

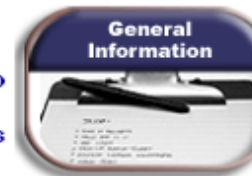


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Government Performance and Results Act

Print

The mission of the Government Performance and Results Act (GPRA) of 1993 is to improve the confidence of the American people in the capability of the Federal Government by holding all Federal agencies accountable for achieving program results. Under GPRA law, the Substance Abuse and Mental Health Services Administration (SAMHSA) and its three Centers - the Center for Substance Abuse Treatment (CSAT), the Center for Substance Abuse Prevention (CSAP), and the Center for Mental Health Services (CMHS) - are required to set program-specific performance targets, to measure program performance on a regular basis against those targets, and to report annually to Congress on the Centers' results. In short, GPRA is intended to increase program effectiveness and public accountability by promoting a new focus on results, service quality, and customer satisfaction.



For more CSAT GPRA information contact:

Toll-free: 1-888-507-9351

[GPRA Help Desk](#)



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Login

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Welcome to the new CSAT GPRA Web Site!

The SAIS web application will be down from 7:00 am to 8:00 am on Fridays for routine maintenance. We apologize for the inconvenience.

By entering your username and password, you are confirming authorized access to this application.

Please enter your username and password below.

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Data Entry

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The Data Entry section of the CSAT GPRA Web site allows grantees to submit their data directly to CSAT online. Grantees may:

- Enter new data
- Edit existing data



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Grant Selection

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Grant Selection

GFA Selected GFAs

Addictions Treatment for Homeless	▲	v	
Assertive Adolescent Family Treatment	■		
Campus SBI	■		
Effective Adolescent Treatment	■		
HIV/AIDS Outreach Program	▼		

Grant # Grantee Name

City State

Actions	GFA	Grantee	Grant No	City	State



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Interview Selection

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* For more info on advanced features of the Query function, click "Help" in the upper right corner of this screen.

GFA: HIV/AIDS Outreach Program **Target-to-Date:** 355
Grantee Name: Bailey House, Inc. - HIV/AIDS Outreach Program **Intakes-to-Date:** 386
Grant #: TI15703 **Coverage Rate:** 108%
Grant Target: 575
Annual Target: 115

Client Interview Selection

Client ID Intake Date Status ▼

Client Intake Records

[Add Client Intake](#)

Client ID	Intake Date	Status	Intake(387)	3 Month(0)	6 Month(230)	12 Month(60)	Discharge(90)
001	1/27/2004	Active	View Edit Del	N/A	View Edit Del	View Edit Del	View Edit Del
004	5/25/2004	Active	View Edit Del	N/A	View Edit Del	View Edit Del	View Edit Del
009	12/2/2004	Active	View Edit Del	N/A	View Edit Del	Add	View Edit Del
042	6/23/2005	Active	View Edit Del	N/A	View Edit Del	Add	Add
091	8/23/2005	Active	View Edit Del	N/A	View Edit Del	Add	Add
116	4/29/2004	Active	View Edit Del	N/A	View Edit Del	View Edit Del	View Edit Del
121	5/12/2004	Active	View Edit Del	N/A For 3 Month	View Edit Del	View Edit Del	View Edit Del
123	5/27/2004	Active	View Edit Del	N/A	View Edit Del	Add	View Edit Del
124	6/14/2004	Active	View Edit Del	N/A	View Edit Del	View Edit Del	View Edit Del
125	6/22/2004	Active	View Edit Del	N/A	View Edit Del	View Edit Del	View Edit Del



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Discretionary Services

Client ID: 340001
Grant ID: TI17334

A. RECORD MANAGEMENT

Client ID

Contract/Grant ID

Client Type

Interview Type

Did you conduct a follow-up/
discharge interview?

Interview Date mm/dd/yyyy

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

 a. Did the client screen positive for co-occurring mental health and substance use disorders?



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Grant ID: TI15703

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A. RECORD MANAGEMENT - SERVICES

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

Modality

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



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A. RECORD MANAGEMENT - SERVICES

Treatment Services

[SBIRT GRANTS: YOU MUST SELECT "YES" FOR AT LEAST ONE OF THE TREATMENT SERVICES NUMBERED 1 THROUGH 4.]

- | | | | |
|--------------------------------|------|--|------|
| 1. Screening | No ▼ | 8. Group Counseling | No ▼ |
| 2. Brief Intervention | No ▼ | 9. Family/Marriage Counseling | No ▼ |
| 3. Brief Treatment | No ▼ | 10. Co-Occurring Treatment/
Recovery Services | No ▼ |
| 4. Referral to Treatment | No ▼ | 11. Pharmacological Interventions | No ▼ |
| 5. Assessment | No ▼ | 12. HIV/AIDS Counseling | No ▼ |
| 6. Treatment/Recovery Planning | No ▼ | 13. Other Clinical Services (Specify) | No ▼ |
| 7. Individual Counseling | No ▼ | | |



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A. RECORD MANAGEMENT - SERVICES

