

**Transformation Accountability (TRAC)**  
Center for Mental Health Services

**NOMs Client-Level Measures for Discretionary  
Programs Providing Direct Services**

**SERVICES TOOL**  
**Child/Adolescent *or* Caregiver**  
**Combined Respondent Version**



March 2011  
*Version 7*

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Public reporting burden for this collection of information is estimated to average 30 minutes per response if all items are asked of a consumer/participant; to the extent that providers already obtain much of this information as part of their ongoing consumer/participant intake or follow-up, less time will be required. Send comments regarding this burden estimate or any other aspect of this collection of information to SAMHSA Reports Clearance Officer, Room 7-1045, 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 0930-0285.

**RECORD MANAGEMENT**

Consumer ID

Grant ID (Grant/Contract/Cooperative Agreement)

Site ID

**1. Assessment**

- Baseline Assessment
- 6-Month Reassessment
- 12-Month Reassessment
- 18-Month Reassessment
- 24-Month Reassessment
- 30-Month Reassessment
- 36-Month Reassessment
- 42-Month Reassessment
- 48-Month Reassessment
- 54-Month Reassessment
- 60-Month Reassessment
- 66-Month Reassessment
- Clinical Discharge

**2. Interview Conducted?**

- Yes *[GO TO 3]*
- No

**2a. Why was the interview not conducted? Choose only one.**

***[PLEASE MARK YOUR ANSWER UNDER THE COLUMN RELATING TO THE ASSESSMENT TYPE]***

	Baseline Assessment	Reassessments	Clinical Discharge
Consumer refused interview	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not able to obtain consent from proxy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Consumer was impaired/unable to provide consent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Consumer cannot be reached for interview		<input type="radio"/>	<input type="radio"/>
Staff previously indicated “Administrative data only” or “No data” would be submitted		<input type="radio"/> <b><i>[IF THIS ANSWER IS SELECTED, GO TO SECTION I]</i></b>	<input type="radio"/> <b><i>[IF THIS ANSWER IS SELECTED, GO TO SECTION J]</i></b>

***[IF THIS IS A CLINICAL DISCHARGE, GO TO 2c]***

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**RECORD MANAGEMENT (Continued)**

**2b. What data will be submitted for the next reassessment?**

- Interview data
- Administrative data only - [Record Management, Sections I or J &K] – will not attempt any subsequent interviews
- No data - will only provide discharge status [Record Management & Section J] when discharged

***[GO TO 3]***

**2c. *[CLINICAL DISCHARGE ONLY]* What data will be submitted for this Clinical Discharge?**

- Administrative data only - [Record Management and Sections J &K]
- No data – will only provide discharge status [Record Management & Section J]

**3. When was the interview conducted or attempted?**

***[REASSESSMENTS AND CLINICAL DISCHARGE: IF ANSWERED “CONSUMER CANNOT BE REACHED FOR INTERVIEW” IN 2a, GO TO INSTRUCTIONS BELOW 5]***

\_\_\_\_|\_\_\_\_| / \_\_\_\_|\_\_\_\_| / \_\_\_\_|\_\_\_\_|\_\_\_\_|  
MONTH            DAY            YEAR

*[IF THIS IS A BASELINE GO TO 4, ALL OTHERS GO TO 5]*

**4. When did the consumer first receive services under the grant for this episode of care?**

\_\_\_\_|\_\_\_\_| / \_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|  
MONTH            YEAR

**5. Was the respondent the child or the caregiver?**

- Child    *[PREFER CHILD AGE 11 AND OLDER]*
- Caregiver

*[IF THIS IS A BASELINE, GO TO SECTION A.]*

*[FOR ALL REASSESSMENTS:*

*IF AN INTERVIEW WAS CONDUCTED, GO TO SECTION B.]*

*IF AN INTERVIEW WAS NOT CONDUCTED, GO TO SECTION I.]*

*[FOR A CLINICAL DISCHARGE:*

*IF AN INTERVIEW WAS CONDUCTED, GO TO SECTION B.]*

*IF AN INTERVIEW WAS NOT CONDUCTED, GO TO SECTION J.]*

**A. DEMOGRAPHIC DATA**

*[SECTION A IS ONLY COLLECTED AT BASELINE. IF THIS IS NOT A BASELINE, GO TO SECTION B.]*

**1. What is your [child's] gender?**

- MALE
- FEMALE
- TRANSGENDER
- OTHER (SPECIFY) \_\_\_\_\_
- REFUSED

**2. Are you [Is your child] Hispanic or Latino?**

- YES
- NO *[GO TO 3]*
- REFUSED *[GO TO 3]*

*[IF YES] What ethnic group do you consider yourself [your child]? Please answer yes or no for each of the following. You may say yes to more than one.*

