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

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

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