Case Management Services

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

Medical Services

- | | | | |
|-------------------------|----|--|----|
| 1. Medical Care | No | 3. HIV/ AIDS Medical Support & Testing | No |
| 2. Alcohol/Drug Testing | No | 4. Other Medical Services (Specify) | No |

After Care Services

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



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A. RECORD MANAGEMENT - SERVICES

Education Services

- | | | | |
|------------------------------|----|---------------------------------------|----|
| 1. Substance Abuse Education | No | 3. Other Education Services (Specify) | No |
| 2. HIV/AIDS Education | No | | |

Peer-To-Peer Recovery Support Services

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

Please specify



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A. RECORD MANAGEMENT - DEMOGRAPHICS

1. What is your gender? Other (Specify)

2. Are you Hispanic or Latino?

[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.

Central American	<input type="text" value="No"/>	Puerto Rican	<input type="text" value="No"/>
Cuban	<input type="text" value="No"/>	South American	<input type="text" value="No"/>
Dominican	<input type="text" value="No"/>	Other (Specify)	<input type="text" value="No"/>
Mexican	<input type="text" value="Yes"/>	Not Applicable	

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

Black or African American	<input type="text" value="No"/>	White	<input type="text" value="No"/>
Asian	<input type="text" value="No"/>	American Indian	<input type="text" value="No"/>
Native Hawaiian or other Pacific Islander	<input type="text" value="No"/>		
Alaska Native	<input type="text" value="No"/>		

4. What is your date of birth? Month: Day: Year:

5. Are you a veteran?



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B. DRUG AND ALCOHOL USE

1. During the past 30 days, how many days have you used the following:

	# of Days	RF/DK
a. Any alcohol	<input type="text" value="0"/>	<input type="text" value=""/>
b1. Alcohol to intoxication (5+ drinks in one sitting)	<input type="text" value=""/>	<input type="text" value="Not Applicable"/>
b2. Alcohol to intoxication (4 or fewer drinks in one sitting and felt high)	<input type="text" value=""/>	<input type="text" value="Not Applicable"/>
c. Illegal drugs	<input type="text" value="0"/>	<input type="text" value=""/>
d. Both alcohol and drugs (on the same day)	<input type="text" value=""/>	<input type="text" value="Not Applicable"/>



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B. DRUG AND ALCOHOL USE

2. During the past 30 days, how many days have you used any of the following:

	# of Days	RF/DK	Route
a. Cocaine/Crack	0	<input type="button" value="v"/>	Not Applicable <input type="button" value="v"/>
b. Marijuana/Hashish	0	<input type="button" value="v"/>	Not Applicable <input type="button" value="v"/>
c. Opiates:			
1. Heroin	0	<input type="button" value="v"/>	Not Applicable <input type="button" value="v"/>
2. Morphine	0	<input type="button" value="v"/>	Not Applicable <input type="button" value="v"/>
3. Diluadid	0	<input type="button" value="v"/>	Not Applicable <input type="button" value="v"/>
4. Demerol	0	<input type="button" value="v"/>	Not Applicable <input type="button" value="v"/>
5. Percocet	0	<input type="button" value="v"/>	Not Applicable <input type="button" value="v"/>
6. Darvon	0	<input type="button" value="v"/>	Not Applicable <input type="button" value="v"/>
7. Codeine	0	<input type="button" value="v"/>	Not Applicable <input type="button" value="v"/>
8. Tylenol 2,3,4	0	<input type="button" value="v"/>	Not Applicable <input type="button" value="v"/>
9. Oxycontin/Oxycodone	0	<input type="button" value="v"/>	Not Applicable <input type="button" value="v"/>



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B. DRUG AND ALCOHOL USE

2. During the past 30 days, how many days have you used any of the following:

	# of Days	RF/DK	Route
d. Non-prescription methadone	0	<input type="button" value="v"/>	Not Applicable <input type="button" value="v"/>
e. Hallucinogens/psychedelics, PCP, MDMA, LSD, Mushrooms or Mescaline	0	<input type="button" value="v"/>	Not Applicable <input type="button" value="v"/>
f. Methamphetamine or other amphetamines	0	<input type="button" value="v"/>	Not Applicable <input type="button" value="v"/>
g. 1. Benzodiazepines: Diazepam, Alprazolam, Triazolam, and Estazolam	0	<input type="button" value="v"/>	Not Applicable <input type="button" value="v"/>
2. Barbiturates: Mephobarbital and pentobarbital sodium	0	<input type="button" value="v"/>	Not Applicable <input type="button" value="v"/>
3. Non-prescription GHB	0	<input type="button" value="v"/>	Not Applicable <input type="button" value="v"/>
4. Ketamine	0	<input type="button" value="v"/>	Not Applicable <input type="button" value="v"/>
5. Other tranquilizers, downers, sedatives or hypnotics	0	<input type="button" value="v"/>	Not Applicable <input type="button" value="v"/>
h. Inhalants	0	<input type="button" value="v"/>	Not Applicable <input type="button" value="v"/>
i. Other illegal drugs (Specify)	0	<input type="button" value="v"/>	Not Applicable <input type="button" value="v"/>

