental Health Facility /Community Agency | <input type="radio"/> Acute Psychiatric / State Hospital |
| | <input type="radio"/> Other |

Administrative Information

Partnership Status

Provider Number/ NPI: _____

* Full Service Partnership (PSP) Program ID: _____

* Partnership Service Coordinator (PSC) ID: _____

Program Information

In which additional program(s) is the Partner involved?	Currently (mark all that apply)
1. AB2034	<input type="checkbox"/>
2. Governor's Homeless Initiative (GHI)	<input type="checkbox"/>
3. MHSA Housing Program	<input type="checkbox"/>

Residential Information – Includes Hospitalizations and Incarcerations

Residential Setting	Tonight (Choose one)	Yesterday As of 11:59 pm The day before partnership (Choose one)	During the past 12 months Indicate the total # of occurrences	During the past 12 months Indicate the total # of days (Column must = 365 days)	Prior to the last 12 months (Mark all that apply)
General Living Arrangement					
1. In an apartment or house alone/with spouse/partner/minor children/other dependents/roommate(must hold lease or share in rent/mortgage)	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="checkbox"/>
2. With one or both biological /adoptive parents	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="checkbox"/>
3. With adult family member(s) other than parents - non-foster care	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="checkbox"/>
4. Single Room Occupancy (must hold lease)	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="checkbox"/>
Shelter/Homeless					
5. Emergency Shelter/Temporary Housing (includes living with friends but not paying rent)	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="checkbox"/>
6. Homeless (includes living in their car)	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="checkbox"/>
Supervised Placement					
7. Unlicensed but supervised individual placement (includes paid caretakers, personal care attendants)	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="checkbox"/>
8. Assisted Living Facility	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="checkbox"/>
9. Unlicensed but supervised congregate placement (includes group living homes, sober living homes)	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="checkbox"/>
10. Licensed Community Care Facility (Board and Care)	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="checkbox"/>
Hospital					
11. Acute Medical Hospital	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="checkbox"/>
12. Acute Psychiatric Hospital/ Psychiatric Health Facility (PHF)	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="checkbox"/>
13. State Psychiatric Hospital	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="checkbox"/>

Residential Program

14. Licensed Residential Treatment (includes crisis, short-term, long-term, substance abuse, dual diagnosis residential programs)	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="checkbox"/>
15. Skilled Nursing Facility (physical)	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="checkbox"/>
16. Skilled Nursing Facility (psychiatric)	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="checkbox"/>
17. Long-Term Institutional Care (Institution for Mental Disease (IMD), Mental Health Rehabilitation Center (MHRC))	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="checkbox"/>
Justice Placement					
18. Jail	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="checkbox"/>
19. Prison	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="checkbox"/>
Other					
20. Other	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="checkbox"/>
21. Unknown	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="checkbox"/>

Education

Highest Level of Education Completed: Choose One

- No High School Diploma / No GED
- GED Coursework
- High School Diploma/ GED
- Some college/ Some Technical or Vocational Training
- Associate’s Degree (e.g. A.A., A.S./ Technical or Vocational Degree)
- Bachelor’s Degree (e.g. B.A., B.S.)
- Master’s Degree (e.g. M.A., M.S.)
- Doctoral Degree (e.g., M.D., Ph.D.)

For the Education Settings below, indicate where the Partner

Educational Setting	Was During the Past 12 Months	Is Currently
	# of Weeks	(mark all that apply)
1. Not in school of any Kind	_____	<input type="checkbox"/>
2. High School / Adult Education	_____	<input type="checkbox"/>
3. Technical / Vocational School	_____	<input type="checkbox"/>
4. Community College / 4 year College	_____	<input type="checkbox"/>
5. Graduate School	_____	<input type="checkbox"/>
6. Other	_____	<input type="checkbox"/>

Recovery Goals

<input type="radio"/> Yes	<input type="radio"/> No	Does one of the Partner's current recovery goals include any kind of education at this time?
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Employment Information

