Assessments

ALOC Screening Document

Date:_____ **Time:**_____ **Log #**_____ **Screener:**_____

Preferred Name:_____ **Date of Birth:** _____ **Age:**_____

Gender: M / F / GNB / Transgender **Ethnicity**:_____

Preferred Language:_____ **Phone #:** _____

Client Address/Place of Residence: _____City:_____ Zip:_____

**** What is most important to you, that you want help with?***

_____

_____

Drug of Choice:	Route of Administration:	Frequency last 30 days:	Quantity:	Frequency last 12 months:	Last Date of Use:

Do you use opioids regularly? Y / N ***If Yes:*** **Do you worry about the use of opioids?** Y/ N

Do you have current Medical Coverage: Y / N ***If Yes:*** **Insurance Provider**:_____

Current Medical Condition(s):_____

If yes, Primary Care Provider:_____ Where:_____

Current Psychiatric Diagnosis/Condition(s):_____ When:_____

If Yes, Mental Health Professional Name:_____ Where:_____

Current Prescribed Medication:	Taking it?: Yes/No	How Many Days' Supply Does Client Have Available?:

Living Situation: Homeless/ Stable Residence/Living with a Partner / Living with Family / Other

Are you pregnant?: Y / N / Unknown **Are you married/partnered?:** Y/ N Single?

Child:	Age:	Gender	Living With You?: Yes / No	Seeking Custody?: Yes / No

Source of Income #: _____ **Social Security #:** _____

For funding purposes only, have you ever been arrested? Y / N

DIMENSION 1. Acute Intoxication and/or Withdrawal Potential

(a) Do you have a history of serious withdrawal, life-threatening symptoms or seizures during withdrawal? e.g., need for IV therapy; hospital for seizure control; psychosis with DT's; medication management with close nurse monitoring and medical management?__No__Yes;
(b) Do you currently have severe, life-threatening and/or similar withdrawal symptoms? ___No ___Yes
(c) Currently having opioid withdrawal symptoms? (Restlessness, chills, sweats, runny nose, pain, stomach cramps)__No___Yes
If yes: consider OTP/NTP level of care

Select one: No Risk/Stable (0) Mild (1) Moderate (2) Significant (3) Severe (4)

DIMENSION 2. Biomedical Conditions/Complications

(a) Do you have any current severe physical health problems? e.g., bleeding from mouth/rectum in past 24 hrs.; recent, unstable hypertension; severe pain in chest, abdomen, head; significant problems in balance, gait, sensory/motor abilities not related to intoxication. ___No ___Yes
(b) Do you have history or recent episode of seizures/convulsions; TB diagnosis, emphysema, Hep. C, heart condition? __No __Yes

Select one: No Risk/Stable (0) Mild (1) Moderate (2) Significant (3) Severe (4)

DIMENSION 3. Emotional/Behavioral/Cognitive Conditions/Complications

(a) Are you in imminent danger of harming yourself or someone else? e.g., SI+ with intent, plan, means to succeed; HI+ or violent ideation, impulses, uncertainty about ability to control impulses, with means to act. ___No ___Yes;
(b) Are you unable to function in ADL's, care for self with imminent, dangerous consequences? e.g., unable to bathe, feed, care for self- due to psychosis, organicity or uncontrolled intoxication with threat of imminent DTS/O as regards death or severe injury. ___No ___Yes
(c) Will the client benefit from a co-occurring capable program as opposed to a co-occurring enhanced program? ___No ___Yes

Select one: No Risk/Stable (0) Mild (1) Moderate (2) Significant (3) Severe (4)

DIMENSION 4. Readiness to Change

(a) Does the client appear to need SUD treatment/recovery and/or mental health treatment, but is ambivalent or feels it's unnecessary? e.g., severe addiction, but client feels controlled use is still OK; psychotic, but blames a conspiracy. ___No ___Yes;
(b) Have you been coerced or mandated to have assessment and/or treatment by Mental Health Court or CJ system, health or social services, work/school, or family/significant other? ___No ___Yes
(c) Client is in which Stage of Change? __Precontemplation__Contemplation__Preparation__Action__Maintenance

Select one: No Risk/Stable (0) Mild (1) Moderate (2) Significant (3) Severe (4)

DIMENSION 5. Relapse/Continued Use/Continued Problem Potential

(a) Do you understand your relapse potential, but need structure to maintain therapeutic gains? ___No ____Yes;
(b) Are you unwilling and/or ambivalent to create a relapse or continued use prevention plan? ___No ____Yes
(c) Will you continue to use/have active symptoms in imminently dangerous manner, without immediate containment? ___No___Yes

Select one: No Risk/Stable (0) Mild (1) Moderate (2) Significant (3) Severe (4)

DIMENSION 6. Recovery Environment

(a) Are there any dangerous family, significant others, living, work, or school situations threatening your safety, immediate well-being, and/or sobriety? e.g., living with a drug dealer; someone with a Substance Use Disorder or using drugs or alcohol; client is experiencing abuse by a partner or significant other; homeless in freezing temperatures. ___No ___Yes
(b) How would you describe your relationships? e.g., family, significant other, co-workers, friends, and peers.__Actively toxic__Not supportive__Marginally supportive__Moderately supportive__Very supportive

Select one: No Risk/Stable (0) Mild (1) Moderate (2) Significant (3) Severe (4)

OTHER. Any other information related to treatment needs you'd like to discuss (i.e. language, sexual orientation, gender identity, disability, accessibility of services, etc.)? If yes, please explain:_____

ASAM Clinical Placement Scoring Summary

Please refer to the responses provided on the previous page to help guide your risk rating for each of the six dimensions. The determined risk rating should inform your level of care selection—a higher risk rating warrants a higher intensity of services.

Risk Ratings	Intensity of Service Need	Dimensions					
		1	2	3	4	5	6
(0) No Risk or Stable – Current risk absent. Any acute or chronic problem mostly stabilized.	No immediate services needed.						
(1) Mild – Minimal, current difficulty or impairment. Minimal or mild signs and symptoms. Any acute or chronic problems soon able to be stabilized and functioning restored with minimal difficulty.	Low intensity of services needed for this dimension. Treatment strategies usually able to be delivered tin outpatient settings.						
(2) Moderate – Moderate difficulty or impairment. Moderate signs and symptoms. Some difficulty coping or understanding, but able to function with clinical and other support services and assistance.	Moderate intensity of services, skills training or supports needed for this level of risk. Treatment strategies may require intensive levels of outpatient care.						
(3) Significant – Serious difficulties or impairment. Substantial difficulty coping or understanding and being able to function even with clinical support.	Moderately high intensity of services, skills training, or supports needed. May be in danger or near imminent danger.						
(4) Severe – Severe difficulty or impairment. Serious, gross or persistent signs and symptoms. Very poor ability to tolerate and cope with problems. Is in imminent danger.	High intensity of services, skills training, or supports needed. More immediate, urgent services may require inpatient or residential settings; or closely monitored case management services and a frequency greater than daily.						

I. Key Findings Supporting Placement Decision:

II. Indicated Level of Care:

III. Actual Level of Care:

ASAM Leves of Care	Program to which referred
- Early Intervention (SBIRT, DUI, Diversion-PC1000) - OTP/NTP Methadone programs/Medication Assisted Treatment - 1 Outpatient Services - 2.1 Intensive Outpatient Services - RR/OT Recovery Residence plus Outpatient - RR/IOT Recovery Residence plus Intensive Outpatient - 3.1 Low-Intensity Residential Services - 3.3 Population-Specific High-Intensity Residential Services - 3.5 Clinically Managed High-Intensity Residential Services - 3.7 Medically Monitored Inpatient Services - 4.0 Medically managed Inpatient Services - 1-WM Ambulatory Withdrawal Mgmt. w/out Extended On-Site Monitoring - 3.2-WM Residential Withdrawal Management	(see ACBHCS Provider Lists) Program Referred To:_____ Contact Person: _____ First Offered Appointment Date:_____Time:_____ Intake Appointment Date:_____Time:_____

Availability to admit into Care: Immediately / Delayed

If delayed, reason: Patient Preference / Level of Care Availability / Other Special Pop. Specific / ADA Access

Interim Service Referral: Date:_____Time:_____Where:_____ With:_____

Schedule In Person Assessment: Date:_____Time:_____Where: *North / South* With:_____

Do You Consent to Releasing Your Information to the Providers we refer you to? (Y/N)

Staff Signature (required):	**Date:**
Supervisors Signature (required):	**Date:**

*** ASAM Screening Tool SUD_ASAM FINAL rev 09-26-2018**

National Center for PTSD
POSTTRAUMATIC STRESS DISORDER

Life Events Checklist (LEC) for *DSM-5*

Standard Version

Version date: 27 October 2013

Reference: Weathers, F. W., Blake, D. D., Schnurr, P. P., Kaloupek, D. G., Marx, B. P., & Keane, T. M. (2013). *The Life Events Checklist for DSM-5 (LEC-5) – Standard.* [Measurement instrument]. Available from http://www.ptsd.va.gov/

URL: http://www.ptsd.va.gov/professional/assessment/te-measures/life_events_checklist.asp

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LEC-5

Instructions: Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)						
2. Fire or explosion						
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)						
4. Serious accident at work, home, or during recreational activity						
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)						
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)						
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)						
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)						
9. Other unwanted or uncomfortable sexual experience						
10. Combat or exposure to a war-zone (in the military or as a civilian)						
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)						
12. Life-threatening illness or injury						
13. Severe human suffering						
14. Sudden violent death (for example, homicide, suicide)						
15. Sudden accidental death						
16. Serious injury, harm, or death you caused to someone else						
17. Any other very stressful event or experience						

Mental Health Screening Form–III (MHSF–III)

Instructions: In this program, we help people with *all* their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you to deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency *without your permission.* If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note, each item refers to your *entire life history, not* just your current situation. This is why each question begins, "Have you ever . . . "

Please circle "yes" or "no" for each question.

