

Tennessee Outcomes Measurement System (TOMS)
Adult Mental Health Survey for NOMS Reporting (A001N v. 1.2)

*** This page to be completed by staff. ***

Agency ID: Clinic ID: Clinician ID:

Consumer ID: - Last Name:
 (first 5 letters only)

Survey Completion Date: / / Start Date for This Episode of Care: / /

Date of Birth: / /

1. How are the consumer's services funded?

- | | |
|--|--|
| 13 <input type="checkbox"/> Amerigroup | 17 <input type="checkbox"/> Commercial |
| 12 <input type="checkbox"/> United Healthcare Community Plan | 18 <input type="checkbox"/> Grant |
| 16 <input type="checkbox"/> VSHP | 15 <input type="checkbox"/> Self Pay |
| 5 <input type="checkbox"/> Safety Net | 19 <input type="checkbox"/> Other |
| 14 <input type="checkbox"/> Medicare | |

To complete the following questions, ask the consumer.

2. What is your gender?

- 1 ☐ Male
 0 ☐ Female

3. Are you Hispanic or Latino?

- 1 ☐ Hispanic / Latino
 0 ☐ Not Hispanic / Latino

4. What is your race? (Select all that apply.)

- 1 ☐ American Indian or Alaska Native
 2 ☐ Asian
 3 ☐ Black or African American
 4 ☐ Native Hawaiian or Other Pacific Islander
 5 ☐ White

5. Which of the following best describes your relationship status? (Select one.)

- | | |
|--|--------------------------------------|
| 7 <input type="checkbox"/> Never Married | 4 <input type="checkbox"/> Separated |
| 8 <input type="checkbox"/> Married/Living with boyfriend or girlfriend | 5 <input type="checkbox"/> Divorced |
| | 6 <input type="checkbox"/> Widowed |

6. What is the highest grade in school or level of education you have completed? (Select one.)

- 00 ☐ No years of schooling
 15 ☐ Self-contained special education class (not in a specific grade)
 13 ☐ Nursery School, Pre-School (Including Head Start)

- | | |
|---|--|
| 14 <input type="checkbox"/> Kindergarten | 10 <input type="checkbox"/> 10 th grade |
| 01 <input type="checkbox"/> 1 st grade | 11 <input type="checkbox"/> 11 th grade |
| 02 <input type="checkbox"/> 2 nd grade | 12 <input type="checkbox"/> 12 th grade |
| 03 <input type="checkbox"/> 3 rd grade | 16 <input type="checkbox"/> Vocational School |
| 04 <input type="checkbox"/> 4 th grade | 17 <input type="checkbox"/> College Undergraduate Freshman (1 st year) |
| 05 <input type="checkbox"/> 5 th grade | 18 <input type="checkbox"/> College Undergraduate Sophomore (2 nd year) |
| 06 <input type="checkbox"/> 6 th grade | 19 <input type="checkbox"/> College Undergraduate Junior (3 rd year) |
| 07 <input type="checkbox"/> 7 th grade | 20 <input type="checkbox"/> College Undergraduate Senior (4 th year) |
| 08 <input type="checkbox"/> 8 th grade | 21 <input type="checkbox"/> Graduate or Professional School
(e.g., Master's, Doctoral, Medical or Law School) |
| 09 <input type="checkbox"/> 9 th grade | |

7. Will the consumer take the survey?

- 1 ☐ Yes → *Continue to instructions below*
 2 ☐ Consumer is unwilling
 3 ☐ Consumer is unable today

Please read the following instructions to the consumer:

This survey gives you a chance to tell us how you are doing. Your answers will be used by your care provider to help plan your treatment. There are three ways to answer questions on the survey: circle the number or check the box that corresponds to your answer, or write your answer (always a number) in the boxes provided.

In the past 7 days ...

1. How many hours did you work for pay? (If none, enter 0)

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Number of Hours

2. If you did **NOT** work for pay, please select one response that best describes your situation. (If you did work for pay, please select, "Does not apply"):

- 1 ☐ Unemployed, but actively looking for paid work
- 2 ☐ Homemaker
- 3 ☐ Student
- 4 ☐ Retired
- 5 ☐ Disabled
- 6 ☐ In prison or other institution
- 7 ☐ Sheltered/non-competitive employment
- 8 ☐ Other (specify): _____
- * ☐ Does not apply

In the past 30 days ...

3. On how many days did you drink five or more alcoholic drinks? (If none, enter 0.)

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Number of Days

4. On how many days did you use any drugs to get high? (If none, enter 0.)
(For example, marijuana, meth, cocaine, or narcotics such as Oxycontin or codeine.)

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Number of Days

5. How many times were you arrested? (If none, enter 0.)

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Number of Times

6. On how many nights did you stay overnight in a hospital, psychiatric institution, or substance abuse program? (If none, enter 0.)

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Number of Nights

In the past 30 days ...

7. Where did you live most of the time? (Check only one.)

- 10 ☐ Private Residence – Independent Living (Alone, with friends, a spouse, or family members)
- 11 ☐ Private Residence – Dependent Living (Dependent on others for assistance in this living situation)
- 3 ☐ Institutional Setting (Nursing home, hospital, etc.)
- 4 ☐ Jail or correctional facility
- 5 ☐ Homeless/living in homeless shelter
- 12 ☐ Foster Home
- 13 ☐ Residential Care (Group home, rehabilitation center, etc.)
- 14 ☐ Crisis Residence (A time-limited residential program)