3. In the past 30 days, have you injected drugs?

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



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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.] Housed ▼

If "Housed" Dormitory/College Residence ▼

Other Housed (Specify) Not Applicable

2. During the past 30 days, how stressful have things been for you because of your use of alcohol or other drugs? Considerably ▼

3. During the past 30 days, has your use of alcohol or other drugs caused you to reduce or give up important activities? Somewhat ▼

4. During the past 30 days, has your use of alcohol or other drugs caused you to have emotional problems? Considerably ▼

5. Are you currently pregnant? Not Applicable

6. Do you have children? Yes ▼

a. How many children do you have? 2 ▼

b. Are any of your children living with someone else due to a child protection court order? No ▼

c. How many of your children are living with someone else due to a child protection court order? Not Applicable ▼

d. For how many of your children have you lost parental rights?
[THE CLIENT'S PARENTAL RIGHTS WERE TERMINATED.] REFUSED ▼



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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?) Not enrolled ▼

Other (Specify)

2. What is the highest level of education you have finished, whether or not you received a degree?
College or university/2nd year completed/Associate's degree (AA, AS) ▼

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.)* Unemployed, disabled ▼

Other (Specify)

4. Approximately, how much money did YOU receive (pre-tax individual income) in the past 30 days from:

		RF/DK			RF/DK		
a. Wages	\$	<input type="text" value="0"/>	<input type="text"/>	e. Non-legal income	\$	<input type="text" value="0"/>	<input type="text"/>
b. Public assistance	\$	<input type="text" value="193"/>	<input type="text"/>	f. Family and/or friends	\$	<input type="text"/>	Not Applicable ▼
c. Retirement	\$	<input type="text" value="0"/>	<input type="text"/>	g. Other (Specify)	\$	<input type="text"/>	MISSING DATA ▼
d. Disability	\$	<input type="text" value="0"/>	<input type="text"/>			<input type="text"/>	



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E. CRIME AND CRIMINAL JUSTICE STATUS

	Times	RF/DK
1. In the past 30 days, how many times have you been arrested?	<input type="text" value="0"/>	<input type="text" value=""/>
2. In the past 30 days, how many times have you been arrested for drug-related offenses?	<input type="text" value=""/>	<input type="text" value="Not Applicable"/>
	Nights	RF/DK
3. In the past 30 days, how many nights have you spent in jail/prison?	<input type="text" value="0"/>	<input type="text" value=""/>
	Times	RF/DK
4. In the past 30 days, how many times have you committed a crime?	<input type="text" value=""/>	<input type="text" value="Not Applicable"/>
5. Are you currently awaiting charges, trial, or sentencing?	<input type="text" value="Not Applicable"/>	
6. Are you currently on parole or probation?	<input type="text" value="Not Applicable"/>	



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F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT RECOVERY

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

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

a. Inpatient Treatment for: nights

i. Physical complaint	<input type="text" value="No"/>	<input type="text"/>	<input type="text" value="Not Applicable"/>
ii. Mental or emotional difficulties	<input type="text" value="No"/>	<input type="text"/>	<input type="text" value="Not Applicable"/>
iii. Alcohol or substance abuse	<input type="text" value="No"/>	<input type="text"/>	<input type="text" value="Not Applicable"/>

b. Outpatient Treatment for: times

i. Physical complaint	<input type="text" value="No"/>	<input type="text"/>	<input type="text" value="Not Applicable"/>
ii. Mental or emotional difficulties	<input type="text" value="No"/>	<input type="text"/>	<input type="text" value="Not Applicable"/>
iii. Alcohol or substance abuse	<input type="text" value="No"/>	<input type="text"/>	<input type="text" value="Not Applicable"/>

c. Emergency Room Treatment for: times

i. Physical complaint	<input type="text" value="No"/>	<input type="text"/>	<input type="text" value="Not Applicable"/>
ii. Mental or emotional difficulties	<input type="text" value="No"/>	<input type="text"/>	<input type="text" value="Not Applicable"/>
iii. Alcohol or substance abuse	<input type="text" value="No"/>	<input type="text"/>	<input type="text" value="Not Applicable"/>



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F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY

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

Yes ▼

Altogether, how many:

Contacts RF/DK

a. Sexual contacts (vaginal, oral, or anal) did you have?

1 [] ▼

b. Unprotected sexual contacts did you have?

