

PCAP Client Module Monthly Update

Agency Name: _____

Site Name: _____

Client #: _____

Date: ___ / ___ / _____

Complete this form at end of every month.

Monthly update for the month of:	<input type="checkbox"/> January	<input type="checkbox"/> February	<input type="checkbox"/> March	<input type="checkbox"/> April	<input type="checkbox"/> May	<input type="checkbox"/> June
	<input type="checkbox"/> July	<input type="checkbox"/> August	<input type="checkbox"/> September	<input type="checkbox"/> October	<input type="checkbox"/> November	<input type="checkbox"/> December
Year:	_____					

A. Was client seen this month (face-to face)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
If not at least once, please explain: _____			
B. If client has disappeared, are you in contact with a tracing source?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> N/A
Who? _____			
How long has she been missing? _____			
What have you done to try to find client? _____			
C. Client location is known, but she is avoiding contact:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> N/A
D. How many times was target child seen this month (face-to face)?	_____		

IN THE PAST MONTH, did client:	UNKNOWN
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1. Use illicit drugs? <i>If No or Unknown, skip to Question 2</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>									
If yes, what? (check yes or no for each):												
a. Cocaine	<input type="checkbox"/> No or Don't Know	<input type="checkbox"/> Yes										
b. Heroin	<input type="checkbox"/> No or Don't Know	<input type="checkbox"/> Yes										
c. Marijuana	<input type="checkbox"/> No or Don't Know	<input type="checkbox"/> Yes										
d. Methamphetamine	<input type="checkbox"/> No or Don't Know	<input type="checkbox"/> Yes										
e. Other (specify below)	<input type="checkbox"/> No or Don't Know	<input type="checkbox"/> Yes										
Specify Other: _____												
2a. Drink alcohol?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, but not a problem	<input type="checkbox"/> Yes, & has problem	<input type="checkbox"/>								
2b. During the past 30 days, on how many days did you _____ days drink one or more of an alcoholic beverage?				<input type="checkbox"/>								
2c. How many drinks did you have on a typical day when you were drinking alcohol in the past 30 days?	<input type="checkbox"/> 10 or more	<input type="checkbox"/> 9	<input type="checkbox"/> 8	<input type="checkbox"/> 7	<input type="checkbox"/> 6	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/>
2d. How often did you have 4 or more drinks in one day in the past 30 days?	<input type="checkbox"/> 10 or more	<input type="checkbox"/> 9	<input type="checkbox"/> 8	<input type="checkbox"/> 7	<input type="checkbox"/> 6	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/>
3. Relapse? (alcohol or drugs)	<input type="checkbox"/> No	<input type="checkbox"/> Once	<input type="checkbox"/> More than Once	<input type="checkbox"/> Not Abstinent	<input type="checkbox"/>							
4. Any alcohol/drug treatment?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Completed	<input type="checkbox"/> Yes, In progress	<input type="checkbox"/> Dropped	<input type="checkbox"/>							
a. Where / What kind? _____												
5. Is client using birth control regularly?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, regularly	<input type="checkbox"/> Only sometimes	<input type="checkbox"/>								
a. What kind of birth control? _____												
6. Is client pregnant?	<input type="checkbox"/> No	<input type="checkbox"/> Yes				<input type="checkbox"/>						
7. If client was pregnant this month but is not now, outcome:	<input type="checkbox"/> Terminated	<input type="checkbox"/> Miscarried	<input type="checkbox"/> Resulted in birth	<input type="checkbox"/> N/A	<input type="checkbox"/>							

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-xxxx. Public reporting burden for this collection of information is estimated to average 6 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.

Client #: _____

Date: ___ / ___ / _____

IN THE PAST MONTH, did client:	UNKNOWN
<i>If Q8, 9, 10, or 11 YES, briefly note details in comments, if known</i>	
8. Leave baby (TC or other) with inadequate or no caretaker? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	<input type="checkbox"/>
9. Put any of her children in unsafe situations? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	<input type="checkbox"/>
10. Gain or lose custody of any child? <input type="checkbox"/> No <input type="checkbox"/> Yes, temporary <input type="checkbox"/> Yes, permanent <input type="checkbox"/> N/A a. If so, who? To who? _____	<input type="checkbox"/>
11. Was a report made to CPS this past month? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A <i>If No report, Unknown, or N/A, skip to Question 12</i> a. Report made by: <input type="checkbox"/> Advocate <input type="checkbox"/> Other Person: _____ b. Report made on: <input type="checkbox"/> Client <input type="checkbox"/> Other Person: _____ c. Report made on behalf of: <input type="checkbox"/> Target Child <input type="checkbox"/> Other Child <input type="checkbox"/> Target Child+Others d. Reason for report: _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sources of income this month:	
12. Any employment? (Her employment) <input type="checkbox"/> No <input type="checkbox"/> Yes a. If employed, is her employment her main source of income? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	<input type="checkbox"/> <input type="checkbox"/>
13. Any TANF/Welfare? (Does not incl. food stamps, medical benefits) <input type="checkbox"/> No <input type="checkbox"/> Yes a. If receiving TANF/Welfare, is it the main source of income? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	<input type="checkbox"/> <input type="checkbox"/>
14. List all other sources of income this month: _____	<input type="checkbox"/>

Comments: _____

Advocate #: _____