1. Have you *ever* talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem? ..... Yes No
2. Have you *ever* felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems? ..... Yes No
3. Have you *ever* been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem? ..... Yes No
4. Have you *ever* been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons? ..... Yes No
5. Have you *ever* heard voices no one else could hear or seen objects or things which others could not see? ..... Yes No
6. (a) Have you *ever* been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself? ..... Yes No
   (b) Did you ever attempt to kill yourself? ..... Yes No
7. Have you *ever* had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed? ..... Yes No
8. Have you *ever* experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help? ..... Yes No
9. Have you *ever* given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property? ..... Yes No
10. Have you *ever* felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior? ..... Yes No
11. Have you *ever* experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner? ..... Yes No
12. Was there *ever* a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up? ..... Yes No

continued on other side

13. Have you *ever* had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly nonstop, when you moved quickly from one activity to another, when you needed little sleep, and when you believed you could do almost anything? .... Yes No

14. Have you *ever* had spells or attacks when you suddenly felt anxious, frightened, or uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, or you felt dizzy or unsteady, as if you would faint? ..... Yes No

15. Have you *ever* had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate. ..... Yes No

16. Have you *ever* lost considerable sums of money through gambling or had problems at work, in school, or with your family and friends as a result of your gambling? ..... Yes No

17. Have you *ever* been told by teachers, guidance counselors, or others that you have a special learning problem? ..... Yes No

Print client's name: _____

Program to which client will be assigned: _____

Name of admissions counselor: _____ Date: _____

Reviewer's comments: _____

_____

_____

_____

_____

National Center for PTSD
POSTTRAUMATIC STRESS DISORDER

The Primary Care PTSD Screen for *DSM-5* (PC-PTSD-5)

Version date: 2015

Reference: Prins, A., Bovin, M. J., Kimerling, R., Kaloupek, D. G, Marx, B. P., Pless Kaiser, A., & Schnurr, P. P. (2015). *The Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)* [Measurement instrument]. Available from http://www.ptsd.va.gov

URL: http://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp

PC-PTSD-5

Description

The Primary Care PTSD Screen for *DSM-5* (PC-PTSD-5) is a 5-item screen designed to identify individuals with probable PTSD. Those screening positive require further assessment, preferably with a structured interview.

Scoring

The measure begins with an item designed to assess whether the respondent has had any exposure to traumatic events. If a respondent denies exposure, the PC-PTSD-5 is complete with a score of 0.

If a respondent indicates a trauma history – experiencing a traumatic event over the course of his or her life – the respondent is instructed to answer five additional yes/no questions (see below) about how that trauma has affected him or her over the past month.

Preliminary results from validation studies suggest that the PC-PTSD-5 should be considered "positive" (i.e., the patient has probable PTSD) if the total score for the five questions about how a traumatic event has affected him or her over the past month is three or more.

Example

In the past month, have you…

1. had nightmares about the event(s) or thought about the event(s) when you did not want to?				
	YES		NO	
2. tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?				
	YES		NO	
3. been constantly on guard, watchful, or easily startled?				
	YES		NO	
4. felt numb or detached from people, activities, or your surroundings?				
	YES		NO	
5. felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?				
	YES		NO	
Total Score:			**If total score is 3 or more, screen indicates probable PTSD.**	

ID # _____

PC-PTSD-5

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide.

Have you ever experienced this kind of event?

YES NO

If no, screen total = 0. Please stop here.

If yes, please answer the questions below.

In the past month, have you…

1. had nightmares about the event(s) or thought about the event(s) when you did not want to?

   YES NO

2. tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?

   YES NO

3. been constantly on guard, watchful, or easily startled?

   YES NO

4. felt numb or detached from people, activities, or your surroundings?

   YES NO

5. felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?

   YES NO

Form Approved
OMB No. 0930-0208
Expiration Date: 02/28/2022

Substance Abuse and Mental Health Services Administration (SAMHSA)

Center for Substance Abuse Treatment (CSAT)

Government Performance and Results Act (GPRA) Client Outcome Measures for Discretionary Programs

SAMHSA's Performance Accountability and Reporting System (SPARS)
March 2019

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A. RECORD MANAGEMENT

Client ID |____|____|____|____|____|____|____|____|____|____|____|____|____|____|____|____|

Client Type:

- ○ Treatment client
- ○ Client in recovery

Contract/Grant ID |____|____|____|____|____|____|____|____|____|____|

Interview Type ***[CIRCLE ONLY ONE TYPE.]***

Intake ***[GO TO INTERVIEW DATE.]***

6-month follow-up: Did you conduct a follow-up interview? ○ Yes ○ No
[IF NO, GO DIRECTLY TO SECTION I.]

3-month follow-up ***[ADOLESCENT PORTFOLIO ONLY]***:
Did you conduct a follow-up interview? ○ Yes ○ No
[IF NO, GO DIRECTLY TO SECTION I.]

Discharge**:** Did you conduct a discharge interview? ○ Yes ○ No
[IF NO, GO DIRECTLY TO SECTION J.]

Interview Date |____|____| / |____|____| / |____|____|____|____|
Month Day Year

A. BEHAVIORAL HEALTH DIAGNOSES

[REPORTED BY PROGRAM STAFF.]

Please indicate the client's current behavioral health diagnoses using the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM) codes listed below. Please note that some substance use disorder ICD-10-CM codes have been crosswalked to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), descriptors. Select up to three diagnoses. For each diagnosis selected, please indicate whether it is primary, secondary, or tertiary, if known. Only one diagnosis can be primary, only one can be secondary, and only one can be tertiary.

Behavioral Health Diagnoses	Diagnosed?	For each diagnosis selected, please indicate whether the diagnosis is primary, secondary, or tertiary, if known		
	Select up to 3	Primary	Secondary	Tertiary
SUBSTANCE USE DISORDER DIAGNOSES				
Alcohol-related disorders				
F10.10 – Alcohol use disorder, uncomplicated, mild	○	○	○	○
F10.11 – Alcohol use disorder, mild, in remission	○	○	○	○
F10.20 – Alcohol use disorder, uncomplicated, moderate/severe	○	○	○	○
F10.21 – Alcohol use disorder, moderate/severe, in remission	○	○	○	○
F10.9 – Alcohol use, unspecified	○	○	○	○
Opioid-related disorders				
F11.10 – Opioid use disorder, uncomplicated, mild	○	○	○	○
F11.11 – Opioid use disorder, mild, in remission	○	○	○	○
F11.20 – Opioid use disorder, uncomplicated, moderate/severe	○	○	○	○
F11.21 – Opioid use disorder, moderate/severe, in remission	○	○	○	○
F11.9 – Opioid use, unspecified	○	○	○	○
Cannabis-related disorders				
F12.10 – Cannabis use disorder, uncomplicated, mild	○	○	○	○
F12.11 – Cannabis use disorder, mild, in remission	○	○	○	○
F12.20 – Cannabis use disorder, uncomplicated, moderate/severe	○	○	○	○
F12.21 – Cannabis use disorder, moderate/severe, in remission	○	○	○	○
F12.9 – Cannabis use, unspecified	○	○	○	○
Sedative-, hypnotic-, or anxiolytic-related disorders	▪	▪	▪	▪
F13.10 – Sedative, hypnotic, or anxiolytic use disorder, uncomplicated, mild	○	○	○	○
F13.11 – Sedative, hypnotic, or anxiolytic use disorder, mild, in remission	○	○	○	○

A. BEHAVIORAL HEALTH DIAGNOSES (CONTINUED)

Behavioral Health Diagnoses	Diagnosed?	For each diagnosis selected, please indicate whether diagnosis is primary, secondary, or tertiary, if known		
	Select up to 3	Primary	Secondary	Tertiary
F13.20 – Sedative, hypnotic, or anxiolytic use disorder, uncomplicated, moderate/severe	○	○	○	○
F13.21 – Sedative, hypnotic, or anxiolytic use disorder, moderate/severe, in remission	○	○	○	○
F13.9 – Sedative, hypnotic, or anxiolytic use, unspecified	○	○	○	○
Cocaine-related disorders	▪	▪	▪	▪
F14.10 – Cocaine use disorder, uncomplicated, mild	○	○	○	○
F14.11 – Cocaine use disorder, mild, in remission	○	○	○	○
F14.20 – Cocaine use disorder, uncomplicated, moderate/severe	○	○	○	○
F14.21 – Cocaine use disorder, moderate/severe, in remission	○	○	○	○
F14.9 – Cocaine use, unspecified	○	○	○	○
Other stimulant-related disorders	▪	▪	▪	▪
F15.10 – Other stimulant use disorder, uncomplicated, mild	○	○	○	○
F15.11 – Other stimulant use disorder, mild, in remission	○	○	○	○
F15.20 – Other stimulant use disorder, uncomplicated, moderate/severe	○	○	○	○
F15.21 – Other stimulant use disorder, moderate/severe, in remission	○	○	○	○
F15.9 – Other stimulant use, unspecified	○	○	○	○
Hallucinogen-related disorders	▪	▪	▪	▪
F16.10 – Hallucinogen use disorder, uncomplicated, mild	○	○	○	○
F16.11 – Hallucinogen use disorder, mild, in remission	○	○	○	○
F16.20 – Hallucinogen use disorder, uncomplicated, moderate/severe	○	○	○	○
F16.21 – Hallucinogen use disorder moderate/severe, in remission	○	○	○	○
F16.9 – Hallucinogen use, unspecified	○	○	○	○
Inhalant-related disorders	▪	▪	▪	▪
F18.10 – Inhalant use disorder, uncomplicated, mild	○	○	○	○
F18.11 – Inhalant use disorder, mild, in remission	○	○	○	○
F18.20 – Inhalant use disorder, uncomplicated, moderate/severe	○	○	○	○
F18.21 – Inhalant use disorder, moderate/severe, in remission	○	○	○	○
F18.9 – Inhalant use, unspecified	○	○	○	○