1 [] ▼

c. Unprotected sexual contacts were with an individual who is or was:

1. HIV positive or has AIDS

0 [] ▼

2. An injection drug user

0 [] ▼

3. High on some substance

0 [] ▼

4. Have you ever been tested for HIV?

[] ▼

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

[] ▼



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F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY

5. 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	<input type="text" value="0"/>	<input type="text" value=""/>
b. Experienced serious anxiety or tension	<input type="text" value="0"/>	<input type="text" value=""/>
c. Experienced hallucinations	<input type="text" value="0"/>	<input type="text" value=""/>
d. Experienced trouble understanding, concentrating, or remembering	<input type="text" value="15"/>	<input type="text" value=""/>
e. Experienced trouble controlling violent behavior	<input type="text" value="0"/>	<input type="text" value=""/>
f. Attempted suicide	<input type="text" value="0"/>	<input type="text" value=""/>
g. Been prescribed medication for psychological/emotional problem	<input type="text" value="0"/>	<input type="text" value=""/>

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



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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 non-professional, 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.]*

	Times	RF/DK
Not Applicable	<input type="text"/>	Not Applicable

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

Not Applicable	<input type="text"/>	Not Applicable
----------------	----------------------	----------------

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

Not Applicable	<input type="text"/>	Not Applicable
----------------	----------------------	----------------

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

Not Applicable	<input type="text"/>
----------------	----------------------

5. To whom do you turn when you are having trouble?

Not Applicable	<input type="text"/>
----------------	----------------------

Other (Specify):



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A. RECORD MANAGEMENT

Client ID

Contract/Grant ID

Client Type

Interview Type

Did you conduct a follow-up/
discharge interview?

Interview Date mm/dd/yyyy

1. Was the client screened by your program for co-occurring mental health and substance use disorders?
- a. Did the client screen positive for co-occurring mental health and substance use disorders?

A. RECORD MANAGEMENT - SERVICES

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

Modality

- | | | | |
|--|----------------------------------|-------------------------------------|---------------------------------|
| 1. Case Management | <input type="text" value="No"/> | 9. Detoxification (Select Only One) | |
| 2. Day Treatment | <input type="text" value="No"/> | A. Hospital Inpatient | <input type="text" value="No"/> |
| 3. Inpatient/Hospital (Other Than Detox) | <input type="text" value="No"/> | B. Free Standing Residential | <input type="text" value="No"/> |
| 4. Outpatient | <input type="text" value="Yes"/> | C. Ambulatory Detoxification | <input type="text" value="No"/> |



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5. Outreach	<input type="checkbox"/>	10. After Care	<input type="checkbox"/>
6. Intensive Outpatient	<input type="checkbox"/>	11. Recovery Support	<input type="checkbox"/>
7. Methadone	<input type="checkbox"/>	12. Other (Specify)	<input type="checkbox"/>
8. Residential/Rehabilitation	<input type="checkbox"/>		

A. RECORD MANAGEMENT - SERVICES

Treatment Services

[SBIRT GRANTS: YOU MUST SELECT 'YES' FOR AT LEAST ONE OF THE TREATMENT SERVICES NUMBERED 1 THROUGH 4.]

1. Screening	<input type="checkbox"/>	8. Group Counseling	<input type="checkbox"/>
2. Brief Intervention	<input type="checkbox"/>	9. Family/Marriage Counseling	<input type="checkbox"/>
3. Brief Treatment	<input type="checkbox"/>	10. Co-Occurring Treatment/ Recovery Services	<input type="checkbox"/>
4. Referral to Treatment	<input type="checkbox"/>	11. Pharmacological Interventions	<input type="checkbox"/>
5. Assessment	<input type="checkbox"/>	12. HIV/AIDS Counseling	<input type="checkbox"/>
6. Treatment/Recovery Planning	<input type="checkbox"/>	13. Other Clinical Services (Specify)	<input type="checkbox"/>
7. Individual Counseling	<input type="checkbox"/>		



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A. RECORD MANAGEMENT - SERVICES

Case Management Services

- | | | | |
|--|---------------------------------|---|---------------------------------|
| 1. Family Services (Including Marriage Education, Parenting, Child Development Services) | <input type="text" value="No"/> | 4. Individual Services Coordination | <input type="text" value="No"/> |
| 2. Child Care | <input type="text" value="No"/> | 5. Transportation | <input type="text" value="No"/> |
| 3. Employment Service | | 6. HIV/AIDS Service | <input type="text" value="No"/> |
| A. Pre-Employment | <input type="text" value="No"/> | 7. Supportive Transitional Drug-Free Housing Services | <input type="text" value="No"/> |
| B. Employment Coaching | <input type="text" value="No"/> | 8. Other Case Management Services (Specify) | <input type="text" value="No"/> |

Medical Services

- | | | | |
|-------------------------|---------------------------------|--|---------------------------------|
| 1. Medical Care | <input type="text" value="No"/> | 3. HIV/ AIDS Medical Support & Testing | <input type="text" value="No"/> |
| 2. Alcohol/Drug Testing | <input type="text" value="No"/> | 4. Other Medical Services (Specify) | <input type="text" value="No"/> |

After Care Services

- | | | | |
|-----------------------|---------------------------------|--|---------------------------------|
| 1. Continuing Care | <input type="text" value="No"/> | 4. Self-Help and Support Groups | <input type="text" value="No"/> |
| 2. Relapse Prevention | <input type="text" value="No"/> | 5. Spiritual Support | <input type="text" value="No"/> |
| 3. Recovery Coaching | <input type="text" value="No"/> | 6. Other After Care Services (Specify) | <input type="text" value="No"/> |