	YES	NO	REFUSED
Central American	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cuban	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dominican	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mexican	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Puerto Rican	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
South American	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
OTHER	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> <i>[IF YES, SPECIFY BELOW]</i>
(SPECIFY) _____			

**3. What race do you consider yourself [your child]? Please answer yes or no for each of the following. You may say yes to more than one.**

	YES	NO	REFUSED
Black or African American	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asian	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Native Hawaiian or other Pacific Islander	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alaska Native	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
White	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
American Indian	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**4. What is your [your child's] month and year of birth?**

\_\_\_\_|\_\_\_\_| / \_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|  
MONTH                      YEAR                       REFUSED

***[STOP HERE IF BASELINE INTERVIEW WAS NOT CONDUCTED AND DEMOGRAPHIC DATA WAS ABSTRACTED FROM RECORDS. ALL OTHERS CONTINUE.]***

**B. FUNCTIONING**

1. How would you rate your [your child's] overall health right now?

- Excellent
- Very Good
- Good
- Fair
- Poor
- REFUSED
- DON'T KNOW

2. In order to provide the best possible mental health and related services, we need to know what you think about how well you were [your child was] able to deal with everyday life during the past 30 days. Please indicate your disagreement/agreement with each of the following statements.

*[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER (CAREGIVER).]*

STATEMENT	RESPONSE OPTIONS						
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	REFUSED	NOT APPLICABLE
a. I am [my child is] handling daily life.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
b. I get [my child gets] along with family members.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. I get [my child gets] along with friends and other people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
d. I am [my child is] doing well in school and/or work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. I am [my child is] able to cope when things go wrong.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
f. I am satisfied with our family life right now.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

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**B. FUNCTIONING (Continued)**

*[IF THE CAREGIVER IS THE RESPONDENT GO TO THE OPTIONAL GAF QUESTION.]*

3. The following questions ask about how you have been feeling during the past 30 days. For each question, please indicate how often you had this feeling.

*[READ EACH QUESTION FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]*

QUESTION	RESPONSE OPTIONS						
<b>During the past 30 days, about how often did you feel ...</b>	<b>All of the Time</b>	<b>Most of the Time</b>	<b>Some of the Time</b>	<b>A Little of the Time</b>	<b>None of the Time</b>	<b>REFUSED</b>	<b>DON'T KNOW</b>
<b>a. nervous?</b>	○	○	○	○	○	○	○
<b>b. hopeless?</b>	○	○	○	○	○	○	○
<b>c. restless or fidgety?</b>	○	○	○	○	○	○	○
<b>d. so depressed that nothing could cheer you up?</b>	○	○	○	○	○	○	○
<b>e. that everything was an effort?</b>	○	○	○	○	○	○	○
<b>f. worthless?</b>	○	○	○	○	○	○	○

**B. FUNCTIONING (Continued)**

*[IF THE CAREGIVER IS THE RESPONDENT GO TO THE OPTIONAL GAF QUESTION.]*

4. The following questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we'll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed.

*[READ EACH QUESTION FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]*

QUESTION	RESPONSE OPTIONS					
	Never	Once or Twice	Weekly	Daily or Almost Daily	REFUSED	DON'T KNOW
<b>In the past 30 days, how often have you used...</b>						
<b>a. tobacco products (cigarettes, chewing tobacco, cigars, etc.)?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>b. alcoholic beverages (beer, wine, liquor, etc.)?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>b1. [IF B &gt;= ONCE OR TWICE, AND RESPONDENT MALE], How many times in the past 30 days have you had five or more drinks in a day? [CLARIFY IF NEEDED: (A standard alcoholic beverage (e.g., 12 oz beer, 5 oz wine, 1.5 oz liquor)].</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>b2. [IF B &gt;= ONCE OR TWICE, AND RESPONDENT NOT MALE], How many times in the past 30 days have you had four or more drinks in a day? [CLARIFY IF NEEDED: (A standard alcoholic beverage (e.g., 12 oz beer, 5 oz wine, 1.5 oz liquor)].</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>c. cannabis (marijuana, pot, grass, hash, etc.)?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>d. cocaine (coke, crack, etc.)?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>e. prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>f. methamphetamine (speed, crystal meth, ice, etc.)?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>g. inhalants (nitrous oxide, glue, gas, paint thinner, etc.)?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>h. sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>i. hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>j. street opioids (heroin, opium, etc.)?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>k. prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>l. other – specify:</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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**B. FUNCTIONING (Continued)**

