

## **Center for Mental Health Services**

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

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



*SPARS Version 3.0*

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Public reporting burden for this collection of information is estimated to average 40 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 15E57B, 5600 Fishers Lane, 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**

**[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:**

<input type="checkbox"/> Baseline  <b>[ENTER THE MONTH AND YEAR WHEN THE CONSUMER FIRST RECEIVED SERVICES UNDER THE GRANT FOR THIS EPISODE OF CARE.]</b>            /           /                     MONTH DAY YEAR	<input type="checkbox"/> Reassessment  <b>Which 6-month reassessment?</b>                      <b>[ENTER 06 FOR A 6-MONTH, 12 FOR A 12-MONTH, 18 FOR AN 18-MONTH ASSESSMENT, ETC.]</b>	<input type="checkbox"/> Clinical Discharge
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**2. Was the interview conducted?**

<input type="checkbox"/> Yes  <b>When?</b>            /           /                     MONTH DAY YEAR	<input type="checkbox"/> No  <b>Why not? Choose only one.</b>  <input type="checkbox"/> Not able to obtain consent from proxy <input type="checkbox"/> Consumer was impaired or unable to provide consent <input type="checkbox"/> Consumer refused this interview only <input type="checkbox"/> Consumer was not reached for interview <input type="checkbox"/> Consumer refused all interviews  <b>[GO TO THE INSTRUCTIONS BELOW QUESTION 4.]</b>
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**3. Was the respondent the child or the caregiver?**

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

**4. Behavioral Health Diagnoses**

Please indicate the consumer’s current behavioral health diagnoses using the International Classification of Diseases, 10<sup>th</sup> revision, Clinical Modification (ICD-10-CM) codes listed below. Please note that some substance use disorder ICD-10-CM codes have been crosswalked to Diagnostic and Statistical Manual of Mental Disorders, (DSM-5) descriptors.

Select up to three diagnoses. For each diagnosis selected, please indicate whether it is primary, secondary, or tertiary, if known. Only one diagnosis can be primary, only one can be secondary, and only one can be tertiary.

	Diagnosed?	For each diagnosis selected, please indicate whether diagnosis is primary, secondary or tertiary if known.		
	Select up to three.	Primary	Secondary	Tertiary
<b>SUBSTANCE USE DISORDER DIAGNOSES</b>				
<b>Alcohol Related Disorders</b>				
F10.10 – Alcohol use disorder, uncomplicated, mild	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F10.11 – Alcohol use disorder, mild, in remission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F10.20 – Alcohol use disorder, uncomplicated, moderate/severe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F10.21 – Alcohol use disorder, moderate/severe, in remission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F10.9 – Alcohol use, unspecified	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Opioid related disorders</b>				
F11.10 – Opioid use disorder, uncomplicated, mild	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F11.11 – Opioid use disorder, mild, in remission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F11.20 – Opioid use disorder, uncomplicated, moderate/severe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F11.21 – Opioid use disorder, moderate/severe, in remission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F11.9 – Opioid use, unspecified	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cannabis related disorders</b>				
F12.10 – Cannabis use disorder, uncomplicated, mild	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F12.11 – Cannabis use disorder, mild, in remission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F12.20 – Cannabis use disorder, uncomplicated, moderate/severe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F12.21 – Cannabis use disorder, moderate/severe, in remission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F12.9 – Cannabis use, unspecified	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Sedative, hypnotic, or anxiolytic related disorders</b>				
F13.10 – Sedative, hypnotic, or anxiolytic-related use disorder, uncomplicated, mild	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F13.11 – Sedative, hypnotic, or anxiolytic-related use disorder, mild, in remission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F13.20 – Sedative, hypnotic, or anxiolytic-related use disorder, uncomplicated, moderate/severe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F13.21 – Sedative, hypnotic, or anxiolytic-related use disorder, moderate/severe, in remission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F13.9 – Sedative, hypnotic, or anxiolytic-related use, unspecified	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cocaine related disorders</b>				
F14.10 – Cocaine use disorder, uncomplicated, mild	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F14.11 – Cocaine use disorder, mild, in remission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Diagnosed?	For each diagnosis selected, please indicate whether diagnosis is primary, secondary or tertiary if known.		
		Select up to three.	Primary	Secondary
F14.20 – Cocaine use disorder, uncomplicated, moderate/severe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F14.21 – Cocaine use disorder, moderate/severe, in remission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F14.9 – Cocaine use, unspecified	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other stimulant related disorders</b>				
F15.10 – Other stimulant use disorder, uncomplicated, mild	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F15.11 – Other stimulant use disorder, mild, in remission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F15.20 – Other stimulant use disorder, uncomplicated, moderate/severe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F15.21 – Other stimulant use disorder, moderate/severe, in remission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F15.9 – Other stimulant use, unspecified	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Hallucinogen related disorders</b>				
F16.10 – Hallucinogen use disorder, uncomplicated, mild	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F16.11 – Hallucinogen use disorder, mild, in remission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F16.20 – Hallucinogen use disorder, uncomplicated, moderate/severe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F16.21 – Hallucinogen use disorder moderate/severe, in remission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F16.9 – Hallucinogen use, unspecified	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Inhalant related disorders</b>				
F18.10 – Inhalant use disorder, uncomplicated, mild	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F18.11 – Inhalant use disorder, mild, in remission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F18.20 – Inhalant use disorder, uncomplicated, moderate/severe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F18.21 – Inhalant use disorder, moderate/severe, in remission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F18.9 – Inhalant use, unspecified	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other psychoactive substance related disorders</b>				
F19.10 – Other psychoactive substance use disorder, uncomplicated, mild	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F19.11 – Other psychoactive substance use disorder, in remission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F19.20 – Other psychoactive substance use disorder, uncomplicated, moderate/severe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F19.21 – Other psychoactive substance use disorder, moderate/severe, in remission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F19.9 – Other psychoactive substance use, unspecified	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Nicotine dependence</b>				