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A. RECORD MANAGEMENT - SERVICES

Education Services

- | | | | |
|------------------------------|----------------------------------|---------------------------------------|---------------------------------|
| 1. Substance Abuse Education | <input type="text" value="Yes"/> | 3. Other Education Services (Specify) | <input type="text" value="No"/> |
| 2. HIV/AIDS Education | <input type="text" value="No"/> | | |

Peer-To-Peer Recovery Support Services

- | | | | |
|--|---------------------------------|---|---------------------------------|
| 1. Peer Coaching or Mentoring | <input type="text" value="No"/> | 4. Information and Referral | <input type="text" value="No"/> |
| 2. Housing Support | <input type="text" value="No"/> | 5. Other Peer-to-Peer Recovery Support Services (Specify) | <input type="text" value="No"/> |
| 3. Alcohol-and Drug-Free Social Activities | <input type="text" value="No"/> | | |

A. RECORD MANAGEMENT - DEMOGRAPHICS

1. What is your gender? Other (Specify)
2. Are you Hispanic or Latino?

*[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.

- | | | | |
|------------------|---|-----------------|---|
| Central American | <input type="text" value="Not Applicable"/> | Puerto Rican | <input type="text" value="Not Applicable"/> |
| Cuban | <input type="text" value="Not Applicable"/> | South American | <input type="text" value="Not Applicable"/> |
| Dominican | <input type="text" value="Not Applicable"/> | Other (Specify) | <input type="text" value="Not Applicable"/> |



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1. What is your gender? Male Other (Specify)

2. Are you Hispanic or Latino? No

[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.

Central American	<input type="text"/> Not Applicable	Puerto Rican	<input type="text"/> Not Applicable
Cuban	<input type="text"/> Not Applicable	South American	<input type="text"/> Not Applicable
Dominican	<input type="text"/> Not Applicable	Other (Specify)	<input type="text"/> Not Applicable
Mexican	<input type="text"/> Not Applicable		<input type="text"/>

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

Black or African American	<input type="text"/> Yes	White	<input type="text"/> No
Asian	<input type="text"/> No	American Indian	<input type="text"/> No
Native Hawaiian or other Pacific Islander	<input type="text"/> No		
Alaska Native	<input type="text"/> No		

4. What is your date of birth?

Month: 4 Day: Year: 1951

5. Are you a veteran? Yes



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B. DRUG AND ALCOHOL USE

1. During the past 30 days, how many days have you used the following:

	# of Days	RF/DK
a. Any alcohol	0	
b1. Alcohol to intoxication (5+ drinks in one sitting)		Not Applicable
b2. Alcohol to intoxication (4 or fewer drinks in one sitting and felt high)		Not Applicable
c. Illegal drugs	0	
d. Both alcohol and drugs (on the same day)		Not Applicable

B. DRUG AND ALCOHOL USE

2. During the past 30 days, how many days have you used any of the following:

	# of Days	RF/DK	Route
a. Cocaine/Crack	0		Not Applicable
b. Marijuana/Hashish	0		Not Applicable
c. Opiates:			
1. Heroin	0		Not Applicable
2. Morphine	0		Not Applicable
3. Diluadid	0		Not Applicable



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d. Both alcohol and drugs (on the same day)

B. DRUG AND ALCOHOL USE

2. During the past 30 days, how many days have you used any of the following:

	# of Days	RF/DK	Route
a. Cocaine/Crack	0		Not Applicable
b. Marijuana/Hashish	0		Not Applicable
c. Opiates:			
1. Heroin	0		Not Applicable
2. Morphine	0		Not Applicable
3. Diluadid	0		Not Applicable
4. Demerol	0		Not Applicable
5. Percocet	0		Not Applicable
6. Darvon	0		Not Applicable
7. Codeine	0		Not Applicable
8. Tylenol 2,3,4	0		Not Applicable
9. Oxycontin/Oxycodone	0		Not Applicable

B. DRUG AND ALCOHOL USE

2. During the past 30 days, how many days have you used any of the following:



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B. DRUG AND ALCOHOL USE

2. During the past 30 days, how many days have you used any of the following:

	# of Days	RF/DK	Route
d. Non-prescription methadone	0		Not Applicable
e. Hallucinogens/psychedelics, PCP, MDMA, LSD, Mushrooms or Mescaline	0		Not Applicable
f. Methamphetamine or other amphetamines	0		Not Applicable
g. 1. Benzodiazepines: Diazepam, Alprazolam, Triazolam, and Estazolam	0		Not Applicable
2. Barbiturates: Mephobarbital and pentobarbital sodium	0		Not Applicable
3. Non-prescription GHB	0		Not Applicable
4. Ketamine	0		Not Applicable
5. Other tranquilizers, downers, sedatives or hypnotics	0		Not Applicable
h. Inhalants	0		Not Applicable
i. Other illegal drugs (Specify)	0		Not Applicable

3. In the past 30 days, have you injected drugs? No

4. In the past 30 days, how often did you use a syringe/needle, cooker, cotton, or water that someone else used? Not Applicable



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

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.]
 If "Housed"
 Other Housed (Specify)
2. During the past 30 days, how stressful have things been for you because of your use of alcohol or other drugs?
3. During the past 30 days, has your use of alcohol or other drugs caused you to reduce or give up important activities?
4. During the past 30 days, has your use of alcohol or other drugs caused you to have emotional problems?
5. Are you currently pregnant?
6. Do you have children?
 - a. How many children do you have?
 - b. Are any of your children living with someone else due to a child protection court order?
 - c. How many of your children are living with someone else due to a child protection court order?
 - d. For how many of your children have you lost parental rights?
[THE CLIENT'S PARENTAL RIGHTS WERE TERMINATED.]