*[OPTIONAL: GAF SCORE REPORTED BY GRANTEE STAFF AT PROJECT'S DISCRETION.]*

DATE GAF WAS ADMINISTERED:           |\_|\_|\_|/|\_|\_|\_|/|\_|\_|\_|\_|\_|\_|  
  MONTH        DAY                    YEAR

WHAT WAS THE CONSUMER'S SCORE?    GAF = |\_|\_|\_|\_|\_|

*[OPTIONAL: CBCL TOTAL PROBLEMS T-SCORE REPORTED BY GRANTEE STAFF AT PROJECT'S DISCRETION.]*

DATE CBCL WAS ADMINISTERED:       |\_|\_|\_|/|\_|\_|\_|/|\_|\_|\_|\_|\_|\_|  
  MONTH        DAY                    YEAR

WHAT WAS THE CONSUMER'S SCORE?    TOTAL PROBLEMS T-SCORE =    |\_|\_|\_|\_|\_|



**C. STABILITY IN HOUSING**

1. In the past 30 days how many ...	Number of Nights/ Times	REFUSED	DON'T KNOW
a. nights have you [has your child] been homeless?	_ _ _	<input type="radio"/>	<input type="radio"/>
b. nights have you [has your child] spent in a hospital for mental health care?	_ _ _	<input type="radio"/>	<input type="radio"/>
c. nights have you [has your child] spent in a facility for detox/inpatient or residential substance abuse treatment?	_ _ _	<input type="radio"/>	<input type="radio"/>
d. nights have you [has your child] spent in correctional facility including juvenile detention, jail, or prison?	_ _ _	<input type="radio"/>	<input type="radio"/>

***[ADD UP THE TOTAL NUMBER OF NIGHTS SPENT HOMELESS, IN HOSPITAL FOR MENTAL HEALTH CARE, IN DETOX/INPATIENT OR RESIDENTIAL SUBSTANCE ABUSE TREATMENT, OR IN A CORRECTIONAL FACILITY. (ITEMS A-D, CANNOT EXCEED 30 NIGHTS)]***

|\_|\_|\_|

e. times have you [has your child] gone to an emergency room for a psychiatric or emotional problem?	_ _ _	<input type="radio"/>	<input type="radio"/>
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*[IF 1A, 1B, 1C, OR 1D IS 16 OR MORE NIGHTS, GO TO SECTION D.]*

**2. In the past 30 days, where have you [has your child] been living most of the time?**

*[DO NOT READ RESPONSE OPTIONS TO CONSUMER (CAREGIVER). SELECT ONLY ONE.]*

- CAREGIVER'S OWNED OR RENTED HOUSE, APARTMENT, TRAILER, OR ROOM
- INDEPENDENT OWNED OR RENTED HOUSE, APARTMENT, TRAILER OR ROOM
- SOMEONE ELSE'S HOUSE, APARTMENT, TRAILER, OR ROOM
- HOMELESS (SHELTER, STREET/OUTDOORS, PARK)
- GROUP HOME
- FOSTER CARE (SPECIALIZED THERAPEUTIC TREATMENT)
- TRANSITIONAL LIVING FACILITY
- HOSPITAL (MEDICAL)
- HOSPITAL (PSYCHIATRIC)
- DETOX/INPATIENT OR RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
- CORRECTIONAL FACILITY (JUVENILE DETENTION CENTER/JAIL/PRISON)
- OTHER HOUSED (SPECIFY) \_\_\_\_\_
- REFUSED
- DON'T KNOW

