DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

FORM APPROVED:
OMB No. 0930-0074
Expires: 4/30/07

ANNUAL CLINICAL TRAINING PAYBACK ACTIVITIES CERTIFICATION

NOTE: Please type. Complete all sections as appropriate. Return the completed forms to the office designated on the reverse side of the cover information and instruction sheet.

NAME *(Last, First, Middle Initial)*	PHS GRANT NUMBER	
ADDRESS *(Correct if address has changed)*	REPORTING PERIOD FROM: THROUGH:	
	RECORD OF PAYBACK OBLIGATION (TOTAL MONTHS)	
	KNOWN OBLIGATION	PAYBACK SERVICE PREVIOUSLY CREDITED
		Preferred / Alternative

TO BE COMPLETED BY FORMER TRAINEE *(Check one of the following)*

1. ☐ Have not engaged in payback service during reporting period *(Complete only Section V)*
2. ☐ Have elected to engage in financial payback *(Complete Section V)*
3. ☐ Have been engaged in continuous preferred payback service during reporting period *(Complete Sections I, III, IV, and V)*
4. ☐ Have been engaged in continuous alternative payback service previously approved by DHHS *(Complete Sections II, III, IV, and V)*

SECTION I - CONTINUOUS PREFERRED PAYBACK SERVICE

1. Position Title ______
2. Total number of months engaged in payback in this position **during** the reporting period listed above ______
   Dates **during** reporting period: From ______ *(Month, day, year)* through ______ *(Month, day, year)*
3. Full-time payback service of at least 30 hours a week was in:
   a. ☐ Public inpatient mental institution
   b. ☐ Community Mental Health Centers Act grant recipient of Federal funds
   c. ☐ Psychiatric manpower shortage area designated under Sec. 332 of the PHS Act ______ *(Name of County)*
   d. ☐ Other public/private **non-profit** service delivery agency where over 50% of clients are priority populations

SECTION II - CONTINUOUS ALTERNATIVE PAYBACK SERVICE

1. Position Title ______
2. Date of approval by Department of Health and Human Services of alternative service ______
3. Number of months engaged in alternative payback in this position **during** reporting period: ______
   From ______ *(Month, day, year)* through ______ *(Month, day, year)*
4. Alternative full-time payback service of at least 30 hours a week was in:
   a. ☐ Public/private **non-profit** service delivery agency where not less then 25% of clients are priority populations AND more than 50% of my time is devoted to those populations
   b. ☐ Teaching, research, or evaluation directed at improving services to the priority populations; or a position fostering closer collaboration with health services in a public or private non-profit agency
   c. ☐ Administration or indirect service in a public or private **non-profit** agency where activities are directed at priority populations
   d. ☐ Other *(Specify)* ______

DO NOT TAKE FORM APART—A VALIDATED COPY WILL BE SENT TO YOU.

SECTION III - NATURE OF PAYBACK SERVICE IN THIS POSITION

TYPE OF LOCATION

(Check One)

B. ☐ Public mental hospital *(including outpatient departments)*
C. ☐ Private mental hospital *(including outpatient departments)*
D. ☐ VA hospital/clinic *(general or psychiatric)*
F. ☐ General hospital *(with or without psychiatric inpatient units)*
G. ☐ Health maintenance organization; other general health service setting
H. ☐ Community mental health service setting *(includes freestanding outpatient clinics)*
J. ☐ Alcohol/drug abuse treatment or rehabilitation setting
K. ☐ Residential treatment center for emotionally disturbed or mentally retarded
L. ☐ Social Service Agency
M. ☐ University/college academic department or unit *(including medical school or other health professional school)*
N. ☐ Military
P. ☐ Justice/corrections system
Q. ☐ Primary or secondary school system
R. ☐ Government *(Federal, State or local)* or professional organization: non-service delivery setting
S. ☐ Research or consulting firm; business or industry
T. ☐ Individual or group private practice *(allowed only in designated shortage areas)*
V. ☐ Other not listed above *(please specify)* ______