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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?

Other (Specify)

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

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.)*
 Other (Specify)

4. Approximately, how much money did YOU receive (pre-tax individual income) in the past 30 days from:

		RF/DK		RF/DK
a. Wages	\$ 0	<input type="text"/>	e. Non-legal income	\$ 0 <input type="text"/>
b. Public assistance	\$ 193	<input type="text"/>	f. Family and/or friends	\$ <input type="text"/> Not Applicable
c. Retirement	\$ 0	<input type="text"/>	g. Other (Specify)	\$ <input type="text"/> MISSING DATA
d. Disability	\$ 0	<input type="text"/>		<input type="text"/>

E. CRIME AND CRIMINAL JUSTICE STATUS

Times RF/DK



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a. Wages	\$ 0		e. Non-legal income	\$ 0	
b. Public assistance	\$ 193		f. Family and/or friends	\$	Not Applicable
c. Retirement	\$ 0		g. Other (Specify)	\$	MISSING DATA
d. Disability	\$ 0				

E. CRIME AND CRIMINAL JUSTICE STATUS

	Times	RF/DK
1. In the past 30 days, how many times have you been arrested?	0	
2. In the past 30 days, how many times have you been arrested for drug-related offenses?		Not Applicable
	Nights	RF/DK
3. In the past 30 days, how many nights have you spent in jail/prison?	0	
	Times	RF/DK
4. In the past 30 days, how many times have you committed a crime?		Not Applicable
5. Are you currently awaiting charges, trial, or sentencing?		Not Applicable
6. Are you currently on parole or probation?		Not Applicable



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F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY

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

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

a. Inpatient Treatment for: nights

i. Physical complaint	No <input type="text" value=""/>	NA <input type="text" value=""/>	<input type="text" value=""/>
ii. Mental or emotional difficulties	No <input type="text" value=""/>	NA <input type="text" value=""/>	<input type="text" value=""/>
iii. Alcohol or substance abuse	No <input type="text" value=""/>	NA <input type="text" value=""/>	<input type="text" value=""/>

b. Outpatient Treatment for: times

i. Physical complaint	No <input type="text" value=""/>	NA <input type="text" value=""/>	<input type="text" value=""/>
ii. Mental or emotional difficulties	No <input type="text" value=""/>	NA <input type="text" value=""/>	<input type="text" value=""/>
iii. Alcohol or substance abuse	No <input type="text" value=""/>	NA <input type="text" value=""/>	<input type="text" value=""/>

c. Emergency Room Treatment for: times

i. Physical complaint	No <input type="text" value=""/>	NA <input type="text" value=""/>	<input type="text" value=""/>
ii. Mental or emotional difficulties	No <input type="text" value=""/>	NA <input type="text" value=""/>	<input type="text" value=""/>
iii. Alcohol or substance abuse	No <input type="text" value=""/>	NA <input type="text" value=""/>	<input type="text" value=""/>



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c. Emergency Room Treatment for:	times		
i. Physical complaint	No <input type="text"/>	NA <input type="text"/>	<input type="text"/>
ii. Mental or emotional difficulties	No <input type="text"/>	NA <input type="text"/>	<input type="text"/>
iii. Alcohol or substance abuse	No <input type="text"/>	NA <input type="text"/>	<input type="text"/>

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT RECOVERY

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

Altogether, how many:

	Contacts	RF/DK
a. Sexual contacts (vaginal, oral, or anal) did you have?	NA <input type="text"/>	<input type="text"/>
b. Unprotected sexual contacts did you have?	NA <input type="text"/>	<input type="text"/>
c. Unprotected sexual contacts were with an individual who is or was:		
1. HIV positive or has AIDS	NA <input type="text"/>	<input type="text"/>
2. An injection drug user	NA <input type="text"/>	<input type="text"/>
3. High on some substance	NA <input type="text"/>	<input type="text"/>
4. Have you ever been tested for HIV?	No <input type="text"/>	
a. Do you know the results of your HIV testing?	Not Applicable <input type="text"/>	

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F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT RECOVERY

