

AMH MEASURES AND OUTCOMES TRACKING SYSTEM  
for SUPPORTED HOUSING RENTAL ASSISTANCE PROGRAMS  
CLIENT INFORMATION ENTRIES TIP SHEET

Effective 1-25-2016

NOTE: "Client" = RA Program Participant

Item #	Items	Entry	Instruction
<b>CLIENT PROFILE</b>			
1	AGENCY IDENTIFIER	Name	Complete
2	LAST NAME	Client's legal last name	Complete
3	FIRST NAME	Client's legal first name	Complete
4	MIDDLE NAME	Client's legal middle name or initial	Complete (optional)
5	LAST NAME AT BIRTH	Client's legal last name at birth	Complete
6	DATE OF BIRTH	Client's date of birth	Enter only "known" date; not estimate
7	CLIENT TREATMENT STATUS	Client's current treatment status	Use "Assessment Only" when participant applies for RA; when client receives RA, add new tx episode and mark status as "active". Participation in services is voluntary.
8	CLIENT ID	Unique identifier assigned by Agency to client	Complete
9	OREGON MEDICAID NUMBER	Unique client identifier; includes OHP, MMIS number	Required only if client has been assigned one of these numbers
10	RACE	Client reported	Enter all that apply
11	ETHNICITY	Client reported	Client's specific Hispanic origin if applicable
12	GENDER	Client reported	Options: Male, Female, Other
13	MARITAL STATUS	Client's current marital status	Complete
14	VETERAN	Client has served in one of the uniformed services	If currently serving or past service.
15	COMPETITIVE EMPLOYMENT	Client's current employment state	Enter all that apply
16	LIVING ARRANGEMENT	Client's residential status (initial report)	Status immediately prior to joining program
17	DATE OF STATUS CHANGE FOR LIVING ARRANGEMENT	Client's estimated date of change in living arrangement	Note the formatting of date provided in MOTS Manual; not required for initial entry, only for subsequent update
18	COUNTY OF RESIDENCE	Client's current county of residence in Oregon	Complete
19	COUNTY OF RESPONSIBILITY	Client's current county of responsibility	County that holds the contracted service
<b>BEHAVIORAL HEALTH CLIENT INFORMATION</b>			
1	DATE OF ADMISSION	Date Client received first direct service	Enter date client started to receive rental assistance; note formatting of date provided in manual
2	ZIP CODE OF RESIDENCE	Zip code for client's current residence	Enter zip code for residential "living arrangement" identified above in item #16
3	STATE OF RESIDENCE	Client's current state of residence	Enter state other than Oregon only if client entering program immediately upon arriving in Oregon
4	ESTIMATED GROSS HOUSEHOLD MONTHLY INCOME	Total gross household monthly income for all family members of the household	Enter "0" for no income; enter "1" if client refuses to answer; enter amount of income as reported by client
5	SOURCE OF INCOME/SUPPORT	Client's principal source of financial support	Enter only one response from list of valid entries
6	EXPECTED/ACTUAL SOURCE OF PAYMENT	Source(s) of payment for treatment (if any)	Enter all that apply; enter "other" if response should be "none"
7	TOTAL NUMBER OF DEPENDENTS	No. of people dependent on the client's income	May include biological and/or non-biological dependents
8	TOTAL NUMBER OF CHILD DEPENDENTS	No. of children in household dependent on client's income	Children are defined as ages 0-17 years

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<b>BEHAVIORAL HEALTH CLIENT INFORMATION (cont.)</b>			
9	PRIMARY HEALTH INSURANCE	Client's health insurance coverage (if any)	Enter only one response from list of valid entries
10	REFERRED FROM	Person/organization referring client to RA program	Enter all that apply
11	REFERRED TO	Person/organization client referred to for services, if any	Enter all that apply; RA program requires that services must be voluntary so entry may be "none"
12	TRIBAL AFFILIATION	Clients specific affiliation	Enter tribe, if not listed, other. Enter "not applicable" if there is no tribal affiliation
13	INTERPRETER	Type of interpretation required	If clients requires/requests assistance re: language or hearing
14	PREGNANT	Client reported	If Gender is reported as "Male" and client is not pregnant enter "NA"
15	HIGHEST SCHOOL GRADE COMPLETED	Grades completed (not number of years of attendance)	Enter number of yrs; numeric values provided in MOTS Manual
16	TOBACCO USE	Client's current use of tobacco	Enter one response only
17	SUBSTANCE USE DURING LAST 90 DAYS	NA	For RA program clients, enter "unknown"
18	LEGAL STATUS	Client involvement in criminal justice system	ONLY for clients in criminal justice system; enter all that apply. If client is not in criminal justice system choose "None".
19	NUMBER OF ARRESTS IN PAST MONTH	NA	Leave blank for RA program clients
20	TOTAL ARRESTS	NA	Leave blank for RA program clients
21	NUMBER OF DUII ARRESTS IN PAST MONTH	NA	Leave blank for RA program clients
22	TOTAL DUII ARRESTS	NA	Leave blank for RA program clients
23	DRIVERS LICENSE NUMBER	NA	NOT REQUIRED
24	STATE ID NUMBER	NA	NOT REQUIRED
25	SCHOOL ATTENDANCE IMPROVEMENT	NA	Enter "NA"
26	ACADEMIC IMPROVEMENT	NA	Enter "NA"
27	SCHOOL BEHAVIOR IMPROVEMENTS	NA	Enter "NA"
28	DIAGNOSIS	Diagnosis at time of report	Use an ICD - 10 code in the Z59 series (Z590-Z599). And when known other valid diagnosis codes.
29	GLOBAL ASSESSMENT OF FUNCTIONING	Current GAF score	This field is optional and should be left blank if client does not have a score.
30	PEER DELIVERED SERVICES	Promotion and use of peer delivered services	Enter one response only; RA program requires that participation in services is voluntary so entry may be "none"
31	INFECTIOUS DISEASE RISK ASSESSMENT	Results of Infectious Disease Risk Assessment	If none, enter "not completed"
32	TREATMENT PLAN INDICATOR	Key performance indicators significant to client's Treatment Plan, goals for recovery	Enter all appropriate indicators if client has Treatment Plan; if not, enter just "housing"
33	MENTAL HEALTH CURRENT LEVEL OF CARE (LOC)	NA	Leave blank
34	MENTAL HEALTH LEVEL OF CARE (LOC) SCORE	NA	Leave blank

