OMB No. 0930-0285

Expiration Date 11/30/2013

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**

***CMHS***

Center for Mental Health Services

SAMHSA

March 2013

 *Version 10*

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**RECORD MANAGEMENT**

***[RECORD MANAGEMENT IS REPORTED BY GRANTEE STAFF AT BASELINE, REASSESSMENT AND DISCHARGE REGARDLESS OF WHETHER AN INTERVIEW IS CONDUCTED.]***

**Consumer ID** |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|

**Grant ID (Grant/Contract/Cooperative Agreement)** |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|

**Site ID** |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|

1. **Indicate Assessment Type:**

|  |  |  |
| --- | --- | --- |
| Baseline | Reassessment    | Clinical Discharge  |
| ***[ENTER THE MONTH AND YEAR WHEN THE CONSUMER FIRST RECEIVED SERVICES UNDER THE GRANT FOR THIS EPISODE OF CARE.]*** | **Which 6-month reassessment?** |\_\_\_\_|\_\_\_\_|   |  |
| |\_\_\_\_|\_\_\_\_| /  |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_| MONTH                YEAR | ***[ENTER 06 FOR A 6-MONTH, 12 FOR A 12-MONTH, 18 FOR AN 18-MONTH ASSESSMENT, ETC.]*** |  |

1. **Was the interview conducted?**

|  |  |
| --- | --- |
|  Yes **When?** |\_\_\_\_|\_\_\_\_| / |\_\_\_\_|\_\_\_\_| / |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|  MONTH DAY YEAR  |  No **Why not? Choose only one.**Not able to obtain consent from proxy  Consumer was impaired or unable to provide consent  Consumer refused this interview only  Consumer was not reached for interview  Consumer refused all interviews***[GO TO THE INSTRUCTIONS BELOW QUESTION 3.]*** |

**3. 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.]***

1. **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 |  |  |  |
| Cuban |  |  |  |
| Dominican |  |  |  |
| Mexican |  |  |  |
| Puerto Rican |  |  |  |
| South American |  |  |  |
| OTHER |  |  |  ***[IF YES, SPECIFY BELOW.]*** |
| (SPECIFY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. **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** |
| Alaska Native |  |  |  |
| American Indian |  |  |  |
| Asian |  |  |  |
| Black or Afican American |  |  |  |
| Native Hawaiian or Other Pacific Islander |  |  |  |
| White |  |  |  |

1. **What is your [your child’s] month and year of birth?**

|\_\_\_\_|\_\_\_\_| / |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|

 MONTH YEAR  REFUSED

***[STOP HERE IF THE BASELINE INTERVIEW WAS NOT CONDUCTED. ALL OTHERS CONTINUE TO SECTION B.]***

**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.** |  |  |  |  |  |  |  |
| **b. I get [my child gets] along with family members.** |  |  |  |  |  |  |  |
| **c. I get [my child gets] along with friends and other people.** |  |  |  |  |  |  |  |
| **d. I am [my child is] doing well in school and/or work.** |  |  |  |  |  |  |  |
| **e. I am [my child is] able to cope when things go wrong.** |  |  |  |  |  |  |  |
| **f. I am satisfied with our family life right now.** |  |  |  |  |  |  |  |

**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 |
| **During the past 30 days, about how often did you feel …** | **All of the Time** | **Most****of the Time** |  **Some of the Time** | **A Little of the Time** | **None of the Time** | **REFUSED** | **DON’T KNOW** |
| **a. nervous?** |  |  |  |  |  |  |  |
| **b. hopeless?** |  |  |  |  |  |  |  |
| **c. restless or fidgety?** |  |  |  |  |  |  |  |
| **d. so depressed that nothing could cheer you up?** |  |  |  |  |  |  |  |
| **e. that everything was an effort?** |  |  |  |  |  |  |  |
| **f. worthless?** |  |  |  |  |  |  |  |

**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 |
| **In the past 30 days, how often have you used…** | **Never** | **Once or****Twice** | **Weekly** | **Daily or****Almost****Daily** | **REFUSED** | **DON’T****KNOW** |
| **a. tobacco products (cigarettes, chewing tobacco, cigars, etc.)?** |  |  |  |  |  |  |
| **b. alcoholic beverages (beer, wine, liquor, etc.)?** |  |  |  |  |  |  |
| **b1. *[IF b >= 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)*]*.** |  |  |  |  |  |  |
| **b2. *[IF b >= 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)*]*.** |  |  |  |  |  |  |
| **c. cannabis (marijuana, pot, grass, hash, etc.)?** |  |  |  |  |  |  |
| **d. cocaine (coke, crack, etc.)?** |  |  |  |  |  |  |
| **e. prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)?** |  |  |  |  |  |  |
| **f. methamphetamine (speed, crystal meth, ice, etc.)?** |  |  |  |  |  |  |
| **g. inhalants (nitrous oxide, glue, gas, paint thinner, etc.)?** |  |  |  |  |  |  |
| **h. sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)?** |  |  |  |  |  |  |
| **i. hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)?** |  |  |  |  |  |  |
| **j. street opioids (heroin, opium, etc.)?** |  |  |  |  |  |  |
| **k. prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)?** |  |  |  |  |  |  |
| **l. other – specify:** |  |  |  |  |  |  |

