OMB # 0930- XXXX
Expiration Date: xx/xx/xxxx

**PCAP Client Module**

# Biannual Documentation of Client Progress

**Agency Name:** ______________________ **Site Name:** _________________________

**Client #:** __ __ __ __ __ __ **Date:** __ __ / __ __ / __ __ __ __

A. Documentation month *(Based on enrollment date):* 6 12 18 24 30 36

B. 6-month period covered by this form: Start date: __ __ / __ __ / __ __ __ __

End date: __ __ / __ __ / __ __ __ __

## SECTION 1. ALCOHOL/DRUG TREATMENT

*Document client involvement with any and all alcohol/drug treatment during this 6-month period. Be sure to note outcome of any previously "in progress" treatment from last 6-month report.*

| | A. No 0 | Yes, Completed 1 | Yes, In Progress 2 | Yes, But Dropped 3 | Don't Know -7 | B. Name of Treatment Facility/Agency |
|---|---|---|---|---|---|---|
| 1. Inpatient (30 day, or less than 30 day) | | | | | | |
| 2. Inpatient (more than 30 day)<br>*If No, skip to Question 3.*<br>a. Length of Program: __ __ __ days *DK = -7*<br>b. Time she spent IN Program: __ __ __ days *DK = -7* | | | | | | |
| 3. Outpatient | | | | | | |
| 4. Methadone dosing | | | | | | |
| 5. Alcohol/drug support group<br>*If No, skip to Question 6.*<br>a. Type of group: AA NA/CA both other: ______________ | | | | | | |
| 6. Individual counseling | | | | | | |
| 7. Detox | | | | | | |
| 8. Treatment program in jail or prison | | | | | | |
| 9. Other treatment, specify what kind:______________________ | | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 10. Treatment was for: | Alcohol | Drugs | Both | N/A* | Don't Know |
| 11. Treatment was: | Mandated | Voluntary | | N/A | Don't Know |
| 12. Was/were her child(ren) with her in treatment? | No | Yes | | N/A | Don't Know |
| 13. Any alcohol/drug assessment for tx done? | No | Yes | | | Don't Know |
| 14. Did she have UA monitoring? *(outside of treatment)* | No | Yes | | | Don't Know |

Comments on ALCOHOL/DRUG TREATMENT:



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 40 minutes 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:** __ __ / __ __ / __ __ __ __

## SECTION 2. ABSTINENCE FROM ALCOHOL & DRUGS

Complete at end of 6-month documentation period. As of the date this 6-month period ends:

| | | | | Don't Know -7 |
|---|---|---|---|---|
| 15. Is client currently clean from drugs? *(for at least one month)*<br>*If Yes or Don't Know, skip to Question 17.* | No | Yes | | |
| 16. If using at end of 6-month period, what drugs does client use now? *(check a response for each)* | | | | |
| a. Cocaine | No or Don't Know | Yes | | |
| b. Heroin | No or Don't Know | Yes | | |
| c. Marijuana | No or Don't Know | Yes | | |
| d. Crack | No or Don't Know | Yes | | |
| e. Methamphetamine | No or Don't Know | Yes | | |
| f. Other | No or Don't Know | Yes | | |
| *Specify other:*______________________ | | | | |
| 17. How many months currently clean? *(Total consecutive PCAP months, not just of last 6)*<br>*(Code 00 if used in last month of this 6-month period)* | ___ ___ months | | | |
| 18. Is client currently abstinent from alcohol? *(for at least one month)* | No | Yes | | |
| 19. How many months currently abstinent? *(Total consecutive PCAP months, not just of last 6)*<br>*(Code 00 if drank in last month of this 6-month period)* | ___ ___ months | | | |
| 20. Does client have a problem with alcohol?<br>*(i.e., alcoholic; answer even if client does not currently drink)* | No | Yes | | |
| 21. Since starting PCAP, what is the longest number of months in a row client has been clean and sober with no relapses, even if currently using.<br>(*Do not count cigarettes & methadone use. Do not count time when she was not enrolled in PCAP). Check only ONE.* | Never<br>6-11<br>24-29 | 1-2<br>12-17<br>30-35 | 3-5<br>18-23<br>all 36 | |