A. BEHAVIORAL HEALTH DIAGNOSES (CONTINUED)

Behavioral Health Diagnoses	Diagnosed?	For each diagnosis selected, please indicate whether diagnosis is primary, secondary, or tertiary, if known		
	Select up to 3	Primary	Secondary	Tertiary
Other psychoactive substance–related disorders	▪	▪	▪	▪
F19.10 – Other psychoactive substance use disorder, uncomplicated, mild	○	○	○	○
F19.11 – Other psychoactive substance use disorder, in remission	○	○	○	○
F19.20 – Other psychoactive substance use disorder, uncomplicated, moderate/severe	○	○	○	○
F19.21 – Other psychoactive substance use disorder, moderate/severe, in remission	○	○	○	○
F19.9 – Other psychoactive substance use, unspecified	○	○	○	○
Nicotine dependence	▪	▪	▪	▪
F17.20 – Tobacco use disorder, mild/moderate/severe	○	○	○	○
F17.21 – Tobacco use disorder, mild/moderate/severe, in remission	○	○	○	○
MENTAL HEALTH DIAGNOSES				
F20 – Schizophrenia	○	○	○	○
F21 – Schizotypal disorder	○	○	○	○
F22 – Delusional disorder	○	○	○	○
F23 – Brief psychotic disorder	○	○	○	○
F24 – Shared psychotic disorder	○	○	○	○
F25 – Schizoaffective disorders	○	○	○	○
F28 – Other psychotic disorder not due to a substance or known physiological condition	○	○	○	○
F29 – Unspecified psychosis not due to a substance or known physiological condition	○	○	○	○
F30 – Manic episode	○	○	○	○
F31 – Bipolar disorder	○	○	○	○
F32 – Major depressive disorder, single episode	○	○	○	○
F33 – Major depressive disorder, recurrent	○	○	○	○
F34 – Persistent mood [affective] disorders	○	○	○	○
F39 – Unspecified mood [affective] disorder	○	○	○	○
F40–F48 – Anxiety, dissociative, stress-related, somatoform, and other nonpsychotic mental disorders	○	○	○	○
F50 – Eating disorders	○	○	○	○
F51 – Sleep disorders not due to a substance or known physiological condition	○	○	○	○
F60.2 – Antisocial personality disorder	○	○	○	○
F60.3 – Borderline personality disorder	○	○	○	○

A. BEHAVIORAL HEALTH DIAGNOSES (CONTINUED)

Behavioral Health Diagnoses	Diagnosed?	For each diagnosis selected, please indicate whether diagnosis is primary, secondary, or tertiary, if known		
	Select up to 3	Primary	Secondary	Tertiary
F60.0, F60.1, F60.4–F69 – Other personality disorders	○	○	○	○
F70–F79 – Intellectual disabilities	○	○	○	○
F80–F89 – Pervasive and specific developmental disorders	○	○	○	○
F90 – Attention-deficit hyperactivity disorders	○	○	○	○
F91 – Conduct disorders	○	○	○	○
F93 – Emotional disorders with onset specific to childhood	○	○	○	○
F94 – Disorders of social functioning with onset specific to childhood or adolescence	○	○	○	○
F95 – Tic disorder	○	○	○	○
F98 – Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence	○	○	○	○
F99 – Unspecified mental disorder	○	○	○	○

○ Don’t know
○ None of the above

A. BEHAVIORAL HEALTH DIAGNOSES (CONTINUED)

1. In the past 30 days, was this client diagnosed with an opioid use disorder?

- ○ Yes
- ○ No ***[SKIP TO 2.]***
- ○ Don't know ***[SKIP TO 2.]***

a. ***[IF YES]*** **In the past 30 days, which U.S. Food and Drug Administration (FDA)-approved medication did the client receive for the treatment of this opioid use disorder?** ***[CHECK ALL THAT APPLY.]***

- ○ Methadone ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Buprenorphine ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Naltrexone ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Extended-release naltrexone ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Client did not receive an FDA-approved medication for an opioid use disorder
- ○ Don't know

2. In the past 30 days, was this client diagnosed with an alcohol use disorder?

- ○ Yes
- ○ No ***[SKIP TO 3 IF INTAKE. SKIP TO SECTION B IF FOLLOW-UP OR DISCHARGE.]***
- ○ Don't know ***[SKIP TO 3 IF INTAKE. SKIP TO SECTION B IF FOLLOW-UP OR DISCHARGE.]***

a. ***[IF YES]*** **In the past 30 days, which FDA-approved medication did the client receive for the treatment of this alcohol use disorder?** ***[CHECK ALL THAT APPLY.]***

- ○ Naltrexone ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Extended-release naltrexone ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Disulfiram ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Acamprosate ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Client did not receive an FDA-approved medication for an alcohol use disorder
- ○ Don't know

[FOLLOW-UP AND DISCHARGE INTERVIEWS: SKIP TO SECTION B.]

3. Was the client screened by your program for co-occurring mental health and substance use disorders?

- ○ YES
- ○ NO ***[SKIP 3a.]***

3a. ***[IF YES]*** **Did the client screen positive for co-occurring mental health and substance use disorders?**

- ○ YES
- ○ NO

[SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT) GRANTS CONTINUE. ALL OTHERS GO TO SECTION A, "PLANNED SERVICES."]

A. BEHAVIORAL HEALTH DIAGNOSES (CONTINUED)

THIS SECTION FOR SBIRT GRANTS ONLY [ITEMS 4, 4A, AND 5 REPORTED ONLY AT INTAKE/BASELINE].

4. How did the client screen for your SBIRT?

- ○ NEGATIVE
- ○ POSITIVE

4a. What was his/her screening score?

Alcohol Use Disorders Identification Test (AUDIT)	=	|____|____|
CAGE	=	|____|____|
Drug Abuse Screening Test (DAST)	=	|____|____|
DAST-10	=	|____|____|
National Institute on Alcohol Abuse and Alcoholism (NIAAA) Guide	=	|____|____|
Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)/Alcohol Subscore	=	|____|____|
Other (Specify)	=	|____|____|

_____
_____
_____

5. Was he/she willing to continue his/her participation in the SBIRT program?

- ○ YES
- ○ NO

A. PLANNED SERVICES

[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT INTAKE/BASELINE.]

Identify the services you plan to provide to the client during the client's course of treatment/recovery. ***[SELECT "YES" OR "NO" FOR EACH ONE.]***

Modality	**Yes**	**No**
[SELECT AT LEAST ONE MODALITY.]		
1. Case Management	○	○
2. Day Treatment	○	○
3. Inpatient/Hospital (Other Than Detox)	○	○
4. Outpatient	○	○
5. Outreach	○	○
6. Intensive Outpatient	○	○
7. Methadone	○	○
8. Residential/Rehabilitation	○	○
9. Detoxification (Select Only One)		
A. Hospital Inpatient	○	○
B. Free-Standing Residential	○	○
C. Ambulatory Detoxification	○	○
10. After Care	○	○
11. Recovery Support	○	○
12. Other (Specify)_____	○	○

Treatment Services	**Yes**	**No**
[SELECT AT LEAST ONE SERVICE.]		
[SBIRT GRANTS: YOU MUST SELECT "YES" FOR AT LEAST ONE OF THE TREATMENT SERVICES NUMBERED 1–4.]		
1. Screening	○	○
2. Brief Intervention	○	○
3. Brief Treatment	○	○
4. Referral to Treatment	○	○
5. Assessment	○	○
6. Treatment/Recovery Planning	○	○
7. Individual Counseling	○	○
8. Group Counseling	○	○
9. Family/Marriage Counseling	○	○
10. Co-Occurring Treatment/ Recovery Services	○	○
11. Pharmacological Interventions	○	○
12. HIV/AIDS Counseling	○	○
13. Other Clinical Services (Specify) _____	○	○

Case Management Services	**Yes**	**No**
1. Family Services (Including Marriage Education, Parenting, Child Development Services)	○	○
2. Child Care	○	○
3. Employment Service		
A. Pre-Employment	○	○
B. Employment Coaching	○	○
4. Individual Services Coordination	○	○
5. Transportation	○	○
6. HIV/AIDS Service	○	○
7. Supportive Transitional Drug-Free Housing Services	○	○
8. Other Case Management Services (Specify)_____	○	○

Medical Services	**Yes**	**No**
1. Medical Care	○	○
2. Alcohol/Drug Testing	○	○
3. HIV/AIDS Medical Support and Testing	○	○
4. Other Medical Services (Specify)_____	○	○

After Care Services	**Yes**	**No**
1. Continuing Care	○	○
2. Relapse Prevention	○	○
3. Recovery Coaching	○	○
4. Self-Help and Support Groups	○	○
5. Spiritual Support	○	○
6. Other After Care Services (Specify)_____	○	○

Education Services	**Yes**	**No**
1. Substance Abuse Education	○	○
2. HIV/AIDS Education	○	○
3. Other Education Services (Specify)_____	○	○

Peer-to-Peer Recovery Support Services	**Yes**	**No**
1. Peer Coaching or Mentoring	○	○
2. Housing Support	○	○
3. Alcohol- and Drug-Free Social Activities	○	○
4. Information and Referral	○	○
5. Other Peer-to-Peer Recovery Support Services (Specify) _____	○	○

A. DEMOGRAPHICS

[ASKED ONLY AT INTAKE/BASELINE.]

