

**ATTACHMENT D: INSTRUMENTS FOR PROJECT STAFF**

D-1 Children's Discharge Tool

D-2 Women's Discharge Tool

D-3 Staff Completed Women's Items

D-4 Staff Completed Child Items

## **Attachment D-1**

### **Children's Discharge Tool**

FEBRUARY 23, 2010 FORMAT

Readmit |  |  
Initial |  |  |

Form Approved  
OMB No. xxxx-xxxx  
Expiration Date xx-xx-xxxx

MOTHER'S ID#  CHILD'S ID#

MOTHER'S GGRA INTAKE DATE          2 0

CHILD'S DISCHARGE DATE:    |    |    |    |    |    |    |    |    |    |    |

EVALUATION PHASE: Discharge ✓ PERSON COMPLETING \_\_\_\_\_ | GRANT# **T1** |

## CHILDREN'S DISCHARGE TOOL

At the time a child is discharged from treatment, this is to be completed by project staff based on review of each child's treatment records.

## 1. Length of stay

## 2. Treatment completion

### 3. Goals of Treatment Plan

Less than 30 days .....

30 days .....

31 – 45 days .....

46 – 60 days .....

61 – 90 days .....

91 – 120 days .....

121 – 180 days .....

181 – 270 days .....

More than 270 days .....

Yes   
No

None achieved .....   
 $\frac{1}{4}$  achieved .....   
 $\frac{1}{2}$  achieved .....   
 $\frac{3}{4}$  achieved .....   
All achieved .....

**4. Has this child resided in this residential treatment facility with the mother?**

Yes.....  
 No ..

**4a. IF NOT, On average, how often has this child visited the mother while she was staying in this residential treatment facility?**

More than once a week.....  
 Weekly ..  
 2-3 times per month.....  
 Monthly ..  
 Less than monthly.....  
 Never ..  
 N/A – child ..

**5. When the child leaves treatment, who will he/she be living with? (Select all that apply.)**

Mother.....  
 Father ..  
 Grandparent.....  
 Other relative ..  
 Friend.....  
 Foster care.....  
 Institution ..  
 Other (specify) \_\_\_\_\_

**6. Why is this child being discharged at this time? (Select all that apply.)**

Mother being discharged from residential facility ..  
 Mother being discharged from treatment altogether.....  
 Child's treatment complete.....  
 Child's administrative discharge ..  
 Child going to live elsewhere ..  
 Mother's request ..  
 Mother's parental rights terminated.....  
 Other (specify) \_\_\_\_\_

<b>SERVICES RECEIVED COLUMN 'A' RESPONSES</b>	<b>NUMBER OF SESSIONS COLUMN 'B' RESPONSES</b>	<b>WHERE AND BY WHOM COLUMN 'C' RESPONSES</b>
1 = Yes	0 = No sessions	1 = On-site by PPW project staff
0 = No	1 = Once	2 = On-site by another agency
-1 = N/A	2 = Every few months	3 = Off-site by PPW project staff
-8 = Don't know	3 = Monthly	4 = Off-site by another agency
	4 = 2-3 x/month	5 = On-site by PPW parent organization staff
	5 = Weekly	6 = Off-site by PPW parent organization staff
	6 = 2-6 x/week	7 = Both on-site and off-site
	7 = Daily	-1 = N/A
	-1 = N/A	

Choose the response category that most closely describes the services received by this child. Record the corresponding value in the box for each column: **A – Services Received**, **B – Number of Sessions**, and **C – Where and by Whom**.

If a child is given a N/A for receiving a service in Column A, then it is anticipated that the child will also receive N/A or None in Columns B-C.