### Alcohol Assessment

| | |
|---|---|
| During the past 30 days, on how many days did you drink one or more of an alcoholic beverage? | ________ days |
| How many drinks did you have on a typical day when you were drinking alcohol in the past 30 days? | ☐10 or more ☐9 ☐8 ☐7 ☐6 ☐5 ☐4 ☐3 ☐2 ☐1 ☐0 |
| How often did you have 4 or more drinks in one day in the past 30 days? | ☐10 or more ☐9 ☐8 ☐7 ☐6 ☐5 ☐4 ☐3 ☐2 ☐1 ☐0 |

Comments on ABSTINENCE FROM ALCOHOL & DRUGS:

**Client #:** __ __ __ __ __ __ **Date:** __ __ / __ __ / __ __ __ __

## SECTION 3. BIRTH CONTROL & PREGNANCY

As of the end of this 6-month period:

22. Is client using birth control regularly? *(i.e., has a consistent birth control method)* No Yes Don't Know

23. What kinds of birth control does she currently use? *(Regular or not; check a response for each)*

| | | |
|---|---|---|
| a. Depo Provera shots | No or Don't Know | Yes |
| b. Norplant | No or Don't Know | Yes |
| c. Tubal Ligation | No or Don't Know | Yes |
| d. IUD | No or Don't Know | Yes |
| e. Pills | No or Don't Know | Yes |
| f. Condoms | No or Don't Know | Yes |
| g. Morning after pill | No or Don't Know | Yes |
| h. Other method | No or Don't Know | Yes |

*Specify other method:* ________________________________________

24. If not using birth control currently, is there a particular reason why not? ________________________________
*If using a method, skip this question*

25. Was client pregnant in last 6 months? No Yes, currently Yes, but not now Don't Know
*If No, Yes currently, or Don't Know, skip to Question 26.*

a. If pregnant in last 6 months but not now, what was the outcome of that pregnancy?

Gave birth to target child Gave birth to another child* Terminated (abortion)

Miscarried Stillbirth* Don't Know

***If outcome was gave birth to another child or stillbirth, submit a Notification of Subsequent Birth Form.***

**Client #:** __ __ __ __ __ __ **Date:** __ __ / __ __ / __ __ __ __

## SECTION 4. CONNECTION TO OTHER SERVICES

SERVICES FOR HOUSEHOLD — *What services has client's household used in the past 6 months? Check appropriate box for each service. If problems with service please note what kind of problems in comments area.*

| | Yes,Working Well 1 | Yes,but Problems 2 | No, But Needed 3 | Np, Not Needed 4 | Don't Know -7 |
|---|---|---|---|---|---|
| 26. Basic Needs *(food banks/clothing/supplies)* | | | | | |
| 27. Food Stamps | | | | | |
| 28. Medical Coupons | | | | | |
| 29. Emergency funds or emergency bill paying service *(utility vouchers/rent assistance, Salvation Army, etc.)* a. Specify type: ___________________________________ | | | | | |
| 30. Public Health Nurse | | | | | |
| 31. Public Housing *(section 8, low income, subsidized)* a. On waiting list? No Yes Waiting list closed | | | | | |
| 32. Emergency housing *(include shelters)* | | | | | |
| 33. Transitional Housing | | | | | |
| 34. Child Protective Services (CPS) *If No, skip to Question 34b.* | | | | | |
| a. IF YES, Who: Target child Other child(ren) Target child+other child(ren) | | | | | |
| b. CPS report filed in last 6 months? No Yes *(if yes, describe in comments)* *If No, skip to Question 35.* c. Report by: Advocate Other Person:__________________________ d. Report on: Client Other Person:__________________________ e. On behalf of: Target child Other child Target child+others | | | | | |

