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*

**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 <u>THIS</u> EPISODE OF CARE.]***<br><br>\|____\|____\| / \|____\|____\|____\|____\|<br>MONTH YEAR | **Which 6-month reassessment?**<br><br>\|____\|____\|<br><br>***[ENTER 06 FOR A 6-MONTH, 12 FOR A 12-MONTH, 18 FOR AN 18-MONTH ASSESSMENT, ETC.]*** | |

**2. Was the interview conducted?**

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

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

- o 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 | ☐ | ☐ | ☐ | |
| Cuban | ☐ | ☐ | ☐ | |
| Dominican | ☐ | ☐ | ☐ | |
| Mexican | ☐ | ☐ | ☐ | |
| Puerto Rican | ☐ | ☐ | ☐ | |
| South American | ☐ | ☐ | ☐ | |
| OTHER (SPECIFY) _____ | ☐ | ☐ | ☐ | *[IF YES, SPECIFY BELOW.]* |

**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 |
|---|---|---|---|
| Alaska Native | ☐ | ☐ | ☐ |
| American Indian | ☐ | ☐ | ☐ |
| Asian | ☐ | ☐ | ☐ |
| Black or Afican American | ☐ | ☐ | ☐ |
| Native Hawaiian or Other Pacific Islander | ☐ | ☐ | ☐ |
| White | ☐ | ☐ | ☐ |

**4. 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 <u>during the past 30 days</u>. 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.** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |

**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** | **Some of the Time** | **A Little of the** | **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?** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**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** | **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.]*

**6. 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

**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
- ○ 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 <u>SINCE HIS/HER LAST NOMS INTERVIEW</u>; THIS INCLUDES CMHS-FUNDED AND NON-FUNDED SERVICES.]***

| **Core Services** | **Provided** | | | |
|---|---|---|---|---|
| | **Yes** | **No** | **UNKNOWN** | **SERVICE NOT AVAILABLE** |
| 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
- ☐ Week
- ☐ Month
- ☐ Year

**UNKNOWN** ☐

| | **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** | | | |
|---|---|---|---|---|
| | **Yes** | **No** | **UNKNOWN** | **SERVICE NOT AVAILABLE** |
| 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? | ☐ | ☐ | ☐ | |