### **SERVICE/TREATMENT ACTIVITY**

	<b>A Services Received</b>	<b>B Sessions</b>	<b>C Where and by Whom</b>
1. Developmental Assessment (based on standardized form/process).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Physical Exam by Healthcare Providers (including height, weight, vital signs, BMI, body systems: respiratory, cardiac, gastrointestinal, genitor-urinary, skin, neurological).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Laboratory Testing (urinalysis, complete blood count, electrolytes, HIV/AIDS & STDs).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Immunization Updates .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Vision Screening (used standard eye charts) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Speech and Hearing Assessment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Dental Assessment (done by dentist) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Nutritional Assessment (done by registered dietitian).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Medical Diagnosing and Follow-up Treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Mental Status Exam for Children .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Recreational Activity (field trips, movies, team sports, cultural experiences, picnics) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Spiritual Activity (meditational activities, attendance at services, watching video tapes, listening to tapes, etc.) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Individual Nurturing (0 to 5 yrs) (this includes being held, rocked, infant massage/stimulation, reading to them, singing to/with them, listening to them and dialoguing with them).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## SERVICE/TREATMENT ACTIVITY (Continued)

		<b>A Services Received</b>	<b>B Sessions</b>	<b>C Where and by Whom</b>
14.	Individual Counseling Related to Effects of Substance Abuse (5 to 17 yrs) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.	Substance Abuse Prevention Education/Classes .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16.	Play Therapy .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17.	Art Therapy .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18.	Group Counseling for Children of Substance Abusers .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19.	Attend AlaTot .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20.	Attend AlaTeen .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21.	Mother-Child Parenting/Bonding Classes .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22.	Father-Child Parenting/Bonding Classes .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23.	Mother/Father/Child Counseling/Classes .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24.	Trauma-related Counseling .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25.	Individual Psychiatric Therapy (based on psychiatric diagnosis) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26.	Group Psychiatric Therapy (based on psychiatric diagnosis) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27.	Special/Remedial Education (for learning disabled) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28.	Evidence of Aftercare Plan .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29.	Established Socio-economic Support at State and Federal Level (if eligible) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30.	Physical Therapy .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31.	Speech Therapy .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32.	Occupational Therapy .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**Attachment D-2****Women's Discharge Tool**

## FEBRUARY 23, 2010 FORMAT

Readmit     
Initial

Form Approved  
OMB No. xxxx-xxxx  
Expiration Date xx-xx-xxxx

MOTHER'S GPRA INTAKE DATE          **20**

WOMAN'S DISCHARGE DATE:       2 0

EVALUATION PHASE: DISCHARGE

PERSON COMPLETING | \_\_\_\_\_ |

GRANT# **TI**

## **WOMEN'S DISCHARGE TOOL**

At the time a woman is discharged from treatment, this is to be completed by project staff based on review of each woman's treatment records.

## 1. Length of stay

## 2. Treatment completion

### 3. Goals of Treatment Plan

Less than 30 days .....

30 days .....

31 – 45 days .....

46 – 60 days .....

61 – 90 days .....

91 – 120 days .....

121 – 180 days .....

181 – 270 days .....

More than 270 days .....

Yes .....

None achieved .....   
 $\frac{1}{4}$  achieved .....   
 $\frac{1}{2}$  achieved .....   
 $\frac{3}{4}$  achieved .....   
All achieved .....

4. At intake, was this woman pregnant, postpartum (less than 12 months since her last delivery), or both?

Pregnant.....

Postpartum.....

Both Pregnant and Postpartum.....

Neither Pregnant nor Postpartum.....

Public reporting burden for this collection of information is estimated to average 35 minutes per response; 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 to SAMHSA Reports Clearance Officer, Room 7-1044, 1 Choke Cherry Road, Rockville, MD 20857. 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 control number for this project is 0930-0269

<b>SERVICES RECEIVED COLUMN 'A' RESPONSES</b>	<b>NUMBER OF SESSIONS COLUMN 'B' RESPONSES</b>	<b>WHERE AND BY WHOM COLUMN 'C' RESPONSE</b>
1 = Yes	0 = No sessions	1 = On-site by PPW project staff
0 = No	1 = Once	2 = On-site by another agency
-1 = N/A	2 = Every few months	3 = Off-site by PPW project staff
-8 = Don't know	3 = Monthly	4 = Off-site by another agency
	4 = 2-3 x/month	5 = On-site by PPW parent organization staff
	5 = Weekly	6 = Off-site by PPW parent organization staff
	6 = 2-6 x/week	7 = Both on-site and off-site
	7 = Daily	-1 = N/A
	-1 = N/A	

In the following section, choose the response category that most closely describes the services received by this woman. Record the corresponding value in the box for each column: **A – Services Received**, **B – Number of Sessions**, and **C – Where and by Whom**.