1. What is your gender?

○ MALE
○ FEMALE
○ TRANSGENDER
○ OTHER (SPECIFY) _____
○ REFUSED

2. Are you Hispanic or Latino?

○ YES
○ NO
○ REFUSED

***[IF YES]* What ethnic group do you consider yourself? Please answer yes or no for each of the following. You may say yes to more than one.**

Ethnic Group	**Yes**	**No**	**Refused**	
Central American	○	○	○	
Cuban	○	○	○	
Dominican	○	○	○	
Mexican	○	○	○	
Puerto Rican	○	○	○	
South American	○	○	○	
Other	○	○	○	***[IF YES, SPECIFY BELOW.]***

(SPECIFY) _____

3. What is your race? Please answer yes or no for each of the following. You may say yes to more than one.

Race	**Yes**	**No**	**Refused**
Black or African American	○	○	○
Asian	○	○	○
Native Hawaiian or other Pacific Islander	○	○	○
Alaska Native	○	○	○
White	○	○	○
American Indian	○	○	○

4. What is your date of birth?*

|____|____| / |____|____| ***[*THE SYSTEM WILL ONLY SAVE MONTH AND YEAR. TO MAINTAIN CONFIDENTIALITY, DAY IS NOT SAVED.]***
Month Day

|____|____|____|____|
Year

○ REFUSED

A. MILITARY FAMILY AND DEPLOYMENT

5. Have you ever served in the Armed Forces, in the Reserves, or in the National Guard? *[IF SERVED]* In which area, the Armed Forces, Reserves, or National Guard did you serve?

- ○ NO
- ○ YES, IN THE ARMED FORCES
- ○ YES, IN THE RESERVES
- ○ YES, IN THE NATIONAL GUARD
- ○ REFUSED
- ○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO QUESTION A6.]

5a. Are you currently on active duty in the Armed Forces, in the Reserves, or in the National Guard? *[IF ACTIVE]* In which area, the Armed Forces, Reserves, or National Guard?

- ○ NO, SEPARATED OR RETIRED FROM THE ARMED FORCES, RESERVES, OR NATIONAL GUARD
- ○ YES, IN THE ARMED FORCES
- ○ YES, IN THE RESERVES
- ○ YES, IN THE NATIONAL GUARD
- ○ REFUSED
- ○ DON'T KNOW

5b. Have you ever been deployed to a combat zone? *[CHECK ALL THAT APPLY.]*

- ○ NEVER DEPLOYED
- ○ IRAQ OR AFGHANISTAN (E.G., Operation Enduring Freedom [OEF]/ Operation Iraqi Freedom [OIF]/ Operation New Dawn [OND])
- ○ PERSIAN GULF (OPERATION DESERT SHIELD/DESERT STORM)
- ○ VIETNAM/SOUTHEAST ASIA
- ○ KOREA
- ○ WWII
- ○ DEPLOYED TO A COMBAT ZONE NOT LISTED ABOVE (E.G., BOSNIA/SOMALIA)
- ○ REFUSED
- ○ DON'T KNOW

[SBIRT GRANTEES: FOR CLIENTS WHO SCREENED NEGATIVE, THE INTAKE INTERVIEW IS NOW COMPLETE.]

A. MILITARY FAMILY AND DEPLOYMENT (CONTINUED)

6. Is anyone in your family or someone close to you on active duty in the Armed Forces, in the Reserves, or in the National Guard or separated or retired from the Armed Forces, Reserves, or National Guard?

- ○ NO
- ○ YES, ONLY ONE
- ○ YES, MORE THAN ONE
- ○ REFUSED
- ○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO SECTION B.]

[IF YES, ANSWER FOR UP TO 6 PEOPLE.]* What is the relationship of that person (Service Member) to you? *[WRITE RELATIONSHIP IN COLUMN HEADING.]

1 = Mother 2 = Father
3 = Brother 4 = Sister
5 = Spouse 6 = Partner
7 = Child 8 = Other (Specify) _____

Has the Service Member experienced any of the following? *[CHECK ANSWER IN APPROPRIATE COLUMN FOR ALL THAT APPLY.]*	**_____ (Relationship) 1.**	**_____ (Relationship) 2.**	**_____ (Relationship) 3.**	**_____ (Relationship) 4.**	**_____ (Relationship) 5.**	**_____ (Relationship) 6.**
6a. Deployed in support of combat operations (e.g., Iraq or Afghanistan)?	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW
6b. Was physically injured during combat operations?	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW
6c. Developed combat stress symptoms/difficulties adjusting following deployment, including post-traumatic stress disorder (PTSD), depression, or suicidal thoughts?	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW
6d. Died or was killed?	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW

B. DRUG AND ALCOHOL USE

	Number of Days	REFUSED	DON'T KNOW
1. During the past 30 days, how many days have you used the following:			
a. Any alcohol ***[IF ZERO, SKIP TO ITEM B1c.]***	|____|____|	○	○
b1. Alcohol to intoxication (5+ drinks in one sitting)	|____|____|	○	○
b2. Alcohol to intoxication (4 or fewer drinks in one sitting and felt high)	|____|____|	○	○
c. Illegal drugs ***[IF B1a OR B1c = 0, REFUSED (RF), DON'T KNOW (DK), THEN SKIP TO ITEM B2.]***	|____|____|	○	○
d. Both alcohol and drugs (on the same day)	|____|____|	○	○

Route of Administration Types:
1. Oral 2. Nasal 3. Smoking 4. Non-intravenous (IV) injection 5. IV
*NOTE THE USUAL ROUTE. FOR MORE THAN ONE ROUTE, CHOOSE THE MOST SEVERE. THE ROUTES ARE LISTED FROM LEAST SEVERE (1) TO MOST SEVERE (5).

2. During the past 30 days, how many days have you used any of the following: *[IF THE VALUE IN ANY ITEM B2a–B2i > 0, THEN THE VALUE IN B1c MUST BE > 0.]*

	Number of Days	RF	DK	Route*	RF	DK
a. Cocaine/Crack	|____|____|	○	○	|____|	○	○
b. Marijuana/Hashish (Pot, Joints, Blunts, Chronic, Weed, Mary Jane)	|____|____|	○	○	|____|	○	○
c. Opiates:						
1. Heroin (Smack, H, Junk, Skag)	|____|____|	○	○	|____|	○	○
2. Morphine	|____|____|	○	○	|____|	○	○
3. Dilaudid	|____|____|	○	○	|____|	○	○
4. Demerol	|____|____|	○	○	|____|	○	○
5. Percocet	|____|____|	○	○	|____|	○	○
6. Darvon	|____|____|	○	○	|____|	○	○
7. Codeine	|____|____|	○	○	|____|	○	○
8. Tylenol 2, 3, 4	|____|____|	○	○	|____|	○	○
9. OxyContin/Oxycodone	|____|____|	○	○	|____|	○	○
d. Non-prescription methadone	|____|____|	○	○	|____|	○	○
e. Hallucinogens/psychedelics, PCP (Angel Dust, Ozone, Wack, Rocket Fuel), MDMA (Ecstasy, XTC, X, Adam), LSD (Acid, Boomers, Yellow Sunshine), Mushrooms, or Mescaline	|____|____|	○	○	|____|	○	○
f. Methamphetamine or other amphetamines (Meth, Uppers, Speed, Ice, Chalk, Crystal, Glass, Fire, Crank)	|____|____|	○	○	|____|	○	○

B. DRUG AND ALCOHOL USE (CONTINUED)

Route of Administration Types:
1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV
*NOTE THE USUAL ROUTE. FOR MORE THAN ONE ROUTE, CHOOSE THE MOST SEVERE. THE ROUTES ARE LISTED FROM LEAST SEVERE (1) TO MOST SEVERE (5).

2. During the past 30 days, how many days have you used any of the following: ***[IF THE VALUE IN ANY ITEM B2a–B2i > 0, THEN THE VALUE IN B1c MUST BE > 0.]***

		Number of Days	RF	DK	Route*	RF	DK
g.	1. Benzodiazepines: Diazepam (Valium); Alprazolam (Xanax); Triazolam (Halcion); and Estasolam (Prosom and Rohypnol, also known as roofies, roche, and cope)	|____|____|	○	○	|____|	○	○
	2. Barbiturates: Mephobarbital (Mebacut) and pentobarbital sodium (Nembutal)	|____|____|	○	○	|____|	○	○
	3. Non-prescription GHB (known as Grievous Bodily Harm, Liquid Ecstasy, and Georgia Home Boy)	|____|____|	○	○	|____|	○	○
	4. Ketamine (known as Special K or Vitamin K)	|____|____|	○	○	|____|	○	○
	5. Other tranquilizers, downers, sedatives, or hypnotics	|____|____|	○	○	|____|	○	○
h.	Inhalants (poppers, snappers, rush, whippets)	|____|____|	○	○	|____|	○	○
i.	Other illegal drugs (Specify) _____	|____|____|	○	○	|____|	○	○

3. In the past 30 days, have you injected drugs? ***[IF ANY ROUTE OF ADMINISTRATION IN B2a–B2i = 4 or 5, THEN B3 MUST = YES.]***

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO SECTION C.]

