ATTACHMENT D: INSTRUMENTS FOR PROJECT STAFF

Attachment D-1

Children's Discharge Tool

FEBRUARY 23, 2010 FORMAT

Readmit |__|
Initial |__|__|

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

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|__|__|

CHILD'S DISCHARGE DATE: |__|__| |__|__| |2|0|__|__|

EVALUATION PHASE: Discharge |✓| PERSON COMPLETING |_____| GRANT# **TI** |__|__|__|__|__|__|

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

- 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 ..... ☐

2. Treatment completion

- Yes ☐
- No ☐

3. Goals of Treatment Plan

- None achieved ..... ☐
- ¼ achieved ..... ☐
- ½ achieved ..... ☐
- ¾ 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) _____ ☐

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

		A Services Received	*B Sessions*	*C Where and by Whom*
1.	Developmental Assessment (based on standardized form/process).....	|___|	|___|	|___|
2.	Physical Exam by Healthcare Providers (including height, weight, vital signs, BMI, body systems: respiratory, cardiac, gastrointestinal, genitor-urinary, skin, neurological).....	|___|	|___|	|___|
3.	Laboratory Testing (urinalysis, complete blood count, electrolytes, HIV/AIDS & STDs).....	|___|	|___|	|___|
4.	Immunization Updates.....	|___|	|___|	|___|
5.	Vision Screening (used standard eye charts).....	|___|	|___|	|___|
6.	Speech and Hearing Assessment.....	|___|	|___|	|___|
7.	Dental Assessment (done by dentist).....	|___|	|___|	|___|
8.	Nutritional Assessment (done by registered dietitian).....	|___|	|___|	|___|
9	Medical Diagnosing and Follow-up Treatment.....	|___|	|___|	|___|
10.	Mental Status Exam for Children.....	|___|	|___|	|___|
11.	Recreational Activity (field trips, movies, team sports, cultural experiences, picnics).....	|___|	|___|	|___|
12.	Spiritual Activity (meditational activities, attendance at services, watching video tapes, listening to tapes, etc.).....	|___|	|___|	|___|
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).....	|___|	|___|	|___|

SERVICE/TREATMENT ACTIVITY (*Continued*)

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

Attachment D-2

Women's Discharge Tool

FEBRUARY 23, 2010 FORMAT

Readmit |__|
Initial |__|__|

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

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|__|__|

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

- 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 ☐

2. Treatment completion

- Yes ☐
- No ☐

3. Goals of Treatment Plan

- None achieved ☐
- ¼ achieved ☐
- ½ achieved ☐
- ¾ 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 ☐

SERVICES RECEIVED COLUMN 'A' RESPONSES	NUMBER OF SESSIONS COLUMN 'B' RESPONSES	WHERE AND BY WHOM COLUMN 'C' RESPONSE
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

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

SERVICE/TREATMENT ACTIVITY (*continued*)

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

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 |__|
   Postpartum |__|
   Both Pregnant and Postpartum |__|
   Neither Pregnant nor Postpartum |__|

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

   First (week 1 to week 12) |__|
   Second (week 13 to week 26) |__|
   Third (week 27 to delivery) |__|
   Don't know |__|
   N/A |__|

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

   Gestational diabetes |__|
   Preeclampsia or pregnancy induced hypertension |__|
   Sexually Transmitted Diseases (STDs) |__|
   Placental problems (previa, abruption, etc.) |__|
   Other (specify) _____ |__|
   None|__|
   Don't know |__|
   N/A |__|

4. If POSTPARTUM, pregnancy outcome:

   Live birth|__|
   Still birth |__|
   Miscarriage |__|
   Pregnancy terminated |__|
   Other (specify) _____ |__|
   Don't know |__|
   N/A |__|

READMIT |__|
INITIALS |__|__|

DATE: |__|__| |__|__| |__|__|__|__| START TIME: |__|__| : |__|__| a.m. |__| p.m. |__| END TIME: |__|__| : |__|__| a.m. |__| p.m. |__|

MOTHER'S ID# |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__| MOTHER'S GPRA INTAKE DATE |__|__| |__|__| |2|0|__|__|

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 |__|
   Postpartum |__|
   Both Pregnant and Postpartum |__|
   Neither Pregnant nor Postpartum |__|

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

   First (week 1 to week 12) |__|
   Second (week 13 to week 26) |__|
   Third (week 27 to delivery) |__|
   Don't know |__|
   N/A |__|

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

   Gestational diabetes |__|
   Preeclampsia or pregnancy induced hypertension |__|
   Sexually Transmitted Diseases (STDs) |__|
   Placental problems (previa, abruption, etc.) |__|
   Other (specify) _____ |__|
   None|__|
   Don't know |__|
   N/A |__|