Comments on SERVICES FOR HOUSEHOLD:

**Client #:** __ __ __ __ __ __   **Date:** __ __ / __ __ / __ __ __ __

| SERVICES FOR CLIENT during past 6 months | Yes,Working Well 1 | Yes,but Problems 2 | No, But Needed 3 | Np, Not Needed 4 | Don't Know -7 |
|---|---|---|---|---|---|
| 35. Healthcare Provider *(doctor)* | | | | | |
| 36. Other Health Service *(eye doctor, PT, dentist;)*<br>a. Specify Type: ______________________________ | | | | | |
| 37. Family Planning Service | | | | | |
| 38. Mental Health Counseling, Individual | | | | | |
| 39. Mental Health Counseling, Group<br>a. Specify Type: ______________________________ | | | | | |
| 40. Domestic Violence Service *(shelter, group, etc.)z*<br>a. Describe: ______________________________ | | | | | |
| 41. Any Legal Services, Civil *(e.g., child custody, restraining order, etc.)*<br>a. Describe: ______________________________ | | | | | |
| 42. Any Legal Services, Criminal<br>a. Describe: ______________________________ | | | | | |
| 43. SSI/Disability *(applications, hearings, etc.)*<br>a. Specify Type: ______________________________ | | | | | |
| 44. Academic/Vocational Skills Training *(applications, attending, tutoring)*<br>a. Describe: ______________________________ | | | | | |
| 45. Personal/Social Skills Training<br>a. Describe: ______________________________ | | | | | |
| 46. Positive Recreation/Enrichment *(exercise, library card, etc.)*<br>a. Specify: ______________________________ | | | | | |
| 47. Other Service<br>a. Specify: ______________________________ | | | | | |

Comments on SERVICES FOR CLIENT:

**Client #:** __ __ __ __ __ __ **Date:** __ __ / __ __ / __ __ __ __

| CUSTODY OF TARGET CHILD | Don't Know -7 |
|---|---|
| 48. Who has legal custody of target child at end of 6 months?<br>Client / Bio dad / Child deceased<br>Other family* / The state / Other*<br>Adoptive family / Tribal authority / *Other, who: ______ | |
| 49. Who does target child live with at end of 6 months?<br>Client / Bio dad / Child deceased<br>Other family* / State/foster family / Other*<br>Adoptive family / Child deceased / *Other, who: ______ | |
| 50. For how many months of the past 6 did the target child live with client? *(code 0 if none; if less than 1 month code 1)* ___ months<br>51. For how many mos. of the past 6 did the target child live in state-paid foster or family care? *(code 0 if none; if less than 1 month code 1)* ___ months | |

Comments on CUSTODY OF TARGET CHILD:

| SERVICES FOR TARGET CHILD (TC) during past 6 months | Yes,Working Well 1 | Yes,but Problems 2 | No, But Needed 3 | Np, Not Needed 4 | Don't Know -7 |
|---|---|---|---|---|---|
| 52. Healthcare Provider *(doctor)* | | | | | |
| 53. Other Health Services *(eye doctor, PT, dentist)*<br>a. Specify Type: ______ | | | | | |
| 54. High Risk Clinic | | | | | |
| 55. FAS Clinic | | | | | |
| 56. Therapeutic Child Care Center | | | | | |
| 57. Daycare/Childcare<br>a. Where: ______ | | | | | |
| 58. Mental Health Counseling for Target Child<br>a. If YES, problem: ______ | | | | | |
| 59. SSI/Disability<br>a. Describe: ______ | | | | | |
| 60. Other Service for Target Child<br>a. If YES, what services? ______ | | | | | |

Comments on SERVICES FOR TARGET CHILD:

**Client #:** __ __ __ __ __ __   **Date:** __ __ / __ __ / __ __ __ __

SERVICES FOR TARGET CHILD (TC) during past 6 months *(continued)*

| | | Don't Know -7 |
|---|---|---|
| 61. Are target child's well-child visits up-to-date? | No Yes | |
| 62. Are target child's immunizations up-to-date? *If Yes, skip to Question 59.*<br>a. If not fully immunized, why not: ________________________ | No Yes | |
| 63. Does TC have chronic medical condition or special healthcare needs?<br>a. Describe: ________________________________________ | No Yes Suspect So | |
| 64. If target child was living with someone other than client, did advocate help or try to help link foster parent/guardian to any direct services for the target child in the past 6 months?<br>**Other, who:* ____________________________________________ | No Yes N/A | |

Comments on SERVICES FOR TARGET CHILD:

SERVICES FOR OTHERS during past 6 months - Only if PCAP advocacy played a role

CLIENT'S OTHER CHILDREN:

| | | Don't Know -7 |
|---|---|---|
| 65. Did client have any children (**biological or not**) living with her in past 6 months? | No Yes | |

Did you or any other PCAP advocate help connect any of the client's children, **biological or not**, to any of the following? *Do not include target child.*

| | | |
|---|---|---|
| 66. Healthcare Services *(doctor, dentist, immunizations)*<br>a. Specify: ____________________________________________________ | No Yes | |
| 67. Public Schools/Educational *(conferences, ed. counseling)*<br>a. Specify: ____________________________________________________ | No Yes | |
| 68. Mental Health/Counseling<br>a. Specify: ____________________________________________________ | No Yes | |
| 69. Recreational/Cultural Activities<br>a. Specify: ____________________________________________________ | No Yes | |
| 70. Other Service for Child<br>a. Specify: ____________________________________________________ | No Yes | |

Comments on SERVICES FOR CLIENT'S OTHER CHILDREN:

**Client #: __ __ __ __ __ __** **Date: __ __ / __ __ / __ __ __ __**

SERVICES FOR OTHERS during past 6 months - Only if PCAP advocacy played a role (continued)

CLIENT'S PARTNER(S):

| | | | | Don't Know -7 |
|---|---|---|---|---|
| 71. | Did client have a partner(s) during this past 6 months? *(supportive or not)*<br>a. Comments on partner(s): ______________________________ | No | Yes | |

Did you or any other PCAP advocate help connect client's partner(s) to any of the following?

| | | | | |
|---|---|---|---|---|
| 72. | Alcohol/Drug Treatment *(incl.assessment)*<br>a. Type: ______________________________ | No | Yes | |
| 73. | Domestic Violence Counseling/Service<br>a. Specify: ______________________________ | No | Yes | |
| 74. | Employment/Job Training Assistance | No | Yes | |
| 75. | Legal *(includes P.O.'s, INS)*<br>a. Specify: ______________________________ | No | Yes | |
| 76. | Other Service for Partner *(incl. medical or mental health)*<br>a. Specify: ______________________________ | No | Yes | |

Comments on SERVICES FOR CLIENT'S PARTNER(S):

CLIENT'S FAMILY: Did you or any other PCAP advocate help connect client's family to any of the following?

| | | | | |
|---|---|---|---|---|
| 77. | Alcohol/Drug Treatment *(incl.assessment)* a. Type: ______________________ | No | Yes | |
| 78. | Domestic Violence Counseling/Service | No | Yes | |
| 79. | Employment/Job Training Assistance | No | Yes | |
| 80. | Other Service for Family Member<br>a. Specify: ______________________________ | No | Yes | |

Comments on SERVICES FOR OTHER CLIENT FAMILY:

SECTION 5. FAMILY STABILITY & CLIENT ACTIVITY

LIVING SITUATION/HOUSING

| 81. In what housing situations has client lived during past 6 months? *(check yes or no for each)* | No 0 | Yes 1 | Don't Know -7 |
|---|---|---|---|
| a. Homeless (01) | | | |
| b. Living in Shelters/Motels (02) | | | |
| c. Living with Friends/Relatives (03) | | | |
| d. Permanent Housing (04) | | | |
| e. Transitional Housing (05) | | | |
| f. Transitional Clean & Sober Housing (06) | | | |
| g. Inpatient treatment *(includes MH & alc/drg tx)* (07) | | | |
| h. Incarcerated *(jail, prison, etc.)* (08) | | | |
| i. Other situation (09): ____________________________________________ | | | |
| **82. What is her CURRENT housing situation?** *(Enter 2 digit number from above)* ___ ___ | | | |

83. Who lives with client in her current housing situation <u>at the END of this 6-month period</u>?

| *Situations with no children* | *Situations with children* |
|---|---|
| Lives alone | Lives with child/children, no other adults |
| Lives with husband, no children | Lives with husband & child/children |
| Lives with boyfriend/girlfriend (domestic partner, no children) | Lives with boyfriend/girlfriend & child/children |
| Lives with parents, grandparents, other family, no children | Lives with relatives & children |
| Lives with in-laws &/or their family, no children | Lives with in-laws &/or their family, plus child/children |
| Lives with non-related women/men (roommates), no children | Lives with non-related roommates & children |
| Some other situation: ______________________________________________________ | |

84. During this 6-month period, was any housing PCAP contracted housing? No Yes

85. Has client moved in past 6 months? Code # of moves. *(00=no moves; 66=too many moves to count)* ___ ___

Comments on LIVING SITUATION/HOUSING:

CLIENT'S BIOLOGICAL CHILDREN (INCLUDING TARGET CHILD)

As of the date the 6-month period ends: Don't Know -7

86. Location of client's biological children (including Target Child):

a. How many of client's biological children live with client? *(code # of children; 00=none)* ___ ___

b. How many of client's biological children do NOT live with client? ___ ___

Comments on BIOLOGICAL CHILDREN:

| SOURCES OF INCOME IN PAST 6 MONTHS | No 0 | Yes 1 | Don't Know -7 |
|---|---|---|---|
| 87. What sources of income has client had in the past 6 months? *(check yes or no for each)*<br>a. Employment *(hers)* (01) | | | |
| b. Odd jobs she does (02) | | | |
| c. Parent/grandparent (03) | | | |
| d. Other relative (04) | | | |
| e. Husband/boyfriend (05) | | | |
| f. Friends/acquaintances (06) | | | |
| g. Welfare (07) | | | |
| h. SSI/Disability (08) | | | |
| i. Other government check *(GAU, etc.)* (09), specify: ______________________ | | | |
| j. Tribal funds (10) | | | |
| k. Other (11), specify: ______________________________________________ | | | |
| l. Drug sales/prostitution (12) | | | |
| m. Fraud/check-kiting (13) | | | |
| n. Other illicit (14), specify:___________________________________________<br><br>88. What is her main source of income <u>at end of 6-month period</u>? *(Enter 2 digit number from above)* ___ ___ | | | |

89. Has client been employed during this 6-month period, even if currently not? No Yes

a. How long employed this 6 month period: ___ months ___ weeks ___ days *(Don't Know = -7 / -7 / -7)*

b. Type of employment None Full-time (F/T) Part-time (P/T) Irregular Work
Was employed, but don't know what type of employment

c. Describe: ____________________________________________________________________

90. Client is currently employed? No Yes, F/T Yes, P/T Yes, Irregular Work
*(Currently=At end of 6 month period)* Yes, employed, but don't know what type of employment

a. Current job: _____________________________________________________

91. Does client currently receive welfare for herself or her children? *(do not include food stamps)* No Yes

a. Number of months client/family received welfare during last 6 months: __ months

92. During the past 6 months, did client: *(if no welfare past 6 months, code No)*

a. STOP receiving welfare No Yes, because of work
Reason: ________________________________________________ Yes, other reason

b. START receiving welfare No Yes, because of work
Reason: ________________________________________________ Yes, other reason