	Diagnosed?	For each diagnosis selected, please indicate whether diagnosis is primary, secondary or tertiary if known.		
	Select up to three.	Primary	Secondary	Tertiary
F17.20 – Tobacco use disorder, mild/moderate/severe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F17.21 – Tobacco use disorder, mild/moderate/severe, in remission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>MENTAL HEALTH DIAGNOSES</u></b>				
F20 – Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F21 – Schizotypal disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F22 – Delusional disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F23 – Brief psychotic disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F24 – Shared psychotic disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F25 – Schizoaffective disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F28 – Other psychotic disorder not due to a substance or known physiological condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F29 – Unspecified psychosis not due to a substance or known physiological condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F30 – Manic episode	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F31 – Bipolar disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F32 – Major depressive disorder, single episode	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F33 – Major depressive disorder, recurrent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F34 – Persistent mood [affective] disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F39 – Unspecified mood [affective] disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F40-F48 – Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F50 – Eating disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F51 – Sleep disorders not due to a substance or known physiological condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F60.2 – Antisocial personality disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F60.3 – Borderline personality disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F60.0, F60.1, F60.4-F69 – Other personality disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F70-F79 – Intellectual disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F80-F89 – Pervasive and specific developmental disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F90 – Attention-deficit hyperactivity disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F91 – Conduct disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F93 – Emotional disorders with onset specific to childhood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F94 – Disorders of social functioning with onset specific to childhood or adolescence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F95 – Tic disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F98 – Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F99 – Unspecified mental disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 
- DON'T KNOW
  - NONE OF THE ABOVE

***[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.**

	<b>YES</b>	<b>NO</b>	<b>REFUSED</b>
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"/> <b>[IF YES, SPECIFY BELOW.]</b>

**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.**

	<b>YES</b>	<b>NO</b>	<b>REFUSED</b>
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

**[IF AN INTERVIEW WAS CONDUCTED CONTINUE TO SECTION B.]**

**[IF AN INTERVIEW WAS NOT CONDUCTED:  
GO TO SECTION H (IF APPLICABLE).  
GRANTEES IN ALL OTHER PROGRAMS STOP HERE.]**

**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"/>	



**[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?	<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"/>

**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
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. <i>[IF B &gt;= ONCE OR TWICE, AND RESPONDENT MALE]</i> , How many times in the past 30 days have you had five or more drinks in a day? <i>[CLARIFY IF NEEDED: A standard alcoholic beverage (e.g., 12 oz beer, 5 oz wine, 1.5 oz liquor)].</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b2. <i>[IF B &gt;= ONCE OR TWICE, AND RESPONDENT NOT MALE]</i> , How many times in the past 30 days have you had four or more drinks in a day? <i>[CLARIFY IF NEEDED: A standard alcoholic beverage (e.g., 12 oz beer, 5 oz wine, 1.5 oz liquor)].</i>	<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 (e-cigarettes, etc.):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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**B: MILITARY FAMILY AND DEPLOYMENT**

**[QUESTIONS 5 AND 6 ARE ONLY ASKED AT BASELINE. IF THIS IS NOT A BASELINE, GO TO SECTION C.]**

**[IF THE CAREGIVER IS THE RESPONDENT, GO TO QUESTION 6.]**

**[IF THE CONSUMER IS YOUNGER THAN 18 YEARS OLD, GO TO QUESTION 6.]**

**5. Are you currently serving on active duty in the Armed Forces, the Reserves, or the National Guard?**

- YES
- NO
- REFUSED
- DON'T KNOW

**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
- DON'T KNOW

**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

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**D. EDUCATION**

**5. 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

**6. 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**

**5. 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.]*

5. 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"/>



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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="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 YOUR PROGRAM DOES NOT REQUIRE SECTION H:**

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

***IF THIS IS A REASSESSMENT INTERVIEW, PLEASE GO TO SECTION I THEN K.]***

***IF THIS IS A CLINICAL DISCHARGE INTERVIEW, PLEASE GO TO SECTION J THEN K.]***

**[IF YOUR PROGRAM DOES REQUIRE SECTION H:**

***IF THIS IS A BASELINE INTERVIEW, PLEASE PROCEED TO SECTION H THEN STOP. THE INTERVIEW WILL BE COMPLETE.]***

***IF THIS IS A REASSESSMENT INTERVIEW, PROCEED TO SECTION H, THEN I AND K.]***

***IF THIS IS A CLINICAL DISCHARGE INTERVIEW, PROCEED TO SECTION H, THEN J AND K.]***

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**H. PROGRAM SPECIFIC QUESTIONS**