If a woman is given a N/A for receiving a service in Column A, then it is anticipated that the woman will also receive N/A or NONE in Columns B-C.

### **SERVICE/TREATMENT ACTIVITY**

	<b>A Services Received</b>	<b>B Sessions</b>	<b>C Where and by Whom</b>
1. Outreach, Screening, and Assessment .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Detoxification.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Case Management Services .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Substance Abuse Education and Treatment .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Physical Exam by Healthcare Providers (including height, weight, vital signs, BMI, body systems: respiratory, cardiac, gastrointestinal, genitor-urinary, skin, neurological) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Laboratory Testing (urinalysis, complete blood count, electrolytes, HIV/AIDS and STDs).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Education, Screening, Counseling, and Treatment of Hepatitis, HIV/AIDS, other STDs .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Vision Screening (used standard eye charts).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Speech and Hearing Assessment .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Dental Assessment (done by dentist).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Nutritional Assessment (done by registered dietitian) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Medical Diagnosing and Follow-up Treatment .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Prenatal Health Care .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Postpartum Health Care .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Mental Health Assessment .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## **SERVICE/TREATMENT ACTIVITY (continued)**

	<b>A Services Received</b>	<b>B Sessions</b>	<b>C Where and by Whom</b>
16. Mental Health Treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Trauma-informed services, including assessment and interventions for:			
a. Emotional abuse.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Sexual abuse .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Physical abuse .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Recreational Activity (field trips, movies, team sports, cultural experiences, picnics).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Spiritual Activity (meditational activities, attendance at services, watching video tapes, listening to tapes, etc.) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Employment Readiness, Training.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Employment Placement.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Permanent Housing Arrangements .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Childcare .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Transportation .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Mother-Child Parenting/Bonding Classes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Mother/Child Counseling/Classes .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Individual Psychiatric Therapy (based on psychiatric diagnosis).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Group Psychiatric Therapy (based on psychiatric diagnosis).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Individual Substance Abuse Counseling .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Group Substance Abuse Counseling.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Family Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Educational Services (for GED and other educational needs).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Discharge Planning (including community reintegration).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Planned or Arranged Post Residential Treatment Continuing Care .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Established Socio-economic Support at State and Federal Level (if eligible).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## **Attachment D-3**

### **Staff Completed Women's Items**

READMIT |\_\_|  
INITIALS |\_\_|\_\_|

DATE: |\_\_|\_\_| |\_\_|\_\_| |**2|0|**|\_\_|\_\_| START TIME: |\_\_|\_\_| : |\_\_|\_\_| a.m. |\_\_| p.m. |\_\_| END TIME: |\_\_|\_\_| : |\_\_|\_\_| a.m. |\_\_| p.m. |\_\_|

MOTHER'S ID# |\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_| MOTHER'S GPRA INTAKE DATE |\_\_|\_\_| |\_\_|\_\_| |**2|0|**|\_\_|\_\_|

EVALUATION PHASE: Intake  PERSON COMPLETING |\_\_\_\_\_| GRANT# **TI** |\_\_|\_\_|\_\_|\_\_|\_\_|

## **INTAKE: STAFF COMPLETED WOMEN'S ITEMS**

This is to be completed by project staff at intake.