Employment During Last 12 Months

Indicate the partner's employment status:	# of Weeks (Column must = 52 Weeks)	Average Hours Per Week	Average Hourly Wage
Competitive Employment: Paid employment in the community in a position that is also open to individuals without a disability.	_____	_____	\$_____
Supported Employment: Competitive Employment (see above) with ongoing on-site or off-site job-related support services provided.	_____	_____	\$_____
Transitional Employment/ Enclave: Paid jobs in the community that are: 1. Open only to individuals with a disability. AND 2. Are either time-limited for the purpose of moving to a more permanent job. OR Are part of a group of disabled individuals who are working as a team in the midst of teams of non-disabled individuals who are performing the same work.	_____	_____	\$_____
Paid In-House Work (Sheltered Workshop / Work Experience / Agency-Owned Business): Paid jobs open only to program participants with a disability. A Sheltered Workshop usually offers sub-minimum wage work in a simulated environment. A Work Experience (Adjustment) <i>Program</i> within an agency provides exposure to the standard expectations and advantages of employment. An Agency-Owned Business serves customers outside the agency and provides realistic work experiences and can be located at the program site or in the community.	_____	_____	\$_____
Non-paid (Volunteer) Work Experience: Non-paid (volunteer) jobs in an agency or volunteer work in the community that provides exposure to the standard expectations of employment.	_____	_____	
Other Gainful / Employment Activity: Any informal employment activity that increases the partner's income (e.g., recycling, gardening, babysitting) OR Participation in formal structured classes and / or workshops providing instruction on issues pertinent to getting a job. (Does NOT include such activities as panhandling or illegal activities such as prostitution).	_____	_____	\$_____
Unemployed	<input type="checkbox"/>		

Current Employment

Indicate the Partner's Employment Status:	Average Hours Per Week	Average Hourly Wage
Competitive Employment: Paid employment in the community in a position that is also open to individuals without a disability.	_____	\$_____
Supported Employment: Competitive Employment (see above) with ongoing on-site or off-site job-related support services provided.	_____	\$_____
Transitional Employment/ Enclave: Paid jobs in the community that are: 1. Open only to individuals with a disability. AND 2. Are either time-limited for the purpose of moving to a more permanent job. OR Are part of a group of disabled individuals who are working as a team in the midst of teams of non-disabled individuals who are performing the same work.	_____	\$_____
Paid In-House Work (Sheltered Workshop / Work Experience / Agency-Owned Business): Paid jobs open only to program participants with a disability. A Sheltered Workshop usually offers sub-minimum wage work in a simulated environment. A Work Experience (Adjustment) Program within an agency provides exposure to the standard expectations and advantages of employment. An Agency-Owned Business serves customers outside the agency and provides realistic work experiences and can be located at the program site or in the community..	_____	\$_____
Non-paid (Volunteer) Work Experience: Non-paid (volunteer) jobs in an agency or volunteer work in the community that provides exposure to the standard expectations of employment.	_____	
Other Gainful / Employment Activity: Any informal employment activity that increases the partner's income (e.g., recycling, gardening, babysitting) OR Participation in formal structured classes and / or workshops providing instruction on issues pertinent to getting a job. (Does NOT include such activities as panhandling or illegal activities such as prostitution).	_____	\$_____
<input type="checkbox"/> Unemployed: Check if the Partner is not employed at this time.		
<input type="radio"/> Yes	<input type="radio"/> No	Does one of the partner's current recovery goals include any kind of employment at this time?

Sources of Financial Support

Indicate all the sources of financial aid used to meet the needs of the partner:	During the Past 12 Months (mark all that apply)	Currently (mark all that apply)
1. Partner's Wages	<input type="checkbox"/>	<input type="checkbox"/>
2. Partner's Spouse/ Significant Other's Wages	<input type="checkbox"/>	<input type="checkbox"/>
3. Savings	<input type="checkbox"/>	<input type="checkbox"/>
4. Other Family Member/Friend	<input type="checkbox"/>	<input type="checkbox"/>
5. Retirement/ Social Security Income	<input type="checkbox"/>	<input type="checkbox"/>
6. Veteran's Assistance Benefits	<input type="checkbox"/>	<input type="checkbox"/>
7. Loan/Credit	<input type="checkbox"/>	<input type="checkbox"/>
8. Housing Subsidy	<input type="checkbox"/>	<input type="checkbox"/>
9. General Relief/General Assistance	<input type="checkbox"/>	<input type="checkbox"/>
10. Food Stamps	<input type="checkbox"/>	<input type="checkbox"/>
11. Temporary Assistance for Needy Families (TANF)	<input type="checkbox"/>	<input type="checkbox"/>
12. Supplemental Security Income/ State Supplementary Payment (SSI/SSP) Program	<input type="checkbox"/>	<input type="checkbox"/>
13. Social Security Disability Insurance (SSDI)	<input type="checkbox"/>	<input type="checkbox"/>
14. State Disability Insurance (SDI)	<input type="checkbox"/>	<input type="checkbox"/>
15. American Indian Tribal Benefits (e.g., per capita revenue sharing, trust disbursements)	<input type="checkbox"/>	<input type="checkbox"/>
16. Other	<input type="checkbox"/>	<input type="checkbox"/>
17. No Financial Support	<input type="checkbox"/>	<input type="checkbox"/>