**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 = |\_\_\_\_|\_\_\_\_|\_\_\_\_|

**B. MILITARY FAMILY AND DEPLOYMENT**

***[QUESTION 5 IS NOT APPLICABLE TO CHILD PROGRAMS.]***

***[QUESTION 6 IS ONLY ASKED AT BASELINE. IF THIS IS NOT A BASELINE, SKIP TO SECTION C.]***

1. **Is anyone in your [your child’s] family or someone close to you [your child] currently serving on active duty in or retired/separated from the Armed Forces, the Reserves, or the National Guard?**
* Yes, only one person
* Yes, more than one person
* No
* REFUSED

**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?** | |\_\_\_\_|\_\_\_\_| |  |  |
| **b. nights have you [has your child] spent in a hospital for mental health care?** | |\_\_\_\_|\_\_\_\_| |  |  |
| **c. nights have you [has your child] spent in a facility for detox/inpatient or residential substance abuse treatment?** | |\_\_\_\_|\_\_\_\_| |  |  |
| **d. nights have you [has your child] spent in correctional facility including juvenile detention, jail, or prison?** | |\_\_\_\_|\_\_\_\_| |  |  |
| ***[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?** | |\_\_\_\_|\_\_\_\_| |  |  |

***[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

**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 DAY
* 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 DAY
* 2 DAYS
* 3 TO 5 DAYS
* 6 TO 10 DAYS
* MORE THAN 10 DAYS
* REFUSED
* DON’T KNOW
* NOT APPLICABLE
1. **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
* 1ST GRADE
* 2ND GRADE
* 3RD GRADE
* 4TH GRADE
* 5TH GRADE
* 6TH GRADE
* 7TH GRADE
* 8TH GRADE
* 9TH GRADE
* 10TH GRADE
* 11TH GRADE
* 12TH GRADE/HIGH SCHOOL DIPLOMA/EQUIVALENT (GED)
* VOC/TECH DIPLOMA
* SOME COLLEGE OR UNIVERSITY
* REFUSED
* DON’T KNOW

**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.** |  |  |  |  |  |  |
| **b. Staff respected my family’s religious/spiritual beliefs.** |  |  |  |  |  |  |
| **c. Staff spoke with me in a way that I understood.** |  |  |  |  |  |  |
| **d. Staff was sensitive to my cultural/ethnic background.** |  |  |  |  |  |  |
| **e. I helped choose my [my child’s] services.** |  |  |  |  |  |  |
| **f. I helped to choose my [my child’s] treatment goals.** |  |  |  |  |  |  |
| **g. I participated in my [my child’s] treatment.** |  |  |  |  |  |  |
| **h. Overall, I am satisfied with the services I [my child] received.** |  |  |  |  |  |  |
| **i. The people helping me [my child] stuck with me [us] no matter what.** |  |  |  |  |  |  |
| **j. I felt I had [my child had] someone to talk to when I [he/she] was troubled.** |  |  |  |  |  |  |
| **k. The services I [my child and/or family] received were right for me [us].** |  |  |  |  |  |  |
| **l. I [my family] got the help I [we] wanted [for my child].** |  |  |  |  |  |  |
| **m. I [my family] got as much help as I [we] needed [for my child].** |  |  |  |  |  |  |

**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.** |  |  |  |  |  |  |
| **b. I have people that I am comfortable talking with about my [my child’s] problems.** |  |  |  |  |  |  |
| **c. In a crisis, I would have the support I need from family or friends.** |  |  |  |  |  |  |
| **d. I have people with whom I can do enjoyable things.** |  |  |  |  |  |  |

***[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.]***

**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.***

**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.]***

**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) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***[Go to section K.]***

**K. SERVICES RECEIVED**

***[SECTION K IS REPORTED BY GRANTEE STAFF AT REASSESSMENT and DISCHARGE UNLESS the CONSUMER REFUSED THIS INTERVIEW OR ALL INTERVIEWS, IN WHICH CASE IT IS OPTIONAL.]***

**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** | **Provided** | **UNKNOWN** | **SERVICE NOT AVAILABLE** |
| **Yes** | **No** |
| 1. Screening |  |  |  |  |
| 2. Assessment |  |  |  |  |
| 3. Treatment Planning or Review |  |  |  |  |
| 4. Psychopharmacological Services |  |  |  |  |
| 5. Mental Health Services |  |  |  |  |

 ***[IF the answer TO 5 ‘MENTAL HEALTH SERVICES’ IS YES, PLEASE ESTIMATE HOW FREQUENTLY MENTAL HEALTH SERVICES WERE DELIVERED.]***

 **Number of times \_\_\_\_\_\_ per**  Day **UNKNOWN**

  Week 

  Month

  Year

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **UNKNOWN** | **SERVICE NOT AVAILABLE** |
| 6. Co-Occurring Services |  |  |  |  |
| 7. Case Management |  |  |  |  |
| 8. Trauma-specific Services |  |  |  |  |
| 9. Was the Consumer referred to another provider for any of the above core services? |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Support Services** | **Provided** | **UNKNOWN** | **SERVICE NOT AVAILABLE** |
| **Yes** | **No** |
| 1. Medical Care |  |  |  |  |
| 2. Employment Services |  |  |  |  |
| 3. Family Services |  |  |  |  |
| 4. Child Care |  |  |  |  |
| 5. Transportation |  |  |  |  |
| 6. Education Services |  |  |  |  |
| 7. Housing Support |  |  |  |  |
| 8. Social Recreational Activities |  |  |  |  |
| 9. Consumer Operated Services |  |  |  |  |
| 10. HIV Testing |  |  |  |  |
| 11. Was the Consumer referred to another provider for any of the above support services? |  |  |  |  |