



Texas Department of Criminal Justice

Texas Correctional Office on Offenders with Medical or Mental Impairments

Screening Form

Date of Screening: _____ Referral Source: TCOOMMI Local Self C2C

Completed By: _____

LMHA: _____ LMHA Client #: _____

CLIENT DEMOGRAPHICS

Client Name: _____ SID #: _____ TDCJ #: _____

Date of Birth: _____ Sex: Male Female Marital Status: _____

Social Security #: _____ TRAS Level: ! _____

Address: _____

County of Residence: _____ Type of Residence: _____

Phone: _____ Email: _____

Children: Yes No # of Children: _____ Who do they live with: _____

Legal Guardian / Power of Attorney: Yes No N/A: _____

Preferred Language Written: _____ Spoken: _____ Veteran: Yes No

Instant Offense: _____

Previous Offense: _____

Supervision Type: Parole Probation Dual

Parole / Probation Begin Date: _____ Discharge Date: _____

Parole / Probation Officer: _____ Phone #: _____

BENEFITS

Do you *Currently* receive any benefits? (SSI, SSDI, SNAP, VA): Yes No N/A (Incarcerated)

If Yes, what type: SSI SSDI SNAP Medicaid Medicare VA
 Other: _____

Have you *Previously* received any benefits? (SSI, SSDI, SNAP, VA): Yes No

If Yes, what type: SSI SSDI SNAP Medicaid Medicare VA
 Other: _____

Private Insurance: Yes No When: _____

Have you *Previously* applied for any benefits? (SSI, SSDI, SNAP, VA): Yes No

If Yes, what type: SSI SSDI SNAP Medicaid Medicare VA
 Other: _____

When: _____ Reason for Denial / Current Status: _____

MENTAL HEALTH

Current Mental Health Treatment? Yes No **Where?** _____

Prior Mental Health Treatment? Yes No **Where?** _____ **When?** _____

TDCJ – EMR Review: Yes No **If No, Why?** _____

TDCJ – EMR Diagnosis: _____

Psychiatric Hospitalizations: Yes No **If Yes, Where?** _____ **When?** _____

History of Suicide Attempts: Yes No **Last Attempt:** _____

Prior Homicidal Ideation: Yes No **Last Ideation:** _____

History of Self Harm: Yes No **Last Event:** _____

Diagnosis: _____

IDD Services in the Past or Diagnosis: Yes No

Current Psychiatric Symptoms: _____

When did symptoms begin? _____

Current Psychotropic medications: _____

Previous Psychotropic medications: _____

When was the last time you took medications? _____

How much medication do you currently have left? _____

MENTAL STATUS

Speech: Coherent Mumbles **Rate:** Average Slow Pressured

Mood & Affect: Euthymic Depressed Elevated Irritable Flat

Labile Level Appropriate Blunted Anxious

Cognition: Logical Concrete Disorganized Tangential Circumstantial

Loose Delusions Paranoia Goal-Oriented Suicidal Ideation

Audio / Visual Hallucinations

ALCOHOL & SUBSTANCE USE

Substance Use History: Yes No **Date of Last Use:** _____

Alcohol Use: Yes No **Date of Last Use:** _____

Drug(s) of Choice: _____

Severity / Pattern of Use: _____

Prior Treatment: Yes No **# of Times:** _____

MEDICAL

Medical Problems: _____

Medications: _____

EDUCATION & EMPLOYMENT HISTORY

Highest Grade Achieved: _____ GED: Yes No Special Ed Classes: Yes No

Currently Employed: Yes No Full Time Part Time Days / Hours: _____

Employer: _____

EDUCATION & EMPLOYMENT HISTORY (Continued)

Type of Work (Past or Present): _____

Do you have trouble keeping a job? Yes No Longest time you held a job: _____

PSYCHOSOCIAL NEEDS ASSESSMENT: (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Medication Maintenance | <input type="checkbox"/> Benefits Application |
| <input type="checkbox"/> Individual Skills Training / Counseling | <input type="checkbox"/> Vocational Training |
| <input type="checkbox"/> Group Skills Training / Counseling | <input type="checkbox"/> Job Placement |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Education / GED |
| <input type="checkbox"/> Housing | <input type="checkbox"/> Identification (ID, TDL, SS #, Birth Certificate) |
| <input type="checkbox"/> Medical Treatment | <input type="checkbox"/> Clothing |
| <input type="checkbox"/> Substance or Alcohol Treatment | <input type="checkbox"/> Other: |

Disposition:

- Eligible for TCOOMMI Program / Schedule for Assessment
- Not Eligible for TCOOMMI Services / Schedule with Local MHMR Center
- Referred to Non-LMHA Services (Private Dr., P.C. etc.)
- No Appropriate MI / IDD Diagnosis / Refer to Other Agencies

Name, Credential, Title

Date