5. 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	<input type="text" value="0"/>	<input type="text"/>
b. Experienced serious anxiety or tension	<input type="text" value="0"/>	<input type="text"/>
c. Experienced hallucinations	<input type="text" value="0"/>	<input type="text"/>
d. Experienced trouble understanding, concentrating, or remembering	<input type="text" value="0"/>	<input type="text"/>
e. Experienced trouble controlling violent behavior	<input type="text" value="0"/>	<input type="text"/>
f. Attempted suicide	<input type="text" value="0"/>	<input type="text"/>
g. Been prescribed medication for psychological/emotional problem	<input type="text" value="0"/>	<input type="text"/>

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

Not Applicable

G. SOCIAL CONNECTEDNESS

1. In the past 30 days, did you attend any voluntary self-help



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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? <i>(In other words, did you participate in a non-professional, 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.)</i>	Not Applicable	Times	RF/DK
			Not Applicable
2. In the past 30 days, did you attend any religious/faith affiliated recovery self-help groups?	Not Applicable		Not Applicable
3. In the past 30 days, did you attend meetings of organizations that support recovery other than the organizations described above?	Not Applicable		Not Applicable
4. In the past 30 days, did you have interaction with family and/or friends that are supportive of your recovery?	Not Applicable		
5. To whom do you turn when you are having trouble?	Not Applicable		
Other (Specify):	<input type="text"/>		



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Discretionary Services

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Grant ID: TI15703

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A. RECORD MANAGEMENT

Client ID	001
Contract/Grant ID	TI15703
Client Type	Treatment Client
Interview Type	6-Month Follow Up
Did you conduct a follow-up/ discharge interview?	No
Interview Date	10/13/2004 mm/dd/yyyy



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I. FOLLOW-UP STATUS

1. What is the follow-up status of the client?
- If "Unable to locate, other", (Specify)
2. Is the client still receiving services from your program?



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A. RECORD MANAGEMENT

Client ID	<input type="text" value="001"/>
Contract/Grant ID	<input type="text" value="TI15703"/>
Client Type	<input type="text" value="Treatment Client"/>
Interview Type	<input type="text" value="6-Month Follow Up"/>
Did you conduct a follow-up/ discharge interview?	<input type="text" value="No"/>
Interview Date	<input type="text" value=""/> mm/dd/yyyy

I. FOLLOW-UP STATUS

1. What is the follow-up status of the client?
- If "Unable to locate, other", (Specify)
2. Is the client still receiving services from your program?



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A. RECORD MANAGEMENT

Client ID	001
Contract/Grant ID	TI15703
Client Type	Treatment Client
Interview Type	Discharge
Did you conduct a follow-up/ discharge interview?	No
Interview Date	10/13/2004 mm/dd/yyyy



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Discretionary Services

Client ID: 340001
Grant ID: TI17334

J. DISCHARGE STATUS

1. On what date was the client discharged? mm/dd/yyyy

2. What is the client's discharge status?

If the client was terminated, what was the reason for termination?

Other (Specify)

3. Did the program test this client for HIV?

4. Did the program refer this client for testing?



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Discretionary Services

Client ID: 001
Grant ID: TI15703

K. SERVICES RECEIVED

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.]

Modality	Days		Days
1. Case Management	<input type="text" value="280"/>	9. Detoxification (Select Only One)	
2. Day Treatment	<input type="text" value="0"/>	A. Hospital Inpatient	<input type="text" value="0"/>
3. Inpatient/Hospital (Other Than Detox)	<input type="text" value="0"/>	B. Free Standing Residential	<input type="text" value="0"/>
4. Outpatient	<input type="text" value="0"/>	C. Ambulatory Detoxification	<input type="text" value="0"/>
5. Outreach	<input type="text" value="0"/>	10. After Care	<input type="text" value="0"/>
6. Intensive Outpatient	<input type="text" value="0"/>	11. Recovery Support	<input type="text" value="0"/>
7. Methadone	<input type="text" value="0"/>	12. Other (Specify)	<input type="text" value="0"/>
8. Residential/Rehabilitation	<input type="text" value="140"/>		



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Discretionary Services

Client ID: 001
Grant ID: TI15703

K. SERVICES RECEIVED

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

[SBIRT GRANTS: YOU MUST HAVE AT LEAST ONE SESSION FOR ONE OF THE TREATMENT SERVICES NUMBERED 1 THROUGH 4.]

	Sessions		Sessions
1. Screening	<input type="text" value="0"/>	8. Group Counseling	<input type="text" value="0"/>
2. Brief Intervention	<input type="text" value="0"/>	9. Family/Marriage Counseling	<input type="text" value="0"/>
3. Brief Treatment	<input type="text" value="0"/>	10. Co-Occurring Treatment/ Recovery Services	<input type="text" value="0"/>
4. Referral to Treatment	<input type="text" value="0"/>	11. Pharmacological Interventions	<input type="text" value="0"/>
5. Assessment	<input type="text" value="0"/>	12. HIV/AIDS Counseling	<input type="text" value="0"/>
6. Treatment/Recovery Planning	<input type="text" value="0"/>	13. Other Clinical Services (Specify)	<input type="text" value="0"/>
7. Individual Counseling	<input type="text" value="0"/>		