Comments on SOURCES OF INCOME:

OTHER EVENTS IN PAST 6 MONTHS

| In the last 6 months, have any of the following events occurred? | No 0 | Yes 1 | Don't Know -7 |
|---|---|---|---|
| 93. Client has taken parenting classes in the last 6 months? *If No, skip to Question 93.* | | | |
| a. Class: ______________________ | | | |
| b. Code # weeks attended *(00=none)* | __ __ weeks | | |
| c. Course completed? | | | |
| 94. Client has a chronic medical condition? *(incl. chronic STD, Hepatitis)* | | | |
| a. Describe/Specify: ______________________ | | | |
| 95. Client has visited the Emergency Room (E.R.) for medical care for herself or a child? ***Inappropriate*** *use of the service. If No, skip to Question 95.* | | | |
| a. Code # of times | __ __ times | | |
| 96. Client has visited the Emergency Room (E.R.) for medical care for herself or a child? ***Appropriate*** *use of the service. If No, skip to Question 96.* | | | |
| a. Code # of times | __ __ times | | |
| 97. To help her maintain a clean and sober lifestyle, does client have in her life: | No | Yes | |
| a. A supportive partner? | | | |
| b. A supportive person (other than partner or advocate)? | | | |
| c. A support system (social, church, 12-step sponsor)? | | | |
| Specify support system:______________________ | | | |
| 98. During the past 6 months, has client been in what you would consider an abusive relationship with her partner(s)? *(If no partner, code No)* | | | |
| a. Describe: ______________________ | | | |
| 99. Has client assaulted anyone in past 6 months? *If No, skip to Question 100.* | | | |
| a. If so, who: Child Partner Other: ______________________ | | | |
| b. Situation: ______________________ | | | |

Comments on OTHER EVENTS:

**Client #:** __ __ __ __ __ __ **Date:** __ __ / __ __ / __ __ __ __

ARRESTS/JAIL

| In the last 6 months, have any of the following events occurred? | No 0 | Yes 1 | Don't Know -7 |
|---|---|---|---|
| 100. Was client arrested in past 6 months? *If No, skip to Question 101.*<br>a. Charges: ____________<br>b. Number of times arrested ___ ___ times<br>c. Charge(s) are: New charge Old warrant Both | | | |
| 101. Was client jailed in past 6 months? *If No, skip to Question 102.*<br>a. Number of times jailed ___ ___ times<br>b. For what? ____________<br>c. Facility: ____________ | | | |
| 102. Was client in Home Detention at any time during past 6 months? | | | |
| 103. Was client in Prison at any time during past 6 months? *If No, skip to Question 104.*<br>a. Facility: ____________<br>b. # of months (of 6): ___ mos | | | |
| 104. Was client on Probation at any time during past 6 months? | | | |
| 105. Did advocate play a role in type of sentence imposed in past 6 months? *If No, skip to Question 106.*<br>a. If yes, how so? ____________ | | | |

Comments on ARRESTS/JAIL:

EDUCATION/TRAINING

| In past 6 months, has client attended and/or completed: | No 0 | Attemded 1 | Completed 2 | Don't Know -7 |
|---|---|---|---|---|
| 106 GED classes<br>a. Where: ____________ | | | | |
| 107. Community college<br>a. Where: ____________ | | | | |
| 108. Four-year college<br>a. Where: ____________ | | | | |
| 109. Vocational training class<br>a. What/where: ____________ | | | | |
| 110. Training through work/employment<br>a. What/where: ____________ | | | | |
| 111. Other course/class<br>a. Specify: ____________ | | | | |

Comments on EDUCATION/TRAINING:

VALIDITY

112. Advocate is confident of accuracy of information presented in this report: Yes Mostly Not at all

Comments on validity: *(if you code Mostly or Not at all, note why)* ______

Comments on client's situation during this six months: ______

Advocate #: __ __ __