4. In the past 30 days, how often did you use a syringe/needle, cooker, cotton, or water that someone else used?

- ○ Always
- ○ More than half the time
- ○ Half the time
- ○ Less than half the time
- ○ Never
- ○ REFUSED
- ○ DON'T KNOW

C. FAMILY AND LIVING CONDITIONS

1. In the past 30 days, where have you been living most of the time? ***[DO NOT READ RESPONSE OPTIONS TO CLIENT.]***

- ○ SHELTER (SAFE HAVENS, TRANSITIONAL LIVING CENTER [TLC], LOW-DEMAND FACILITIES, RECEPTION CENTERS, OTHER TEMPORARY DAY OR EVENING FACILITY)
- ○ STREET/OUTDOORS (SIDEWALK, DOORWAY, PARK, PUBLIC OR ABANDONED BUILDING)
- ○ INSTITUTION (HOSPITAL, NURSING HOME, JAIL/PRISON)
- ○ HOUSED: ***[IF HOUSED, CHECK APPROPRIATE SUBCATEGORY:]***
  - ○ OWN/RENT APARTMENT, ROOM, OR HOUSE
  - ○ SOMEONE ELSE'S APARTMENT, ROOM, OR HOUSE
  - ○ DORMITORY/COLLEGE RESIDENCE
  - ○ HALFWAY HOUSE
  - ○ RESIDENTIAL TREATMENT
  - ○ OTHER HOUSED (SPECIFY) _____
- ○ REFUSED
- ○ DON'T KNOW

2. How satisfied are you with the conditions of your living space?

- ○ Very dissatisfied
- ○ Dissatisfied
- ○ Neither satisfied nor dissatisfied
- ○ Satisfied
- ○ Very satisfied
- ○ REFUSED
- ○ DON'T KNOW

3. During the past 30 days, how stressful have things been for you because of your use of alcohol or other drugs? ***[IF B1a <u>OR</u> B1c > 0, THEN C3 CANNOT = "NOT APPLICABLE."]***

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely
- ○ NOT APPLICABLE ***[USE ONLY IF B1A <u>AND</u> B1C = 0.]***
- ○ REFUSED
- ○ DON'T KNOW

4. During the past 30 days, has your use of alcohol or other drugs caused you to reduce or give up important activities? ***[IF B1a <u>OR</u> B1c > 0, THEN C4 CANNOT = "NOT APPLICABLE."]***

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely
- ○ NOT APPLICABLE ***[USE ONLY IF B1A <u>AND</u> B1C = 0.]***
- ○ REFUSED
- ○ DON'T KNOW

C. FAMILY AND LIVING CONDITIONS (CONTINUED)

5. During the past 30 days, has your use of alcohol or other drugs caused you to have emotional problems? ***[IF B1a OR B1c > 0, THEN C5 CANNOT = "NOT APPLICABLE."]***

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely
- ○ NOT APPLICABLE ***[USE ONLY IF B1a AND B1c = 0.]***
- ○ REFUSED
- ○ DON'T KNOW

6. ***[IF NOT MALE]*** **Are you currently pregnant?**

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

7. Do you have children?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO SECTION D.]

a. How many children do you have? ***[IF C7 = YES, THEN THE VALUE IN C7a MUST BE > 0.]***

|____|____| ○ REFUSED ○ DON'T KNOW

b. Are any of your children living with someone else due to a child protection court order?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO ITEM C7D.]

c. ***[IF YES]*** **How many of your children are living with someone else due to a child protection court order?** ***[THE VALUE IN C7c CANNOT EXCEED THE VALUE IN C7a.]***

|____|____| ○ REFUSED ○ DON'T KNOW

d. For how many of your children have you lost parental rights? ***[THE CLIENT'S PARENTAL RIGHTS WERE TERMINATED.] [THE VALUE IN ITEM C7d CANNOT EXCEED THE VALUE IN C7a.]***

|____|____| ○ REFUSED ○ DON'T KNOW

D. EDUCATION, EMPLOYMENT, AND INCOME

1. Are you currently enrolled in school or a job training program? *[IF ENROLLED]* Is that full time or part time? *[IF CLIENT IS INCARCERATED, CODE D1 AS "NOT ENROLLED."]*

- ○ NOT ENROLLED
- ○ ENROLLED, FULL TIME
- ○ ENROLLED, PART TIME
- ○ OTHER (SPECIFY)_____
- ○ REFUSED
- ○ DON'T KNOW

2. What is the highest level of education you have finished, whether or not you received a degree?

- ○ NEVER ATTENDED
- ○ 1ST GRADE
- ○ 2ND GRADE
- ○ 3RD GRADE
- ○ 4TH GRADE
- ○ 5TH GRADE
- ○ 6TH GRADE
- ○ 7TH GRADE
- ○ 8TH GRADE
- ○ 9TH GRADE
- ○ 10TH GRADE
- ○ 11TH GRADE
- ○ 12TH GRADE/HIGH SCHOOL DIPLOMA/EQUIVALENT
- ○ COLLEGE OR UNIVERSITY/1ST YEAR COMPLETED
- ○ COLLEGE OR UNIVERSITY/2ND YEAR COMPLETED/ASSOCIATE'S DEGREE (AA, AS)
- ○ COLLEGE OR UNIVERSITY/3RD YEAR COMPLETED
- ○ BACHELOR'S DEGREE (BA, BS) OR HIGHER
- ○ VOCATIONAL/TECHNICAL (VOC/TECH) PROGRAM AFTER HIGH SCHOOL BUT NO VOC/TECH DIPLOMA
- ○ VOC/TECH DIPLOMA AFTER HIGH SCHOOL
- ○ REFUSED
- ○ DON'T KNOW

3. Are you currently employed? *[CLARIFY BY FOCUSING ON STATUS DURING MOST OF THE PREVIOUS WEEK, DETERMINING WHETHER CLIENT WORKED AT ALL OR HAD A REGULAR JOB BUT WAS OFF WORK. IF CLIENT IS "ENROLLED, FULL TIME" IN D1 AND INDICATES "EMPLOYED, FULL TIME" IN D3, ASK FOR CLARIFICATION. IF CLIENT IS INCARCERATED AND HAS NO WORK OUTSIDE OF JAIL, CODE D3 AS "UNEMPLOYED, NOT LOOKING FOR WORK."]*

- ○ EMPLOYED, FULL TIME (35+ HOURS PER WEEK, OR WOULD HAVE BEEN)
- ○ EMPLOYED, PART TIME
- ○ UNEMPLOYED, LOOKING FOR WORK
- ○ UNEMPLOYED, DISABLED
- ○ UNEMPLOYED, VOLUNTEER WORK
- ○ UNEMPLOYED, RETIRED
- ○ UNEMPLOYED, NOT LOOKING FOR WORK
- ○ OTHER (SPECIFY)_____
- ○ REFUSED
- ○ DON'T KNOW

D. EDUCATION, EMPLOYMENT, AND INCOME (CONTINUED)

4. Approximately, how much money did YOU receive (pre-tax individual income) in the past 30 days from … ***[IF D3 DOES NOT = "EMPLOYED" AND THE VALUE IN D4a IS GREATER THAN ZERO, PROBE. IF D3 = "UNEMPLOYED, LOOKING FOR WORK" AND THE VALUE IN D4b = 0, PROBE. IF D3 = "UNEMPLOYED, RETIRED" AND THE VALUE IN D4c = 0, PROBE. IF D3 = "UNEMPLOYED, DISABLED" AND THE VALUE IN D4d = 0, PROBE.]***

			RF	DK
a.	Wages	$ |__|__|__| , |__|__|__|	○	○
b.	Public assistance	$ |__|__|__| , |__|__|__|	○	○
c.	Retirement	$ |__|__|__| , |__|__|__|	○	○
d.	Disability	$ |__|__|__| , |__|__|__|	○	○
e.	Non-legal income	$ |__|__|__| , |__|__|__|	○	○
f.	Family and/or friends	$ |__|__|__| , |__|__|__|	○	○
g.	Other (Specify) _____	$ |__|__|__| , |__|__|__|	○	○

5. Have you enough money to meet your needs?

○ Not at all
○ A little
○ Moderately
○ Mostly
○ Completely
○ REFUSED
○ DON'T KNOW

E. CRIME AND CRIMINAL JUSTICE STATUS

1. In the past 30 days, how many times have you been arrested?

|____|____| TIMES ○ REFUSED ○ DON'T KNOW

[IF NO ARRESTS, SKIP TO ITEM E3.]