Legal Issues/ Designations

Arrest Information		
Indicate the number of times the partner was arrested DURING THE PAST 12 MONTHS		<input type="text"/>
<input type="radio"/> Yes	<input type="radio"/> No	Prior 12 Months: Was the partner arrested any time PRIOR TO THE LAST 12 MONTHS?
Probation Information		
<input type="radio"/> Yes	<input type="radio"/> No	Currently: Is the partner CURRENTLY on probation?
<input type="radio"/> Yes	<input type="radio"/> No	Past 12 Months: Was the partner on probation DURING THE PAST 12 MONTHS?
<input type="radio"/> Yes	<input type="radio"/> No	Prior 12 Months: Was the partner on probation any time PRIOR TO THE LAST 12 MONTHS?
Parole Information		
<input type="radio"/> Yes	<input type="radio"/> No	Past 12 Months: Was the partner on any kind of parole DURING THE PAST 12 MONTHS?
<input type="radio"/> Yes	<input type="radio"/> No	Prior 12 Months: Was the partner on any kind of parole any time PRIOR TO THE LAST 12 MONTHS?
Conservatorship Information		
<input type="radio"/> Yes	<input type="radio"/> No	Currently: Is the partner CURRENTLY on conservatorship?
<input type="radio"/> Yes	<input type="radio"/> No	Past 12 Months: Was the partner on conservatorship DURING THE PAST 12 MONTHS?
<input type="radio"/> Yes	<input type="radio"/> No	Prior 12 Months: Was the partner on conservatorship any time PRIOR TO THE LAST 12 MONTHS?
Payee Information		
<input type="radio"/> Yes	<input type="radio"/> No	Currently: Does the partner CURRENTLY have a payee?
<input type="radio"/> Yes	<input type="radio"/> No	Past 12 Months: Did the partner have a payee DURING THE PAST 12 MONTHS?
<input type="radio"/> Yes	<input type="radio"/> No	Prior 12 Months: Did the partner have a payee any time PRIOR TO THE LAST 12 MONTHS?
Custody Information		
Indicate the total number of children the partner has who are CURRENTLY:		
_____ Number placed on W & I Code 300 Status: (dependent of the court)		
_____ Number placed in Foster Care		
_____ Number legally Reunified with partner		
_____ Number Adopted Out		

Emergency Intervention

Indicate the number of emergency interventions (e.g., emergency room visit, crisis stabilization unit) the partner had DURING THE PAST 12 MONTHS that were:

_____ Physical Health Related

_____ Mental Health / Substance Abuse Related

Health Status

<input type="radio"/> Yes	<input type="radio"/> No	Current PCP: Does the partner have a Primary Care Physician (PCP) CURRENTLY?
<input type="radio"/> Yes	<input type="radio"/> No	Past 12 Months PCP: Did the partner have a Primary Care Physician (PCP) DURING THE PAST 12 MONTHS?

Substance Abuse

<input type="radio"/> Yes	<input type="radio"/> No	Ever Issue: In the opinion of the Partnership Service Coordinator (PSC), has the partner ever had a co-occurring mental illness and substance use problem?
<input type="radio"/> Yes	<input type="radio"/> No	Current Issue: In the opinion of the Partnership Service Coordinator (PSC), does the partner currently have an active co-occurring mental illness and substance use problem?
<input type="radio"/> Yes	<input type="radio"/> No	Current Services: Is the partner currently receiving substance abuse services?

County Use Questions

To be tracked on the KET form:	Values
County Use Field # 1	
County Use Field # 2	
County Use Field # 3	
To be tracked on the 3M form:	Values
County Use Field # 1	
County Use Field # 2	
County Use Field # 3	