1. Is this woman pregnant, postpartum (less than 12 months since her last delivery), or both?

Pregnant |\_\_|

Both Pregnant and Postpartum |\_\_|

Postpartum |\_\_|

Neither Pregnant nor Postpartum |\_\_|

2. If PREGNANT, at what trimester of pregnancy is this woman?

First (week 1 to week 12) |\_\_|

Don't know |\_\_|

Second (week 13 to week 26) |\_\_|

N/A |\_\_|

Third (week 27 to delivery) |\_\_|

3. If PREGNANT, has this woman experienced any problems during pregnancy? Select all that apply.

Gestational diabetes |\_\_|

Other (specify) \_\_\_\_\_ |\_\_|

Preeclampsia or pregnancy induced hypertension |\_\_|

None |\_\_|

Sexually Transmitted Diseases (STDs) |\_\_|

Don't know |\_\_|

Placental problems (previa, abruption, etc.) |\_\_|

N/A |\_\_|

4. If POSTPARTUM, pregnancy outcome:

Live birth |\_\_|

Other (specify) \_\_\_\_\_ |\_\_|

Still birth |\_\_|

Don't know |\_\_|

Miscarriage |\_\_|

N/A |\_\_|

Pregnancy terminated |\_\_|

READMIT   
INITIALS

DATE:    **20** START TIME:  :  a.m.  p.m.  END TIME:  :  a.m.  p.m.

MOTHER'S ID#  MOTHER'S GPRA INTAKE DATE   **20**

EVALUATION PHASE: 6-mos post-Intake  PERSON COMPLETING  GRANT# **TI**

## 6 MONTHS POST-INTAKE: STAFF COMPLETED WOMEN'S ITEMS

This is to be completed by project staff at 6 months post-Intake.

1. Is this woman pregnant, postpartum (less than 12 months since her last delivery), or both?

Pregnant

Both Pregnant and Postpartum

Postpartum

Neither Pregnant nor Postpartum

2. If PREGNANT, at what trimester of pregnancy is this woman?

First (week 1 to week 12)

Don't know

Second (week 13 to week 26)

N/A

Third (week 27 to delivery)

3. If PREGNANT, has this woman experienced any problems during pregnancy? Select all that apply.

Gestational diabetes

Other (specify)

Preeclampsia or pregnancy induced hypertension

None

Sexually Transmitted Diseases (STDs)

Don't know

Placental problems (previa, abruption, etc.)

N/A

4. If POSTPARTUM, pregnancy outcome:

Live birth

Other (specify)

Still birth

Don't know

Miscarriage

N/A

Pregnancy terminated

READMIT   
INITIALS

DATE:   **20**  START TIME:  :  a.m.  END TIME:  :  a.m.   
p.m.

MOTHER'S ID#  MOTHER'S GPRA INTAKE DATE   **20**

WOMAN'S DISCHARGE DATE:   **20**

EVALUATION PHASE: Discharge  PERSON COMPLETING  GRANT# **TI**

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## DISCHARGE: STAFF COMPLETED WOMEN'S ITEMS

---

This is to be completed by project staff at discharge.

1. Is this woman pregnant, postpartum (less than 12 months since her last delivery), or both?

Pregnant

Neither Pregnant nor Postpartum

Postpartum

Both Pregnant and Postpartum

2. If PREGNANT, at what trimester of pregnancy is this woman?

First (week 1 to week 12)

Don't know

Second (week 13 to week 26)

N/A

Third (week 27 to delivery)

3. If PREGNANT, has this woman experienced any problems during pregnancy? Select all that apply.

Gestational diabetes

Other (specify)

Preeclampsia or pregnancy induced hypertension

None

Sexually Transmitted Diseases (STDs)

Don't know

Placental problems (previa, abruption, etc.)

N/A

4. If POSTPARTUM, pregnancy outcome:

Live birth

Other (specify)

Still birth

Don't know

Miscarriage

N/A

Pregnancy terminated

READMIT   
INITIALS

DATE:   **20**  START TIME:  :  a.m.   p.m.  END TIME:  :  a.m.   p.m.

MOTHER'S ID#  MOTHER'S GPRA INTAKE DATE   **20**

WOMAN'S DISCHARGE DATE:   **20**

EVALUATION PHASE: 6 months post-Discharge  PERSON COMPLETING  GRANT# TI

## **6 MONTHS POST-DISCHARGE: STAFF COMPLETED WOMEN'S ITEMS**

This is to be completed by project staff at 6 months post-Discharge.