2. In the past 30 days, how many times have you been arrested for drug-related offenses? ***[THE VALUE IN E2 CANNOT BE GREATER THAN THE VALUE IN E1.]***

|____|____| TIMES ○ REFUSED ○ DON'T KNOW

3. In the past 30 days, how many nights have you spent in jail/prison? ***[IF THE VALUE IN E3 IS GREATER THAN 15, THEN C1 MUST = INSTITUTION (JAIL/PRISON). IF C1 = INSTITUTION (JAIL/PRISON), THEN THE VALUE IN E3 MUST BE GREATER THAN OR EQUAL TO 15.]***

|____|____| NIGHTS ○ REFUSED ○ DON'T KNOW

4. In the past 30 days, how many times have you committed a crime? ***[CHECK NUMBER OF DAYS USED ILLEGAL DRUGS IN ITEM B1c. ANSWER HERE IN E4 SHOULD BE EQUAL TO OR GREATER THAN NUMBER IN B1c BECAUSE USING ILLEGAL DRUGS IS A CRIME.]***

|____|____|____| TIMES ○ REFUSED ○ DON'T KNOW

5. Are you currently awaiting charges, trial, or sentencing?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

6. Are you currently on parole or probation?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY

1. How would you rate your overall health right now?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor
- ○ REFUSED
- ○ DON'T KNOW

2. During the past 30 days, did you receive:

a. Inpatient treatment for:

	YES	*[IF YES]* Altogether for how many nights	NO	RF	DK
i. Physical complaint	○	_____nights	○	○	○
ii. Mental or emotional difficulties	○	_____nights	○	○	○
iii. Alcohol or substance abuse	○	_____nights	○	○	○

b. Outpatient treatment for:

	YES	*[IF YES]* Altogether for how many times	NO	RF	DK
i. Physical complaint	○	_____ times	○	○	○
ii. Mental or emotional difficulties	○	_____ times	○	○	○
iii. Alcohol or substance abuse	○	_____ times	○	○	○

c. Emergency room treatment for:

	YES	*[IF YES]* Altogether for how many times	NO	RF	DK
i. Physical complaint	○	_____ times	○	○	○
ii. Mental or emotional difficulties	○	_____ times	○	○	○
iii. Alcohol or substance abuse	○	_____ times	○	○	○

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (CONTINUED)

3. During the past 30 days, did you engage in sexual activity?

- ○ Yes
- ○ No ***[SKIP TO F4.]***
- ○ NOT PERMITTED TO ASK ***[SKIP TO F4.]***
- ○ REFUSED ***[SKIP TO F4.]***
- ○ DON'T KNOW ***[SKIP TO F4.]***

[IF YES] **Altogether, how many:**

		Contacts	RF	DK
a.	Sexual contacts (vaginal, oral, or anal) did you have?	|____|____|	○	○
b.	Unprotected sexual contacts did you have? ***[THE VALUE IN F3b SHOULD NOT BE GREATER THAN THE VALUE IN F3a.] [IF ZERO, SKIP TO F4.]***	|____|____|____|	○	○
c.	Unprotected sexual contacts were with an individual who is or was ***[NONE OF THE VALUES IN F3c1–F3c3 CAN BE GREATER THAN THE VALUE IN F3b.]***			
	1. HIV positive or has AIDS	|____|____|____|	○	○
	2. An injection drug user	|____|____|____|	○	○
	3. High on some substance	|____|____|____|	○	○

4. Have you ever been tested for HIV?

- ○ Yes ***[GO TO F4a.]***
- ○ No ***[SKIP TO F5.]***
- ○ REFUSED ***[SKIP TO F5.]***
- ○ DON'T KNOW ***[SKIP TO F5.]***

a. Do you know the results of your HIV testing?

- ○ Yes
- ○ No

5. How would you rate your quality of life?

- ○ Very poor
- ○ Poor
- ○ Neither poor nor good
- ○ Good
- ○ Very good
- ○ REFUSED
- ○ DON'T KNOW

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (CONTINUED)

6. How satisfied are you with your health?

- ○ Very dissatisfied
- ○ Dissatisfied
- ○ Neither satisfied nor dissatisfied
- ○ Satisfied
- ○ Very satisfied
- ○ REFUSED
- ○ DON'T KNOW

7. Do you have enough energy for everyday life?

- ○ Not at all
- ○ A little
- ○ Moderately
- ○ Mostly
- ○ Completely
- ○ REFUSED
- ○ DON'T KNOW

8. How satisfied are you with your ability to perform your daily activities?

- ○ Very dissatisfied
- ○ Dissatisfied
- ○ Neither satisfied nor dissatisfied
- ○ Satisfied
- ○ Very satisfied
- ○ REFUSED
- ○ DON'T KNOW

9. How satisfied are you with yourself?

- ○ Very dissatisfied
- ○ Dissatisfied
- ○ Neither satisfied nor dissatisfied
- ○ Satisfied
- ○ Very satisfied
- ○ REFUSED
- ○ DON'T KNOW

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (CONTINUED)

10. In the past 30 days, not due to your use of alcohol or drugs, how many days have you:

		Days	RF	DK
a.	Experienced serious depression	|____|____|	○	○
b.	Experienced serious anxiety or tension	|____|____|	○	○
c.	Experienced hallucinations	|____|____|	○	○
d.	Experienced trouble understanding, concentrating, or remembering	|____|____|	○	○
e.	Experienced trouble controlling violent behavior	|____|____|	○	○
f.	Attempted suicide	|____|____|	○	○
g.	Been prescribed medication for psychological/emotional problem	|____|____|	○	○

[IF CLIENT REPORTS ZERO DAYS, RF, OR DK TO ALL ITEMS IN QUESTION F10, SKIP TO ITEM F12.]

11. How much have you been bothered by these psychological or emotional problems in the past 30 days?

○ Not at all
○ Slightly
○ Moderately
○ Considerably
○ Extremely
○ REFUSED
○ DON'T KNOW

F. VIOLENCE AND TRAUMA

12. Have you ever experienced violence or trauma in any setting (including community or school violence; domestic violence; physical, psychological, or sexual maltreatment/assault within or outside of the family; natural disaster; terrorism; neglect; or traumatic grief)?

○ YES
○ NO
○ REFUSED
○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO ITEM F13.]

Did any of these experiences feel so frightening, horrible, or upsetting that, in the past and/or the present, you:

12a. Have had nightmares about it or thought about it when you did not want to?

○ YES
○ NO
○ REFUSED
○ DON'T KNOW

F. VIOLENCE AND TRAUMA (CONTINUED)

12b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

12c. Were constantly on guard, watchful, or easily startled?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

12d. Felt numb and detached from others, activities, or your surroundings?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

13. In the past 30 days, how often have you been hit, kicked, slapped, or otherwise physically hurt?

- ○ Never
- ○ A few times
- ○ More than a few times
- ○ REFUSED
- ○ DON'T KNOW

G. SOCIAL CONNECTEDNESS

1. In the past 30 days, did you attend any voluntary self-help groups for recovery that were not affiliated with a religious or faith-based organization? In other words, did you participate in a nonprofessional, peer-operated organization that is devoted to helping individuals who have addiction-related problems, such as Alcoholics Anonymous, Narcotics Anonymous, Oxford House, Secular Organization for Sobriety, or Women for Sobriety, etc.?

○ YES ***[IF YES]*** SPECIFY HOW MANY TIMES |____|____| ○ REFUSED ○ DON'T KNOW
○ NO
○ REFUSED
○ DON'T KNOW

2. In the past 30 days, did you attend any religious/faith-affiliated recovery self-help groups?

○ YES ***[IF YES]*** SPECIFY HOW MANY TIMES |____|____| ○ REFUSED ○ DON'T KNOW
○ NO
○ REFUSED
○ DON'T KNOW

3. In the past 30 days, did you attend meetings of organizations that support recovery other than the organizations described above?

○ YES ***[IF YES]*** SPECIFY HOW MANY TIMES |____|____| ○ REFUSED ○ DON'T KNOW
○ NO
○ REFUSED
○ DON'T KNOW

4. In the past 30 days, did you have interaction with family and/or friends that are supportive of your recovery?

○ YES
○ NO
○ REFUSED
○ DON'T KNOW

5. To whom do you turn when you are having trouble? *[SELECT ONLY ONE.]*

○ NO ONE
○ CLERGY MEMBER
○ FAMILY MEMBER
○ FRIENDS
○ REFUSED
○ DON'T KNOW
○ OTHER (SPECIFY)_____

6. How satisfied are you with your personal relationships?

○ Very dissatisfied
○ Dissatisfied
○ Neither satisfied nor dissatisfied
○ Satisfied
○ Very satisfied
○ REFUSED
○ DON'T KNOW

H. PROGRAM-SPECIFIC QUESTIONS

YOU ARE NOT RESPONSIBLE FOR COLLECTING DATA ON ALL SECTION H QUESTIONS. YOUR GOVERNMENT PROJECT OFFICER (GPO) HAS PROVIDED GUIDANCE ON WHICH SPECIFIC SECTION H QUESTIONS YOU ARE TO COMPLETE. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT YOUR GPO.

H1. PROGRAM-SPECIFIC QUESTIONS

[QUESTION 1 SHOULD BE REPORTED BY GRANTEE STAFF AT FOLLOW-UP AND DISCHARGE.]

1. Which of the following occurred for the client subsequent to receiving treatment? ***[CHECK ALL THAT APPLY.]***

- ○ Client was reunited with child (or children)
- ○ Client avoided out-of-home placement for child (or children)
- ○ None of the above
- ○ Don't know

H2. PROGRAM-SPECIFIC QUESTIONS

[QUESTION 1 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE.]