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**D. EDUCATION**

**1. During the past 30 days of school, how many days were you [was your child] absent for any reason?**

- 0 DAYS
- 1 DAYS
- 2 DAYS
- 3 TO 5 DAYS
- 6 TO 10 DAYS
- MORE THAN 10 DAYS
- REFUSED
- DON'T KNOW
- NOT APPLICABLE

**a. [IF ABSENT], how many days were unexcused absences?**

- 0 DAYS
- 1 DAYS
- 2 DAYS
- 3 TO 5 DAYS
- 6 TO 10 DAYS
- MORE THAN 10 DAYS
- REFUSED
- DON'T KNOW
- NOT APPLICABLE

**2. What is the highest level of education you have (your child has) finished, whether or not you (he/she has) received a degree?**

- NEVER ATTENDED
- PRESCHOOL
- KINDERGARTEN
- 1<sup>ST</sup> GRADE
- 2<sup>ND</sup> GRADE
- 3<sup>RD</sup> GRADE
- 4<sup>TH</sup> GRADE
- 5<sup>TH</sup> GRADE
- 6<sup>TH</sup> GRADE
- 7<sup>TH</sup> GRADE
- 8<sup>TH</sup> GRADE
- 9<sup>TH</sup> GRADE
- 10<sup>TH</sup> GRADE
- 11<sup>TH</sup> GRADE
- 12<sup>TH</sup> GRADE/HIGH SCHOOL DIPLOMA/EQUIVALENT (GED)
- VOC/TECH DIPLOMA
- SOME COLLEGE OR UNIVERSITY
- REFUSED
- DON'T KNOW

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**E. CRIME AND CRIMINAL JUSTICE STATUS**

**1. In the past 30 days, how many times have you [has your child] been arrested?**

|\_|\_|\_| TIMES      ○ REFUSED      ○ DON'T KNOW

*[IF THIS IS A BASELINE, GO TO SECTION G. OTHERWISE, GO TO SECTION F.]*

**F. PERCEPTION OF CARE**

*[SECTION F IS NOT COLLECTED AT BASELINE. FOR BASELINE INTERVIEWS, GO TO SECTION G.]*

1. In order to provide the best possible mental health and related services, we need to know what you think about the services you [your child] received during the past 30 days, the people who provided it, and the results. Please indicate your disagreement/agreement with each of the following statements.

*[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER (CAREGIVER).]*

STATEMENT	RESPONSE OPTIONS					
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	REFUSED
a. Staff here treated me with respect.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Staff respected my family's religious/spiritual beliefs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Staff spoke with me in a way that I understood.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Staff was sensitive to my cultural/ethnic background.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. I helped choose my [my child's] services.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. I helped to choose my [my child's] treatment goals.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. I participated in my [my child's] treatment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Overall, I am satisfied with the services I [my child] received.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. The people helping me [my child] stuck with me [us] no matter what.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. I felt I had [my child had] someone to talk to when I [he/she] was troubled.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. The services I [my child and/or family] received were right for me [us].	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. I [my family] got the help I [we] wanted [for my child].	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. I [my family] got as much help as I [we] needed [for my child].	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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**F. PERCEPTION OF CARE (Continued)**

**2.** *[INDICATE WHO ADMINISTERED SECTION F - PERCEPTION OF CARE TO THE CONSUMER (CAREGIVER) FOR THIS INTERVIEW.]*

- ADMINISTRATIVE STAFF
- CARE COORDINATOR
- CASE MANAGER
- CLINICIAN PROVIDING DIRECT SERVICES
- CLINICIAN NOT PROVIDING SERVICES
- CONSUMER PEER
- DATA COLLECTOR
- EVALUATOR
- FAMILY ADVOCATE
- RESEARCH ASSISTANT STAFF
- SELF-ADMINISTERED
- OTHER (SPECIFY) \_\_\_\_\_

**G. SOCIAL CONNECTEDNESS**

**1. Please indicate your disagreement/agreement with each of the following statements. Please answer for relationships with persons other than your [your child’s] mental health provider(s) over the past 30 days.**

*[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER (CAREGIVER).]*

STATEMENT	RESPONSE OPTIONS					
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	REFUSED
a. I know people who will listen and understand me when I need to talk.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. I have people that I am comfortable talking with about my [my child’s] problems.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. In a crisis, I would have the support I need from family or friends.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. I have people with whom I can do enjoyable things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*[IF THIS IS A BASELINE, STOP NOW. THE INTERVIEW IS COMPLETE.]*

*[IF THIS IS A REASSESSMENT INTERVIEW, GO TO SECTION I.]*

*[IF THIS IS A CLINICAL DISCHARGE INTERVIEW, GO TO SECTION J.]*

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**H. PROGRAM SPECIFIC QUESTIONS**