1. If no followup was obtained, select reason why.

Refusal

Readmitted to program with new admission replacing prior admission

Unable to locate

Other: \_\_\_\_\_

Incarcerated and unable to gain access

N/A

Deceased

2. Is this woman pregnant, postpartum (less than 12 months since her last delivery), or both?

Pregnant

Neither Pregnant nor Postpartum

Postpartum

No followup obtained

Both Pregnant and Postpartum

3. If PREGNANT, at what trimester of pregnancy is this woman?

First (week 1 to week 12)

Don't know

Second (week 13 to week 26)

N/A

Third (week 27 to delivery)

No followup obtained

4. If PREGNANT, has this woman experienced any problems during pregnancy? Select all that apply.

Gestational diabetes

None

Preeclampsia or pregnancy induced hypertension

Don't know

Sexually Transmitted Diseases (STDs)

N/A

Placental problems (previa, abruption, etc.)

No followup obtained

Other (specify) \_\_\_\_\_

## 5. If POSTPARTUM, pregnancy outcome:

Live birth Other (specify) \_\_\_\_\_ Still birth Don't know Miscarriage N/A Pregnancy terminated No followup obtained

**Attachment D-4****Staff Completed Child Items**

READMIT   
INITIALS

DATE:   **20**  START TIME:  :  a.m.   p.m.  END TIME:  :  a.m.   p.m.

MOTHER'S ID#  CHILD'S ID#

MOTHER'S GPRA INTAKE DATE   **20**

EVALUATION PHASE: Intake  PERSON COMPLETING  GRANT# **TI**

---

## INTAKE: STAFF COMPLETED CHILD ITEMS

---

This tool is to be completed by program staff for each minor child (under 18) of a mother receiving treatment services who is receiving (or the mother anticipates will receive) services. This tool should be completed with the use of treatment records, maternal interviews, and observations.

1. Child Age

years  months

2. Was this child born premature (less than 37 weeks gestation)?

Yes  No

3. Where was the child's primary residence during the past six months?

Biological Mom & Dad

Family Friends

Biological Mom

Foster

Biological Dad

Adoptive

Grandparent(s)

Other (specify)

Biological Relatives

4. Will this child reside in this residential treatment facility with the mother?

Yes  No  Don't know

READMIT   
INITIALS

DATE:   **20**  START TIME:  :  a.m.   p.m.  END TIME:  :  a.m.   p.m.

MOTHER'S ID#  CHILD'S ID#

MOTHER'S GPRA INTAKE DATE   **20**

EVALUATION PHASE: 3 mos post-Intake  PERSON COMPLETING  GRANT# **TI**

## 3 MONTHS POST-INTAKE: STAFF COMPLETED CHILD ITEMS

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This tool is to be completed by program staff for each child of a mother receiving treatment services who is receiving (or the mother anticipates will receive) services. This tool should be completed with the use of treatment records, maternal interviews, and observations.

1. Child Age

years  months

2. Where was the child's primary residence during the past six months?

Biological Mom & Dad

Family Friends

Biological Mom

Foster

Biological Dad

Adoptive

Grandparent(s)

Other (specify)

Biological Relatives

3. Has this child resided in this residential treatment facility with the mother?

Yes  No  Don't know

4. If NO, on average, how often has this child visited the mother while she was staying in this residential treatment facility?

More than once a week

Weekly

2 – 3 times per month

Monthly

Less than monthly

Never

N/A

READMIT   
INITIALS

DATE:   **20**  START TIME:  :  a.m.   p.m.  END TIME:  :  a.m.   p.m.

MOTHER'S ID#  CHILD'S ID#

MOTHER'S GPRA INTAKE DATE   **20**

EVALUATION PHASE: 6 mos post-Intake  PERSON COMPLETING  | GRANT# **TI**

## 6 MONTHS POST-INTAKE: STAFF COMPLETED CHILD ITEMS

---

This tool is to be completed by program staff for each child of a mother receiving treatment services who is receiving (or the mother anticipates will receive) services. This tool should be completed with the use of treatment records, maternal interviews, and observations.