1. Did the *[INSERT GRANTEE NAME]* help you obtain any of the following benefits? *[CHECK ALL THAT APPLY.]*

- ○ Private health insurance
- ○ Medicaid
- ○ Supplemental Security Income (SSI)/ Social Security disability insurance (SSDI)
- ○ Temporary Assistance for Needy Families (TANF)
- ○ Supplemental Nutrition Assistance Program (SNAP)
- ○ Other (Specify) _____
- ○ NONE OF THE ABOVE
- ○ REFUSED
- ○ DON'T KNOW

H3. PROGRAM-SPECIFIC QUESTIONS

[QUESTION 1 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE.]

1. Have you achieved any of the following since you began receiving services or supports from *[INSERT GRANTEE NAME]*? If yes, do you believe that the services you received from *[INSERT GRANTEE NAME]* helped you with this achievement?

Status	Achieved?	If yes, do you believe that the services you received from *[INSERT GRANTEE NAME]* helped you with this achievement?
1a. Enrolled in school	○ Yes ○ No ○ DON'T KNOW ○ REFUSED	○ Yes ○ No ○ DON'T KNOW ○ REFUSED
1b. Enrolled in vocational training	○ Yes ○ No ○ DON'T KNOW ○ REFUSED	○ Yes ○ No ○ DON'T KNOW ○ REFUSED
1c. Currently employed	○ Yes ○ No ○ DON'T KNOW ○ REFUSED	○ Yes ○ No ○ DON'T KNOW ○ REFUSED
1d. Living in stable housing	○ Yes ○ No ○ DON'T KNOW ○ REFUSED	○ Yes ○ No ○ DON'T KNOW ○ REFUSED

H4. PROGRAM-SPECIFIC QUESTIONS

[QUESTION 1 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE.]

1. Please indicate the degree to which you agree or disagree with the following statements:

a. Receiving treatment in a nonresidential setting has enabled me to maintain parenting and family responsibilities while receiving treatment.

- ○ Strongly disagree
- ○ Disagree
- ○ Undecided
- ○ Agree
- ○ Strongly agree
- ○ REFUSED
- ○ DON'T KNOW

b. As a result of treatment, I feel I now have the skills and support to balance parenting and managing my recovery.

- ○ Strongly disagree
- ○ Disagree
- ○ Undecided
- ○ Agree
- ○ Strongly agree
- ○ REFUSED
- ○ DON'T KNOW

H5. PROGRAM-SPECIFIC QUESTIONS

[QUESTION 1 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE.]

1. Please indicate the degree to which you agree or disagree with the following statements:

a. Receiving treatment in a residential setting with my child (or children) has enabled me to focus on my treatment without distractions of parenting and family responsibilities.

- ○ Strongly disagree
- ○ Disagree
- ○ Undecided
- ○ Agree
- ○ Strongly agree
- ○ REFUSED
- ○ DON'T KNOW

b. As a result of treatment, I feel I now have the skills and support to balance parenting and managing my recovery.

- ○ Strongly disagree
- ○ Disagree
- ○ Undecided
- ○ Agree
- ○ Strongly agree
- ○ REFUSED
- ○ DON'T KNOW

H6. PROGRAM-SPECIFIC QUESTIONS

[QUESTION 1 SHOULD BE REPORTED BY GRANTEE STAFF AT INTAKE/BASELINE, FOLLOW-UP, AND DISCHARGE].

1. Please indicate which type of funding was/will be used to pay for the SBIRT services provided to this client. ***[CHECK ALL THAT APPLY.]***

- ○ Current SAMHSA grant funding
- ○ Other federal grant funding
- ○ State funding
- ○ Client's private insurance
- ○ Medicaid/Medicare
- ○ Other (Specify) _____
- ○ Don't know

[IF FOLLOW-UP OR DISCHARGE INTERVIEW, SKIP TO H3.]

[QUESTION 2 SHOULD BE REPORTED BY GRANTEE STAFF ONLY AT INTAKE/BASELINE.]

2. If the client screened positive for substance misuse or a substance use disorder, was the client assigned to the following types of services? ***[IF CLIENT SCREENED NEGATIVE, SELECT "NO" FOR EACH SERVICE BELOW.]***

	Yes	No	Don't Know
Brief Intervention	○	○	○
Brief Treatment	○	○	○
Referral to Treatment	○	○	○

[QUESTION 3 SHOULD BE REPORTED BY GRANTEE STAFF AT INTAKE, BASELINE, FOLLOW-UP, AND DISCHARGE.]

3. Did the client receive the following types of services?

	Yes	No	Don't Know
Brief Intervention	○	○	○
Brief Treatment	○	○	○
Referral to Treatment	○	○	○

H7. PROGRAM-SPECIFIC QUESTIONS

[QUESTION 1 SHOULD BE ANSWERED BY THE CLIENT AT INTAKE/BASELINE, FOLLOW-UP, AND DISCHARGE.]

1. Did the program provide the following?

a. HIV test

- ○ YES
- ○ NO ***[SKIP TO H1b.]***
- ○ REFUSED ***[SKIP TO H1b.]***
- ○ DON'T KNOW ***[SKIP TO H1b.]***

[IF YES] **What was the result?**

- ○ Positive
- ○ Negative ***[SKIP TO H1b.]***
- ○ Indeterminate ***[SKIP TO H1b.]***
- ○ REFUSED ***[SKIP TO H1b.]***
- ○ DON'T KNOW ***[SKIP TO H1b.]***

[IF CLIENT SCREENED POSITIVE] **Were you connected to HIV treatment services?**

- ○ Yes
- ○ No
- ○ REFUSED
- ○ DON'T KNOW

b. Hepatitis B (HBV) test

- ○ YES
- ○ NO ***[SKIP TO H1c.]***
- ○ REFUSED ***[SKIP TO H1c.]***
- ○ DON'T KNOW ***[SKIP TO H1c.]***

[IF YES] **What was the result?**

- ○ Positive
- ○ Negative [***SKIP TO H1c.]***
- ○ Indeterminate [***SKIP TO H1c.]***
- ○ REFUSED [***SKIP TO H1c.]***
- ○ DON'T KNOW [***SKIP TO H1c.]***

[IF CLIENT SCREENED POSITIVE] **Were you connected to HBV treatment services?**

- ○ Yes
- ○ No
- ○ REFUSED
- ○ DON'T KNOW

H7. PROGRAM-SPECIFIC QUESTIONS (CONTINUED)

c. Hepatitis C (HCV) test

- ○ YES
- ○ NO ***[SKIP TO SECTION I OR J/K.]***
- ○ REFUSED ***[SKIP TO SECTION I OR J/K.]***
- ○ DON'T KNOW ***[SKIP TO SECTION I OR J/K.]***

[IF YES] **What was the result?**

- ○ Positive
- ○ Negative ***[SKIP TO SECTION I OR J/K.]***
- ○ Indeterminate ***[SKIP TO SECTION I OR J/K.]***
- ○ REFUSED ***[SKIP TO SECTION I OR J/K.]***
- ○ DON'T KNOW ***[SKIP TO SECTION I OR J/K.]***

[IF CLIENT SCREENED POSITIVE] **Were you connected to HCV treatment services?**

- ○ Yes
- ○ No
- ○ REFUSED
- ○ DON'T KNOW

H8. PROGRAM-SPECIFIC QUESTIONS

[QUESTIONS 1 AND 2 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE.]

1. Have you achieved any of the following since you began receiving peer services through *[INSERT GRANTEE NAME]*? If yes, do you believe that the peer services you received from *[INSERT GRANTEE NAME]* helped you with this achievement?

Status	Achieved?	If yes, do you believe that the peer services you received from *[INSERT GRANTEE NAME]* helped you with this achievement?
1a. Enrolled in school	○ Yes ○ No ○ DON'T KNOW ○ REFUSED	○ Yes ○ No ○ DON'T KNOW ○ REFUSED
1b. Enrolled in vocational training	○ Yes ○ No ○ DON'T KNOW ○ REFUSED	○ Yes ○ No ○ DON'T KNOW ○ REFUSED
1c. Currently employed	○ Yes ○ No ○ DON'T KNOW ○ REFUSED	○ Yes ○ No ○ DON'T KNOW ○ REFUSED
1d. Living in stable housing	○ Yes ○ No ○ DON'T KNOW ○ REFUSED	○ Yes ○ No ○ DON'T KNOW ○ REFUSED

2. To what extent has this program improved your quality of life?

○ To a great extent
○ Somewhat
○ Very little
○ Not at all
○ REFUSED
○ DON'T KNOW

H9. PROGRAM-SPECIFIC QUESTIONS

[QUESTION 1 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE.]

1. Please indicate the degree to which you agree or disagree with the following statements:

i. The use of technology accessed through *[INSERT GRANTEE NAME]* has helped me communicate with my provider.

- ○ Strongly disagree
- ○ Disagree
- ○ Undecided
- ○ Agree
- ○ Strongly agree
- ○ NOT APPLICABLE
- ○ REFUSED
- ○ DON'T KNOW

ii. The use of technology accessed through *[INSERT GRANTEE NAME]* has helped me reduce my substance use.

- ○ Strongly disagree
- ○ Disagree
- ○ Undecided
- ○ Agree
- ○ Strongly agree
- ○ NOT APPLICABLE
- ○ REFUSED
- ○ DON'T KNOW

iii. The use of technology accessed through *[INSERT GRANTEE NAME]* has helped me manage my mental health symptoms.

- ○ Strongly disagree
- ○ Disagree
- ○ Undecided
- ○ Agree
- ○ Strongly agree
- ○ NOT APPLICABLE
- ○ REFUSED
- ○ DON'T KNOW

iv. The use of technology accessed through *[INSERT GRANTEE NAME]* has helped me support my recovery.