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Discretionary Services

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Grant ID: TI15703

K. SERVICES RECEIVED

Case Management Services

1. Family Services (Including Marriage Education, Parenting, Child Development Services)

Sessions

4. Individual Services Coordination

Sessions

2. Child Care

5. Transportation

3. Employment Service

 A. Pre-Employment

7. Supportive Transitional Drug-Free Housing Services

 B. Employment Coaching

8. Other Case Management Services (Specify)

Medical Services

1. Medical Care

Sessions

3. HIV/ AIDS Medical Support & Testing

Sessions

2. Alcohol/Drug Testing

4. Other Medical Services (Specify)

After Care Services

1. Continuing Care

Sessions

4. Self-Help and Support Groups

Sessions

2. Relapse Prevention

5. Spiritual Support

3. Recovery Coaching

6. Other After Care Services (Specify)



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Discretionary Services

Client ID: 001
Grant ID: TI15703

K. SERVICES RECEIVED

Education Services

	Sessions		Sessions
1. Substance Abuse Education	<input type="text" value="0"/>	3. Other Education Services (Specify)	<input type="text" value="0"/>
2. HIV/AIDS Education	<input type="text" value="0"/>		

Peer-To-Peer Recovery Support Services

	Sessions		Sessions
1. Peer Coaching or Mentoring	<input type="text" value="0"/>	4. Information and Referral	<input type="text" value="0"/>
2. Housing Support	<input type="text" value="0"/>	5. Other Peer-to-Peer Recovery Support Services (Specify)	<input type="text" value="0"/>
3. Alcohol-and Drug-Free Social Activities	<input type="text" value="0"/>		

Please specify



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A. RECORD MANAGEMENT

Client ID

Contract/Grant ID

Client Type

Interview Type

Did you conduct a follow-up/
discharge interview?

Interview Date

J. DISCHARGE STATUS

1. On what date was the client discharged?
 2. What is the client's discharge status?
- If the client was terminated, what was the reason for termination?
-
- Other (Specify)
3. Did the program test this client for HIV?
 4. Did the program refer this client for testing?



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K. SERVICES RECEIVED

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.]

Modality	Days		Days
1. Case Management	280	9. Detoxification (Select Only One)	
2. Day Treatment	0	A. Hospital Inpatient	0
3. Inpatient/Hospital (Other Than Detox)	0	B. Free Standing Residential	0
4. Outpatient	0	C. Ambulatory Detoxification	0
5. Outreach	0	10. After Care	0
6. Intensive Outpatient	0	11. Recovery Support	0
7. Methadone	0	12. Other (Specify)	0
8. Residential/Rehabilitation	140		

K. SERVICES RECEIVED

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



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8. Residential/Rehabilitation 140

K. SERVICES RECEIVED

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

[SBIRT GRANTS: YOU MUST HAVE AT LEAST ONE SESSION FOR ONE OF THE TREATMENT SERVICES NUMBERED 1 THROUGH 4.]

	Sessions		Sessions
1. Screening	0	8. Group Counseling	0
2. Brief Intervention	0	9. Family/Marriage Counseling	0
3. Brief Treatment	0	10. Co-Occurring Treatment/ Recovery Services	0
4. Referral to Treatment	0	11. Pharmacological Interventions	0
5. Assessment	0	12. HIV/AIDS Counseling	0
6. Treatment/Recovery Planning	0	13. Other Clinical Services (Specify)	0
7. Individual Counseling	0		

K. SERVICES RECEIVED



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K. SERVICES RECEIVED

Case Management Services

1. Family Services (Including Marriage Education, Parenting, Child Development Services)

Sessions
0

4. Individual Services Coordination

Sessions
0

2. Child Care

0

5. Transportation

0

3. Employment Service

0

6. HIV/AIDS Service

0

 A. Pre-Employment

0

7. Supportive Transitional Drug-Free Housing Services

0

 B. Employment Coaching

0

8. Other Case Management Services (Specify)

0

Medical Services

1. Medical Care

Sessions
0

3. HIV/ AIDS Medical Support & Testing

Sessions
0

2. Alcohol/Drug Testing

0

4. Other Medical Services (Specify)

0

After Care Services

1. Continuing Care

Sessions
0

4. Self-Help and Support Groups

Sessions
0

2. Relapse Prevention

0

5. Spiritual Support

0

3. Recovery Coaching

0

6. Other After Care Services (Specify)

0



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After Care Services

	Sessions		Sessions
1. Continuing Care	0	4. Self-Help and Support Groups	0
2. Relapse Prevention	0	5. Spiritual Support	0
3. Recovery Coaching	0	6. Other After Care Services (Specify)	0

K. SERVICES RECEIVED

Education Services

	Sessions		Sessions
1. Substance Abuse Education	1	3. Other Education Services (Specify)	0
2. HIV/AIDS Education	0		

Peer-To-Peer Recovery Support Services

	Sessions		Sessions
1. Peer Coaching or Mentoring	0	4. Information and Referral	0
2. Housing Support	0	5. Other Peer-to-Peer Recovery Support Services (Specify)	0
3. Alcohol-and Drug-Free Social Activities	0		