1. Child Age

years  months

2. Where was the child's primary residence during the past six months?

Biological Mom & Dad

Family Friends

Biological Mom

Foster

Biological Dad

Adoptive

Grandparent(s)

Other (specify)

Biological Relatives

3. Has this child resided in this residential treatment facility with the mother?

Yes  No  Don't know

4. If NO, on average, how often has this child visited the mother while she was staying in this residential treatment facility?

More than once a week

Weekly

2 – 3 times per month

Monthly

Less than monthly

Never

N/A

READMIT   
INITIALS

DATE:   **20**  START TIME:  :  a.m.  END TIME:  :  a.m.   
p.m.

MOTHER'S ID#  CHILD'S ID#

MOTHER'S GPRA INTAKE DATE   **20**

EVALUATION PHASE: Discharge  PERSON COMPLETING  GRANT# **TI**

---

## DISCHARGE: STAFF COMPLETED CHILD ITEMS

---

This tool is to be completed by program staff for each child of a mother receiving treatment services who is receiving (or the mother anticipates will receive) services. This tool should be completed with the use of treatment records, maternal interviews, and observations.

1. Child Age

years  months

2. Where was the child's primary residence during the past six months?

Biological Mom & Dad

Family Friends

Biological Mom

Foster

Biological Dad

Adoptive

Grandparent(s)

Other (specify)

Biological Relatives

3. Did this child reside in this residential treatment facility with the mother?

Yes  No  Don't know

4. If NO, on average, how often did this child visit the mother while she was staying in this residential treatment facility?

More than once a week

Weekly

2 – 3 times per month

Monthly

Less than monthly

Never

N/A

READMIT |\_\_|  
INITIALS |\_\_|\_\_|

DATE: |\_\_|\_\_| |\_\_|\_\_| |**2|0|**|\_\_|\_\_| START TIME: |\_\_|\_\_| : |\_\_|\_\_| a.m. |\_\_|  
p.m. |\_\_| END TIME: |\_\_|\_\_| : |\_\_|\_\_| a.m. |\_\_|  
p.m. |\_\_|

MOTHER'S ID# |\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_| CHILD'S ID# |\_\_|\_\_|

MOTHER'S GPRA INTAKE DATE |\_\_|\_\_| |\_\_|\_\_| |**2|0|**|\_\_|\_\_|

EVALUATION PHASE: 6 mos post-Discharge || PERSON COMPLETING |\_\_\_\_\_| GRANT# **TI** |\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|

## 6 MONTHS POST-DISCHARGE: STAFF COMPLETED CHILD ITEMS

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This tool is to be completed by program staff for each child of a mother receiving treatment services who is receiving (or the mother anticipates will receive) services. This tool should be completed with the use of treatment records, maternal interviews, and observations.

1. If no followup interview was obtained, select all reasons that apply.

Unable to locate |\_\_|

Parental rights terminated |\_\_|

Mother refused |\_\_|

Child did not receive services |\_\_|

Caregiver refused |\_\_|

Deceased |\_\_|

Child living with someone other than the mother |\_\_|

Other: \_\_\_\_\_ |\_\_|

Mother lacks legal custody (include if custody is  
temporarily on hold) |\_\_|

N/A |\_\_|

2. Child Age

|\_\_|\_\_| years |\_\_|\_\_| months

No followup obtained |\_\_|

3. Where was the child's primary residence during the past six months?

Biological Mom & Dad |\_\_|

Family Friends |\_\_|

Biological Mom |\_\_|

Foster |\_\_|

Biological Dad |\_\_|

Adoptive |\_\_|

Grandparent(s) |\_\_|

Other (specify) \_\_\_\_\_ |\_\_|

Biological Relatives |\_\_|

No followup obtained |\_\_|