ACTIVITIES: NUMBER OF HOURS PER WEEK SPENT IN PAYBACK SERVICE

(List *ACTUAL* Number of Hours for Each Applicable Category)

____ Direct service *(e.g., diagnosis and testing, individual treatment, group work)*
____ Indirect service *(e.g., consultation, education, liaison)*
____ Teaching, research, or evaluation
____ Supervision or administration
____ Other *(specify)* ______________
____ **Total** payback hours per week

PERCENT OF CLIENTS SERVED *BY FACILITY* BELONGING TO PRIORITY POPULATIONS

(Total Need Not Equal 100%)

B. ____ % Minority
C. ____ % American Indian/Alaska Native
D. ____ % Asian
E. ____ % Black or African American
F. ____ % Hispanic or Latino
G. ____ % Native Hawaiian or Other Pacific Islander
H. ____ % Chronically mentally ill
J. ____ % Mentally retarded
K. ____ % Criminals or delinquents
L. ____ % Rape victims
M. ____ % Physically handicapped
N. ____ % Alcohol, drug, and other substance abusers
P. ____ % Children and adolescents
Q. ____ % Elderly
R. ____ % Poverty populations
S. ____ % Migrants
T. ____ % Members of the armed forces or veterans
V. ____ % Residents of areas other than those defined as urbanized by the Department of Commerce
W. ____ % Residents of nursing homes
X. ____ % Other special population ______________ *(specify)*
Y. ____ % AIDS, ARC, and HIV patients/families

PERCENT OF CLIENTS SERVED BY YOU BELONGING TO PRIORITY POPULATIONS

(Total Need Not Equal 100%)

B. ____ % Minority
C. ____ % American Indian/Alaska Native
D. ____ % Asian
E. ____ % Black or African American
F. ____ % Hispanic or Latino
G. ____ % Native Hawaiian or Other Pacific Islander
H. ____ % Chronically mentally ill
J. ____ % Mentally retarded
K. ____ % Criminals or delinquents
L. ____ % Rape victims
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T. ____ % Members of the armed forces or veterans
V. ____ % Residents of areas other than those defined as urbanized by the Department of Commerce
W. ____ % Residents of nursing homes
X. ____ % Other special population ______________ *(specify)*
Y. ____ % AIDS, ARC, and HIV patients/families

SECTION IV - COMPLETE IF SECTION I OR II IS COMPLETED

NAME OF EMPLOYING ORGANIZATION	Verification of Supervisor that employment information reported is accurate *(if supervisor unavailable or, if self-employed, a notarized statement certifying accuracy of information required)*	
ADDRESS OF EMPLOYING ORGANIZATION	NAME OF SUPERVISOR	
	TITLE	TELEPHONE NO.
	SIGNATURE	DATE

SECTION V - CERTIFICATION OF RECIPIENT

I certify that all of the above statements are true, complete, and correct to the best of my knowledge. *(A willfully false certification is a criminal offense. U.S. Code, Title 18, Sec. 1001.)*	SIGNATURE	DATE

Please provide your telephone numbers in case we need to contact you for additional information.

Office: ______/______ -_______

Home: ______/______ -_______

The following to be filled out by SAMHSA official only:

SECTION VI - ACCEPTANCE BY SAMHSA OFFICIAL

LEAVE BLANK	NAME AND TITLE OF SAMHSA OFFICIAL	NUMBER OF MONTHS OF ACCEPTABLE PAYBACK SERVICE THIS REPORTING PERIOD
	SIGNATURE OF SAMHSA OFFICIAL	DATE

NOTE: Payback service reported in excess of your current obligation is applicable only to the grant identified on page 1 of this form and may not be credited toward any future obligation you may incur as a recipient of additional CMHS clinical training support.

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0074. Public reporting burden for this collection of information is estimated to average .18 hours per client per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, Maryland, 20857.

★ U.S. GOVERNMENT PRINTING OFFICE: 1995-386-959/20603