***SOME PROGRAMS HAVE PROGRAM SPECIFIC DATA THAT IS SUBMITTED TO TRAC. CMHS WILL LET YOU KNOW IF YOU ARE REQUIRED TO DO SECTION H, AND YOU WILL HAVE A SEPARATE SECTION H FORM.***

***NO CHILD PROGRAMS ARE REQUIRED TO COLLECT DATA FOR SECTION H AT THIS TIME.***

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**I. REASSESSMENT STATUS**

*[SECTION I IS REPORTED BY GRANTEE STAFF AT REASSESSMENT.]*

**1. Have you or other grant staff had contact with the consumer within 90 days of last encounter?**

- Yes
- No

**2. Is the consumer still receiving services from your project?**

- Yes
- No

***GO TO SECTION K.***



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**J. CLINICAL DISCHARGE STATUS**

*[SECTION J IS REPORTED BY GRANTEE STAFF ABOUT THE CONSUMER AT CLINICAL DISCHARGE]*

**1. On what date was the consumer discharged?**

\_\_\_\_|\_\_\_\_| / \_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|  
MONTH YEAR

**2. What is the consumer's discharge status?**

- Mutually agreed cessation of treatment
- Withdrew from/refused treatment
- No contact within 90 days of last encounter
- Clinically referred out
- Death
- Other (Specify) \_\_\_\_\_

*IF A DISCHARGE INTERVIEW WAS CONDUCTED, CONTINUE TO SECTION K.*

*IF A DISCHARGE INTERVIEW WAS NOT CONDUCTED AND:*

- *IF STAFF PREVIOUSLY INDICATED "ADMINISTRATIVE DATA ONLY" WOULD BE SUBMITTED, CONTINUE TO SECTION K.*
- *IF STAFF PREVIOUSLY INDICATED "NO DATA" WOULD BE SUBMITTED, STOP HERE.*

**K. SERVICES RECEIVED**

***[SECTION K IS REPORTED BY GRANTEE STAFF AT REASSESSMENT AND DISCHARGE UNLESS STAFF PREVIOUSLY INDICATED "NO DATA" WOULD BE SUBMITTED]***

**1. On what date did the consumer last receive services?**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
MONTH YEAR

***[IDENTIFY ALL OF THE SERVICES YOUR PROJECT PROVIDED TO THE CONSUMER SINCE HIS/HER LAST NOMS INTERVIEW; THIS INCLUDES CMHS-FUNDED AND NON-FUNDED SERVICES.]***

Core Services	<u>Provided</u>	
	Yes	No
1. Screening	<input type="radio"/>	<input type="radio"/>
2. Assessment	<input type="radio"/>	<input type="radio"/>
3. Treatment Planning or Review	<input type="radio"/>	<input type="radio"/>
4. Psychopharmacological Services	<input type="radio"/>	<input type="radio"/>
5. Mental Health Services	<input type="radio"/>	<input type="radio"/>

***[IF YES, PLEASE ESTIMATE HOW FREQUENTLY MENTAL HEALTH SERVICES WERE DELIVERED.]***

Number of times \_\_\_\_\_ per  
 Day  
 Week  
 Month  
 Year

	Yes	No
6. Co-Occurring Services	<input type="radio"/>	<input type="radio"/>
7. Case Management	<input type="radio"/>	<input type="radio"/>
8. Trauma-specific Services	<input type="radio"/>	<input type="radio"/>

9. Was the consumer referred to another provider for any of the above core services?

Yes  No

Support Services	<u>Provided</u>	
	Yes	No
1. Medical Care	<input type="radio"/>	<input type="radio"/>
2. Employment Services	<input type="radio"/>	<input type="radio"/>
3. Family Services	<input type="radio"/>	<input type="radio"/>
4. Child Care	<input type="radio"/>	<input type="radio"/>
5. Transportation	<input type="radio"/>	<input type="radio"/>
6. Education Services	<input type="radio"/>	<input type="radio"/>
7. Housing Support	<input type="radio"/>	<input type="radio"/>
8. Social Recreational Activities	<input type="radio"/>	<input type="radio"/>
9. Consumer Operated Services	<input type="radio"/>	<input type="radio"/>
10. HIV Testing	<input type="radio"/>	<input type="radio"/>

11. Was the consumer referred to another provider for any of the above support services?

Yes  No