

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

	No 0	Yes, Completed 1	Yes, In Progress 2	Yes, But Dropped 3	Don't Know -7	Name of Treatment Facility/Agency
1. Inpatient (30 day, or less than 30 day)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Inpatient (more than 30 day) <i>If No, skip to Question 3.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<div style="border: 1px solid black; padding: 5px;"> a. Length of Program: _____ days DK = -7 b. Time she spent IN Program: _____ days DK = -7 </div>						
3. Outpatient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Methadone dosing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Alcohol/drug support group <i>If No, skip to Question 6.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<div style="border: 1px solid black; padding: 5px;"> a. Type of group: <input type="checkbox"/> AA <input type="checkbox"/> NA/CA <input type="checkbox"/> both <input type="checkbox"/> other: _____ </div>						
6. Individual counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Detox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. Treatment program in jail or prison	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. Other treatment, specify what kind: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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

Comments on ALCOHOL/DRUG TREATMENT:

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) <i>If Yes or Don't Know, skip to Question 17.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>
16. If using at end of 6-month period, what drugs does client use now? (check a response 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. Crack	<input type="checkbox"/> No or Don't Know <input type="checkbox"/> Yes	
e. Methamphetamine	<input type="checkbox"/> No or Don't Know <input type="checkbox"/> Yes	
f. Other	<input type="checkbox"/> No or Don't Know <input type="checkbox"/> Yes	
<i>Specify other: _____</i>		
17. How many months currently clean? (Total consecutive PCAP months, not just of last 6) <i>(Code 00 if used in last month of this 6-month period)</i>	___ months	<input type="checkbox"/>
18. Is client currently abstinent from alcohol? (for at least one month)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>
19. How many months currently abstinent? (Total consecutive PCAP months, not just of last 6) <i>(Code 00 if drank in last month of this 6-month period)</i>	___ months	<input type="checkbox"/>
20. Does client have a problem with alcohol? <i>(i.e., alcoholic; answer even if client does not currently drink)</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>
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. <i>(Do not count cigarettes & methadone use. Do not count time when she was not enrolled in PCAP). Check only ONE.</i>	<input type="checkbox"/> Never <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-5 <input type="checkbox"/> 6-11 <input type="checkbox"/> 12-17 <input type="checkbox"/> 18-23 <input type="checkbox"/> 24-29 <input type="checkbox"/> 30-35 <input type="checkbox"/> all 36	<input type="checkbox"/>

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?	<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
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

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>i.e., has a consistent birth control method</i>)		<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know	
23. What kinds of birth control does she currently use? (<i>Regular or not; check a response for each</i>)					
a. Depo Provera shots	<input type="checkbox"/> No or Don't Know	<input type="checkbox"/> Yes			
b. Norplant	<input type="checkbox"/> No or Don't Know	<input type="checkbox"/> Yes			
c. Tubal Ligation	<input type="checkbox"/> No or Don't Know	<input type="checkbox"/> Yes			
d. IUD	<input type="checkbox"/> No or Don't Know	<input type="checkbox"/> Yes			
e. Pills	<input type="checkbox"/> No or Don't Know	<input type="checkbox"/> Yes			
f. Condoms	<input type="checkbox"/> No or Don't Know	<input type="checkbox"/> Yes			
g. Morning after pill	<input type="checkbox"/> No or Don't Know	<input type="checkbox"/> Yes			
h. Other method	<input type="checkbox"/> No or Don't Know	<input type="checkbox"/> Yes			
Specify other method: _____					
24. If not using birth control currently, is there a particular reason why not? _____ <i>If using a method, skip this question</i>					
25. Was client pregnant in last 6 months?		<input type="checkbox"/> No	<input type="checkbox"/> Yes, currently	<input type="checkbox"/> Yes, but not now	<input type="checkbox"/> Don't Know
<i>If No, Yes currently, or Don't Know, skip to Question 26.</i>					
a. If pregnant in last 6 months but not now, what was the outcome of that pregnancy?					
<input type="checkbox"/> Gave birth to target child	<input type="checkbox"/> Gave birth to another child*	<input type="checkbox"/> Terminated (abortion)			
<input type="checkbox"/> Miscarried	<input type="checkbox"/> Stillbirth*	<input type="checkbox"/> 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 <i>(food banks/clothing/supplies)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Food Stamps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Medical Coupons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Emergency funds or emergency bill paying service <i>(utility vouchers/rent assistance, Salvation Army, etc.)</i> a. Specify type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Public Health Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Public Housing <i>(section 8, low income, subsidized)</i> a. On waiting list? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Waiting list closed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Emergency housing <i>(include shelters)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Transitional Housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Child Protective Services (CPS) <i>If No, skip to Question 34b.</i> a. IF YES, Who: <input type="checkbox"/> Target child <input type="checkbox"/> Other child(ren) <input type="checkbox"/> Target child+other child(ren)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. CPS report filed in last 6 months? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(if yes, describe in comments)</i> <i>If No, skip to Question 35.</i> c. Report by: <input type="checkbox"/> Advocate <input type="checkbox"/> Other Person: _____ d. Report on: <input type="checkbox"/> Client <input type="checkbox"/> Other Person: _____ e. On behalf of: <input type="checkbox"/> Target child <input type="checkbox"/> Other child <input type="checkbox"/> Target child+others					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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	No, Not Needed 4	Don't Know -7
35. Healthcare Provider (<i>doctor</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Other Health Service (<i>eye doctor, PT, dentist;</i>) a. Specify Type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. Family Planning Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. Mental Health Counseling, Individual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. Mental Health Counseling, Group a. Specify Type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. Domestic Violence Service (<i>shelter, group, etc.</i>) <input type="checkbox"/> a. Describe: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
41. Any Legal Services, Civil (<i>e.g., child custody, restraining order, etc.</i>) a. Describe: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. Any Legal Services, Criminal a. Describe: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. SSI/Disability (<i>applications, hearings, etc.</i>) a. Specify Type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. Academic/Vocational Skills Training (<i>applications, attending, tutoring</i>) a. Describe: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45. Personal/Social Skills Training a. Describe: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46. Positive Recreation/Enrichment (<i>exercise, library card, etc.</i>) a. Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47. Other Service a. Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments on SERVICES FOR CLIENT:

Client #: _____

Date: ___/___/_____

CUSTODY OF TARGET CHILD

Don't Know
-7

<p>48. Who has legal custody of target child at end of 6 months?</p> <p><input type="checkbox"/> Client <input type="checkbox"/> Bio dad <input type="checkbox"/> Child deceased</p> <p><input type="checkbox"/> Other family* <input type="checkbox"/> The state <input type="checkbox"/> Other*</p> <p><input type="checkbox"/> Adoptive family <input type="checkbox"/> Tribal authority *Other, who: _____</p>	<input type="checkbox"/>
<p>49. Who does target child live with at end of 6 months?</p> <p><input type="checkbox"/> Client <input type="checkbox"/> Bio dad <input type="checkbox"/> Child deceased</p> <p><input type="checkbox"/> Other family* <input type="checkbox"/> State/foster family <input type="checkbox"/> Other*</p> <p><input type="checkbox"/> Adoptive family <input type="checkbox"/> Child deceased *Other, who: _____</p>	<input type="checkbox"/>
<p>50. For how many months of the past 6 did the target child live with client? _____ months <i>(code 0 if none; if less than 1 month code 1)</i></p>	<input type="checkbox"/>
<p>51. For how many mos. of the past 6 did the target child live in <u>state-paid</u> foster or family care? _____ months <i>(code 0 if none; if less than 1 month code 1)</i></p>	<input type="checkbox"/>

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 (<i>doctor</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
53. Other Health Services (<i>eye doctor, PT, dentist</i>) a. Specify Type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
54. High Risk Clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
55. FAS Clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
56. Therapeutic Child Care Center	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
57. Daycare/Childcare a. Where: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
58. Mental Health Counseling for Target Child a. If YES, problem: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
59. SSI/Disability a. Describe: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
60. Other Service for Target Child a. If YES, what services? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments on SERVICES FOR TARGET CHILD:

Client #: _____

Date: ___/___/_____

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

	Know	Don't -7
61. Are target child's well-child visits up-to-date? <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/>
62. Are target child's immunizations up-to-date? <i>If Yes, skip to Question 59.</i> a. If not fully immunized, why not: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/>
63. Does TC have chronic medical condition or special healthcare needs? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Suspect So <input type="checkbox"/> a. Describe: _____		
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? <i>*Other, who: _____</i> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A		<input type="checkbox"/>

Comments on SERVICES FOR TARGET CHILD:

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

CLIENT'S OTHER CHILDREN:

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

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 <i>(doctor, dentist, immunizations)</i> a. Specify: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>
67. Public Schools/Educational <i>(conferences, ed. counseling)</i> a. Specify: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>
68. Mental Health/Counseling a. Specify: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>
69. Recreational/Cultural Activities a. Specify: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>
70. Other Service for Child a. Specify: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>

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*) No Yes
a. Comments on partner(s): _____

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

72. Alcohol/Drug Treatment (<i>incl.assessment</i>) a. Type: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>
73. Domestic Violence Counseling/Service a. Specify: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>
74. Employment/Job Training Assistance	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>
75. Legal (<i>includes P.O.'s, INS</i>) a. Specify: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>
76. Other Service for Partner (<i>incl. medical or mental health</i>) a. Specify: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>

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 (<i>incl.assessment</i>) a. Type: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>
78. Domestic Violence Counseling/Service	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>
79. Employment/Job Training Assistance	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>
80. Other Service for Family Member a. Specify: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>

Comments on SERVICES FOR OTHER CLIENT FAMILY:

Client #: _____

Date: ___/___/_____

SECTION 5. FAMILY STABILITY & CLIENT ACTIVITY

LIVING SITUATION/HOUSING

	No 0	Yes 1	Don't Know -7
81. In what housing situations has client lived during past 6 months? (check yes or no for each)			
a. Homeless (01)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Living in Shelters/Motels (02)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Living with Friends/Relatives (03)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Permanent Housing (04)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Transitional Housing (05)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Transitional Clean & Sober Housing (06)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Inpatient treatment (includes MH & alc/drg tx) (07)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Incarcerated (jail, prison, etc.) (08)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Other situation (09): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
82. What is her CURRENT housing situation? (Enter 2 digit number from above)		__ __	<input type="checkbox"/>
83. Who lives with client in her current housing situation at the END of this 6-month period?			
<i>Situations with no children</i>		<i>Situations with children</i>	
<input type="checkbox"/> Lives alone		<input type="checkbox"/> Lives with child/children, no other adults	<input type="checkbox"/>
<input type="checkbox"/> Lives with husband, no children		<input type="checkbox"/> Lives with husband & child/children	
<input type="checkbox"/> Lives with boyfriend/girlfriend (domestic partner, no children)		<input type="checkbox"/> Lives with boyfriend/girlfriend & child/children	
<input type="checkbox"/> Lives with parents, grandparents, other family, no children		<input type="checkbox"/> Lives with relatives & children	
<input type="checkbox"/> Lives with in-laws &/or their family, no children		<input type="checkbox"/> Lives with in-laws &/or their family, plus child/children	
<input type="checkbox"/> Lives with non-related women/men (roommates), no children		<input type="checkbox"/> Lives with non-related roommates & children	
<input type="checkbox"/> Some other situation: _____			
84. During this 6-month period, was any housing PCAP contracted housing?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>
85. Has client moved in past 6 months? Code # of moves. (00=no moves; 66=too many moves to count)		__ __	<input type="checkbox"/>

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)	<input type="checkbox"/>
b. How many of client's biological children do NOT live with client?	<input type="checkbox"/>

Comments on BIOLOGICAL CHILDREN:

Client #: _____

Date: ___ / ___ / _____

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)			
a. Employment (hers) (01)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Odd jobs she does (02)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Parent/grandparent (03)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Other relative (04)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Husband/boyfriend (05)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Friends/acquaintances (06)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Welfare (07)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. SSI/Disability (08)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Other government check (GAU, etc.) (09), specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Tribal funds (10)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Other (11), specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Drug sales/prostitution (12)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Fraud/check-kiting (13)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Other illicit (14), specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
88. What is her main source of income at end of 6-month period? (Enter 2 digit number from above)		__ __	<input type="checkbox"/>

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:

Client #: _____

Date: ___ / ___ / _____

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? <i>If No, skip to Question 93.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Class: _____			
b. Code # weeks attended (00=none)	_____	weeks	<input type="checkbox"/>
c. Course completed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
94. Client has a chronic medical condition? <i>(incl. chronic STD, Hepatitis)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Describe/Specify: _____			
95. Client has visited the Emergency Room (E.R.) for medical care for herself or a child? <i>Inappropriate use of the service. If No, skip to Question 95.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Code # of times	_____	times	<input type="checkbox"/>
96. Client has visited the Emergency Room (E.R.) for medical care for herself or a child? <i>Appropriate use of the service. If No, skip to Question 96.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Code # of times	_____	times	<input type="checkbox"/>
97. To help her maintain a clean and sober lifestyle, does client have in her life:	No	Yes	
a. A supportive partner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. A supportive person (other than partner or advocate)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. A support system (social, church, 12-step sponsor)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify support system: _____			
98. During the past 6 months, has client been in what you would consider an abusive relationship with her partner(s)? <i>(If no partner, code No)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Describe: _____			
99. Has client assaulted anyone in past 6 months? <i>If No, skip to Question 100.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. If so, who: <input type="checkbox"/> Child <input type="checkbox"/> Partner <input type="checkbox"/> Other: _____			<input type="checkbox"/>
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? <i>If No, skip to Question 101.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Charges: _____			
b. Number of times arrested _____ times			<input type="checkbox"/>
c. Charge(s) are: <input type="checkbox"/> New charge <input type="checkbox"/> Old warrant <input type="checkbox"/> Both			<input type="checkbox"/>
101. Was client jailed in past 6 months? <i>If No, skip to Question 102.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Number of times jailed _____ times			<input type="checkbox"/>
b. For what? _____			
c. Facility: _____			
102. Was client in Home Detention at any time during past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
103. Was client in Prison at any time during past 6 months? <i>If No, skip to Question 104.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Facility: _____			
b. # of months (of 6): _____ mos			<input type="checkbox"/>
104. Was client on Probation at any time during past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
105. Did advocate play a role in type of sentence imposed in past 6 months? <i>If No, skip to Question 106.</i>			
a. If yes, how so? _____			

Comments on ARRESTS/JAIL:

EDUCATION/TRAINING

In past 6 months, has client attended and/or completed:

	No 0	Attended 1	Completed 2	Don't Know -7
106 GED classes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Where: _____				
107. Community college	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Where: _____				
108. Four-year college	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Where: _____				
109. Vocational training class	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. What/where: _____				
110. Training through work/employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. What/where: _____				
111. Other course/class	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Specify: _____				

Comments on EDUCATION/TRAINING:

Client #: _____

Date: ___ / ___ / _____

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 #: _____