

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

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 2-1057, 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.

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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cuban	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dominican	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mexican	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Puerto Rican	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
South American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTHER (SPECIFY) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> [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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
American Indian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Black or African American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Native Hawaiian or Other Pacific Islander	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
White	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.]

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

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. restless or fidgety?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. so depressed that nothing could cheer you up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. that everything was an effort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. worthless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	REFUSED	DON'T KNOW
In the past 30 days, how often have you used...						
a. tobacco products (cigarettes, chewing tobacco, cigars, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. alcoholic beverages (beer, wine, liquor, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)].	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)].	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. cannabis (marijuana, pot, grass, hash, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. cocaine (coke, crack, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. methamphetamine (speed, crystal meth, ice, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. inhalants (nitrous oxide, glue, gas, paint thinner, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

j. street opioids (heroin, opium, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. other – specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

[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?	_ _ _	<input type="checkbox"/>	<input type="checkbox"/>
b. nights have you [has your child] spent in a hospital for mental health care?	_ _ _	<input type="checkbox"/>	<input type="checkbox"/>
c. nights have you [has your child] spent in a facility for detox/inpatient or residential substance abuse treatment?	_ _ _	<input type="checkbox"/>	<input type="checkbox"/>
d. nights have you [has your child] spent in correctional facility including juvenile detention, jail, or prison?	_ _ _	<input type="checkbox"/>	<input type="checkbox"/>

[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="checkbox"/>	<input type="checkbox"/>
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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

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

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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I have people that I am comfortable talking with about my [my child’s] problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. In a crisis, I would have the support I need from family or friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I have people with whom I can do enjoyable things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

[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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Treatment Planning or Review	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Psychopharmacological Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Mental Health Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

[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

	Provided		UNKNOWN	SERVICE NOT AVAILABLE
	Yes	No		
6. Co-Occurring Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Case Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Trauma-specific Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Was the Consumer referred to another provider for any of the above core services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