4. If POSTPARTUM, pregnancy outcome:

   Live birth |__|
   Still birth |__|
   Miscarriage |__|
   Pregnancy terminated |__|
   Other (specify) _____ |__|
   Don't know |__|
   N/A |__|

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|__|__|

WOMAN'S DISCHARGE DATE: |__|__| |__|__| |2|0|__|__|

EVALUATION PHASE: Discharge |_✓_| PERSON COMPLETING |_____| GRANT# **TI** |__|__|__|__|__|__|__|

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 |__|
   Postpartum |__|
   Both Pregnant and Postpartum |__|
   Neither Pregnant nor Postpartum |__|

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

   First (week 1 to week 12) |__|
   Second (week 13 to week 26) |__|
   Third (week 27 to delivery) |__|
   Don't know |__|
   N/A |__|

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

   Gestational diabetes |__|
   Preeclampsia or pregnancy induced hypertension |__|
   Sexually Transmitted Diseases (STDs) |__|
   Placental problems (previa, abruption, etc.) |__|
   Other (specify) _____ |__|
   None|__|
   Don't know |__|
   N/A |__|

4. If POSTPARTUM, pregnancy outcome:

   Live birth|__|
   Still birth |__|
   Miscarriage |__|
   Pregnancy terminated |__|
   Other (specify) _____ |__|
   Don't know |__|
   N/A |__|

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|__|__|

WOMAN'S DISCHARGE DATE: |__|__| |__|__| |2|0|__|__|

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 |__|
   Unable to locate |__|
   Incarcerated and unable to gain access |__|
   Deceased |__|
   Readmitted to program with new admission replacing prior admission |__|
   Other: _____ |__|
   N/A |__|

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

   Pregnant |__|
   Postpartum |__|
   Both Pregnant and Postpartum |__|
   Neither Pregnant nor Postpartum |__|
   No followup obtained |__|

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

   First (week 1 to week 12) |__|
   Second (week 13 to week 26) |__|
   Third (week 27 to delivery) |__|
   Don't know |__|
   N/A |__|
   No followup obtained |__|

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

   Gestational diabetes |__|
   Preeclampsia or pregnancy induced hypertension |__|
   Sexually Transmitted Diseases (STDs) |__|
   Placental problems (previa, abruption, etc.) |__|
   Other (specify)_____|__|
   None|__|
   Don't know |__|
   N/A |__|
   No followup obtained |__|

5. If POSTPARTUM, pregnancy outcome:

Live birth |__|

Still birth |__|

Miscarriage |__|

Pregnancy terminated |__|

Other (specify)_____|__|

Don't know |__|

N/A |__|

No followup obtained |__|

Attachment D-4

Staff Completed Child Items

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: 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 |__|
   Biological Mom |__|
   Biological Dad |__|
   Grandparent(s) |__|
   Biological Relatives |__|
   Family Friends |__|
   Foster |__|
   Adoptive |__|
   Other (specify) _____ |__|

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

   Yes |__| No |__| Don't know |__|

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: 3 mos post-Intake |✓| PERSON COMPLETING |_____| GRANT# **TI** |__|__|__|__|__|__|

3 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 |__|
   Biological Mom |__|
   Biological Dad |__|
   Grandparent(s) |__|
   Biological Relatives |__|
   Family Friends |__|
   Foster |__|
   Adoptive |__|
   Other (specify) _____ |__|

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: |__|__| |__|__| |**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-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 |__|
   Biological Mom |__|
   Biological Dad |__|
   Grandparent(s) |__|
   Biological Relatives |__|
   Family Friends |__|
   Foster |__|
   Adoptive |__|
   Other (specify) _____ |__|

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: |__|__| |__|__| |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: 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 |__|
   Biological Mom |__|
   Biological Dad |__|
   Grandparent(s) |__|
   Biological Relatives |__|
   Family Friends |__|
   Foster |__|
   Adoptive |__|
   Other (specify) _____ |__|

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

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 |__|
   Mother refused |__|
   Caregiver refused |__|
   Child living with someone other than the mother |__|
   Mother lacks legal custody (include if custody is temporarily on hold) |__|
   Parental rights terminated |__|
   Child did not receive services |__|
   Deceased |__|
   Other: _____ |__|
   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 |__|
   Biological Mom |__|
   Biological Dad |__|
   Grandparent(s) |__|
   Biological Relatives |__|
   Family Friends |__|
   Foster |__|
   Adoptive |__|
   Other (specify) _____ |__|
   No followup obtained |__|