- ○ Strongly disagree
- ○ Disagree
- ○ Undecided
- ○ Agree
- ○ Strongly agree
- ○ NOT APPLICABLE
- ○ REFUSED
- ○ DON'T KNOW

H10. PROGRAM-SPECIFIC QUESTIONS

[QUESTIONS 1 AND 1A SHOULD BE REPORTED BY GRANTEE STAFF AT INTAKE/BASELINE, FOLLOW-UP, AND DISCHARGE. QUESTION 1B SHOULD BE REPORTED BY GRANTEE STAFF AT FOLLOW-UP/DISCHARGE IF THE CLIENT HAS BEEN REFERRED FOR SERVICES.]

1. Did the client screen positive for a mental health disorder?

- ○ Client screened positive
- ○ Client screened negative ***[SKIP TO H2.]***
- ○ Client was not screened ***[SKIP TO H2.]***
- ○ Don't know ***[SKIP TO H2.]***

a. ***[IF POSITIVE]*** **Was the client referred to mental health services?**

- ○ Yes
- ○ No ***[SKIP TO H2.]***
- ○ Don't know ***[SKIP TO H2.]***

b. ***[IF YES]*** **Did the client receive mental health services?**

- ○ Yes
- ○ No
- ○ Don't know

[QUESTIONS 2 AND 2A SHOULD BE REPORTED BY GRANTEE STAFF AT INTAKE/BASELINE, FOLLOW-UP, AND DISCHARGE. QUESTION 2B SHOULD BE REPORTED BY GRANTEE STAFF AT FOLLOW-UP/DISCHARGE IF THE CLIENT HAS BEEN REFERRED FOR SERVICES.]

2. Did the client screen positive for a substance use disorder?

- ○ Client screened positive
- ○ Client screened negative
- ○ Client was not screened
- ○ Don't know

[IF THIS IS AT INTAKE/BASELINE AND THE RESPONSE IS NEGATIVE, NOT SCREENED, OR DON'T KNOW, SECTION H IS DONE. IF THIS IS AT FOLLOW-UP OR DISCHARGE AND THE RESPONSE IS NEGATIVE, NOT SCREENED, OR DON'T KNOW, SKIP TO QUESTION 3.]

a. ***[IF POSITIVE]*** **Was the client referred to substance use disorder services?**

- ○ Yes
- ○ No
- ○ Don't know

[IF THIS IS AT INTAKE/BASELINE, SECTION H IS DONE. IF THIS IS AT FOLLOW-UP OR DISCHARGE AND THE RESPONSE IS NO OR DON'T KNOW, SKIP TO QUESTION 3.]

H10. PROGRAM-SPECIFIC QUESTIONS (CONTINUED)

b. *[IF YES]* Did the client receive substance use disorder services?

- ○ Yes
- ○ No
- ○ Don't know

[QUESTION 3 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE.]

3. Please indicate the degree to which you agree or disagree with the following statement: Receiving community-based services through *[INSERT GRANTEE NAME]* has helped me to avoid further contact with the police and the criminal justice system.

- ○ Strongly disagree
- ○ Disagree
- ○ Undecided
- ○ Agree
- ○ Strongly agree
- ○ REFUSED
- ○ DON'T KNOW

I. FOLLOW-UP STATUS

[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT FOLLOW-UP.]

1. What is the follow-up status of the client? ***[THIS IS A REQUIRED FIELD: NA, REFUSED, DON'T KNOW, AND MISSING WILL NOT BE ACCEPTED.]***

- ○ 01 = Deceased at time of due date
- ○ 11 = Completed interview within specified window
- ○ 12 = Completed interview outside specified window
- ○ 21 = Located, but refused, unspecified
- ○ 22 = Located, but unable to gain institutional access
- ○ 23 = Located, but otherwise unable to gain access
- ○ 24 = Located, but withdrawn from project
- ○ 31 = Unable to locate, moved
- ○ 32 = Unable to locate, other (Specify) _____

2. Is the client still receiving services from your program?

- ○ Yes
- ○ No

[IF THIS IS A FOLLOW-UP INTERVIEW, STOP NOW; THE INTERVIEW IS COMPLETE.]

J. DISCHARGE STATUS

[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT DISCHARGE.]

1. On what date was the client discharged?

|____|____| / |____|____| / |____|____|____|____|
MONTH DAY YEAR

2. What is the client's discharge status?

- ○ 01 = Completion/Graduate
- ○ 02 = Termination

If the client was terminated, what was the reason for termination? ***[SELECT ONE RESPONSE.]***

- ○ 01 = Left on own against staff advice with satisfactory progress
- ○ 02 = Left on own against staff advice without satisfactory progress
- ○ 03 = Involuntarily discharged due to nonparticipation
- ○ 04 = Involuntarily discharged due to violation of rules
- ○ 05 = Referred to another program or other services with satisfactory progress
- ○ 06 = Referred to another program or other services with unsatisfactory progress
- ○ 07 = Incarcerated due to offense committed while in treatment/recovery with satisfactory progress
- ○ 08 = Incarcerated due to offense committed while in treatment/recovery with unsatisfactory progress
- ○ 09 = Incarcerated due to old warrant or charged from before entering treatment/recovery with satisfactory progress
- ○ 10 = Incarcerated due to old warrant or charged from before entering treatment/recovery with unsatisfactory progress
- ○ 11 = Transferred to another facility for health reasons
- ○ 12 = Death
- ○ 13 = Other (Specify) _____

J. DISCHARGE STATUS (CONTINUED)

3. Did the program test this client for HIV?

- ○ Yes *[SKIP TO SECTION K.]*
- ○ No *[GO TO J4.]*

4. *[IF NO]* Did the program refer this client for testing?

- ○ Yes
- ○ No

K. SERVICES RECEIVED

[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT DISCHARGE.]

Identify the number of DAYS of services provided to the client during the client's course of treatment/recovery. ***[ENTER ZERO IF NO SERVICES PROVIDED. YOU SHOULD HAVE AT LEAST ONE DAY FOR MODALITY.]***

Modality	**Days**
1. Case Management	|___|___|___|
2. Day Treatment	|___|___|___|
3. Inpatient/Hospital (Other Than Detox)	|___|___|___|
4. Outpatient	|___|___|___|
5. Outreach	|___|___|___|
6. Intensive Outpatient	|___|___|___|
7. Methadone	|___|___|___|
8. Residential/Rehabilitation	|___|___|___|
9. Detoxification (Select Only One):	
A. Hospital Inpatient	|___|___|___|
B. Free-Standing Residential	|___|___|___|
C. Ambulatory Detoxification	|___|___|___|
10. After Care	|___|___|___|
11. Recovery Support	|___|___|___|
12. Other (Specify)_____	|___|___|___|

Identify the number of SESSIONS provided to the client during the client's course of treatment/ recovery. ***[ENTER ZERO IF NO SERVICES PROVIDED.]***

Treatment Services	**Sessions**
[SBIRT GRANTS: YOU MUST HAVE AT LEAST ONE SESSION FOR ONE OF THE TREATMENT SERVICES NUMBERED 1–4.]	
1. Screening	|___|___|___|
2. Brief Intervention	|___|___|___|
3. Brief Treatment	|___|___|___|
4. Referral to Treatment	|___|___|___|
5. Assessment	|___|___|___|
6. Treatment/Recovery Planning	|___|___|___|
7. Individual Counseling	|___|___|___|
8. Group Counseling	|___|___|___|
9. Family/Marriage Counseling	|___|___|___|
10. Co-Occurring Treatment/Recovery Services	|___|___|___|
11. Pharmacological Interventions	|___|___|___|
12. HIV/AIDS Counseling	|___|___|___|
13. Other Clinical Services (Specify)_____	|___|___|___|

Case Management Services	**Sessions**
1. Family Services (Including Marriage Education, Parenting, Child Development Services)	|___|___|___|
2. Child Care	|___|___|___|
3. Employment Service	
A. Pre-Employment	|___|___|___|
B. Employment Coaching	|___|___|___|
4. Individual Services Coordination	|___|___|___|
5. Transportation	|___|___|___|
6. HIV/AIDS Service	|___|___|___|
7. Supportive Transitional Drug-Free Housing Services	|___|___|___|
8. Other Case Management Services (Specify) _____	|___|___|___|

Medical Services	**Sessions**
1. Medical Care	|___|___|___|
2. Alcohol/Drug Testing	|___|___|___|
3. HIV/AIDS Medical Support and Testing	|___|___|___|
4. Other Medical Services (Specify) _____	|___|___|___|

After Care Services	**Sessions**
1. Continuing Care	|___|___|___|
2. Relapse Prevention	|___|___|___|
3. Recovery Coaching	|___|___|___|
4. Self-Help and Support Groups	|___|___|___|
5. Spiritual Support	|___|___|___|
6. Other After Care Services (Specify) _____	|___|___|___|

Education Services	**Sessions**
1. Substance Abuse Education	|___|___|___|
2. HIV/AIDS Education	|___|___|___|
3. Other Education Services (Specify) _____	|___|___|___|

Peer-to-Peer Recovery Support Services	**Sessions**
1. Peer Coaching or Mentoring	|___|___|___|
2. Housing Support	|___|___|___|
3. Alcohol- and Drug-Free Social Activities	|___|___|___|
4. Information and Referral	|___|___|___|
5. Other Peer-to-Peer Recovery Support Services (Specify) _____	|___|___|___|

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