# MOTS ENTRIES FOR CLIENT PROFILE TAB

**Client Profile** Behavioral Health Detail Addiction Detail

1 Agency: AMH - A Magnificent Healer Facility: AMH - A Magnificent Healer

2 Last Name: Smart 3 First Name: Maxwell 4 Middle Name: G  
*Optional*

5 Last Name/Birth: Smart 6 Date of Birth: 04/30/1952 7 Client Treatment Status: Active  
*(mm/dd/yyyy)*

8 Client ID: A7052 9 OR Medicaid Number: *Situational*

10 **Race** 11 Ethnicity: Not of Hispanic Origin  
Alaska Native American Indian Asian Black or African American Native Hawaiian or Other Pac Other Single Race Two or More Unspecified Race  
White

12 Gender: Male 13 Marital Status: Never Married 14 Veteran: Yes, Veteran and Current or Former Active Duty Military

15 **Competitive Employment** 16 Living Arrangement: Residential Facility  
Disabled Full Time Homemaker Hosp. Pt/Res. of Other Not in Labor Force Other Reported Classification Retired  
Part Time

17 Date Living Arrangement Changed: 01/15/2015 *Situational*

18 County of Residence: Clackamas 19 County of Responsibility: Clackamas

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# MOTS ENTRIES FOR CLIENT BEHAVIORAL HEALTH DETAILS

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Client Profile Behavioral Health Detail Addiction Detail

1 Admission Date: 01/15/2015 2 ZIP Code: 97070 3 State of Res: Oregon

4 Estimated Gross Monthly Household Income: 772 5 Source of Income/Support: Disability/SSDI

6 Expected / Actual Source of Payment

AMH County Fin. Assist. Agreemnt Medicaid / OHP Medicare No Charge Other Gov. Payments - Non Medicaid Private Health Insurance Self Pay	Other
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7 Total Number of Dependents: 1 8 Number of Child Dependents: 0

9 Primary Health Insurance: None

10 Referred From

Community Housing Coordinated Care Organization Crisis/Helpline Developmental Disabilities Ser Employer/EAP Employment Services Federal Correctional Institutio	Family/Friend
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11 Referred To

Acute/sub-acute psych facility Aging and People with Disabili Attorney Child Welfare Comm BH Prov in Area Comm BH Prov Out of Area Community Public Health Depa	Community Housing
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12 Tribal Affiliation

Burns Paiute Tribe Conf Trbs Coos, Lowr Ump & Siuslaw Conf Tribes of Grand Ronde Conf Tribes of Siletz Conf Tribes of the Umatilla Conf Tribes of Warm Springs Coosville Indian Tribe	Not Applicable
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13 Interpreter: None 14 Pregnant: N/A

15 Highest School Grade Completed: 12 16 Tobacco Use: No 17 Substance Use Last 90 Days: Unknown

# MOTS ENTRIES FOR CLIENT BEHAVIORAL HEALTH DETAILS

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**18** → **Legal Status**

Guardianship (Child Welfare)	None
Guardianship (Court)	
Incarcerated	
JPSRB	
Parole	
Probation	
PSRB	

**19** → Number of Arrests Past Month:  *Situational*

**20** → Total Arrests:  *Situational*

**21** → Number of DUII Arrests Past Month:  *Situational*

**22** → Total DUII Arrests:  *Situational*

**23** → ODL/OR ID:  *Situational*

**24** → SID:  *Optional*

**25** → School Attendance Improvement:  *Situational*

**26** → Academic Improvement:  *Situational*

**27** → School Behavior Improvement:  *Situational*

**28** → **Diagnosis:**  Search:

Diagnosis	
Z591 : Inadequate housing	<a href="#">Delete</a>

**29** → Global Assessment of Functioning:  *Optional*

**30** → Peer Del Services:

**31** → Infectious Disease Risk Assessment:

**32** → **Treatment Plan Indicator**

Education	Employment Housing
Other	

**33** → MH Assessed LOC Score:  *Situational*

**34** → MH Current LOC:  *Situational*

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