***YOU ARE NOT RESPONSIBLE FOR COLLECTING DATA ON ALL SECTION H QUESTIONS. YOUR GPO HAS PROVIDED YOU GUIDANCE ON WHICH SPECIFIC SECTION H QUESTIONS YOU ARE TO COMPLETE. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT YOUR GPO.***

***FOR A LIST OF PROGRAMS THAT HAVE PROGRAM SPECIFIC DATA, SEE APPENDIX A OF THE NOMS CLIENT-LEVEL MEASURES FOR DISCRETIONARY PROGRAMS PROVIDING DIRECT SERVICES QUESTION-BY-QUESTION INSTRUCTION GUIDE FOR CHILD PROGRAMS.***

**H1. PROGRAM SPECIFIC QUESTIONS**

**[QUESTION 1 SHOULD BE ANSWERED BY THE CONSUMER/CAREGIVER AT BASELINE, REASSESSMENT, AND CLINICAL DISCHARGE.]**

1. In the past 30 days:	Number of Times	REFUSED	DON'T KNOW
a. How many times have you thought about killing yourself?	_ _ _	<input type="checkbox"/>	<input type="checkbox"/>
b. How many times did you attempt to kill yourself?	_ _ _	<input type="checkbox"/>	<input type="checkbox"/>

**[CAREGIVER RESPONSE:]**

1. In the past 30 days:	Yes	No	REFUSED	DON'T KNOW
a. Has your child expressed thoughts to you about killing him or herself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Did your child attempt to kill himself or herself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**[QUESTION 2 SHOULD BE REPORTED BY GRANTEE STAFF AT BASELINE, REASSESSMENT AND CLINICAL DISCHARGE.]**

- 2. Please indicate which type of funding source(s) was (were)/will be used to pay for the services provided to this consumer since their last interview. (Check all that apply):**
- Current SAMHSA grant funding
  - Other federal grant funding
  - State funding
  - Consumer's private insurance
  - Medicaid/Medicare
  - Other (Specify): \_\_\_\_\_

**H2. PROGRAM SPECIFIC QUESTIONS**

**[QUESTIONS 1, 2, AND 3 SHOULD BE ANSWERED BY THE CONSUMER/CAREGIVER AT BASELINE, REASSESSMENT, AND CLINICAL DISCHARGE.]**

**Please indicate your agreement with the following items:**

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

STATEMENT	RESPONSE OPTIONS						
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	REFUSED	DON'T KNOW
<b>1. As a result of treatment and services received, my [my child's] trauma and/or loss experiences were identified and addressed.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. As a result of treatment and services received for trauma and/or loss experiences, my [my child's] problem behaviors/symptoms have decreased.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. As a result of treatment and services received, I [my child has] have shown improvement in daily life, such as in school or interacting with family or friends.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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### H3. PROGRAM SPECIFIC QUESTIONS

*[PROGRAM-SPECIFIC HEALTH ITEMS ARE REPORTED BY GRANTEE STAFF ABOUT THE CONSUMER.]*

**1. Health measurements: (Report Quarterly)**

- |                             |                      |      |                      |
|-----------------------------|----------------------|------|----------------------|
| a. Systolic blood pressure  | <input type="text"/> | mmHg | <input type="text"/> |
| b. Diastolic blood pressure | <input type="text"/> | mmHg | <input type="text"/> |
| c. Weight                   | <input type="text"/> | kg   | <input type="text"/> |
| d. Height                   |                      | cm   | <input type="text"/> |
| e. Waist circumference      | <input type="text"/> | cm   | <input type="text"/> |

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**H4. PROGRAM SPECIFIC QUESTIONS**

***[QUESTION 1 SHOULD BE REPORTED BY GRANTEE STAFF AT REASSESSMENT AND CLINICAL DISCHARGE]***

**1. Has the consumer experienced a first episode of psychosis (FEP) since their last interview?**

- YES
- NO
- DON'T KNOW

**a. [IF YES] Please indicate the approximate date that the consumer initially experienced the FEP.**

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

**b. [IF YES] Was the consumer referred to FEP services?**

- YES
- NO
- DON'T KNOW

**[IF CONSUMER WAS REFERRED TO FEP SERVICES] Please indicate the date that the consumer first received FEP services/treatment.**

    |\_|\_|/|\_|\_|\_|\_|                    DON'T KNOW  
    MONTH  YEAR                            

***[IF THIS IS A BASELINE, STOP HERE.]***

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

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

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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) \_\_\_\_\_

***[GO TO SECTION K.]***

**K. SERVICES RECEIVED**

**[SECTION J 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	<u>Provided</u>		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                      UNKNOWN
   
 Week                      
  
 Month
   
 Year

Core Services (continued)	<u>Provided</u>		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	<u>Provided</u>		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"/>