CSAT GPRA Client Outcome Measures for Discretionary Programs

FINAL DRAFT

A. RECORD MANAGEMENT

Client ID |____|____|____|____|____|____|____|____|____|____|____|____|____|____|____|____|

Client Description by Grant Type:

- ○ Treatment grant client
- ○ Client in recovery grant

Contract/Grant ID |____|____|____|____|____|____|____|____|____|____|

Interview Type ***[CIRCLE ONLY ONE TYPE.]***

Intake ***[GO TO INTERVIEW DATE.]***

3-month follow-up → → → Did you conduct a follow-up interview? ○ Yes ○ No
[IF NO, GO DIRECTLY TO SECTION I.]

6-month follow-up → → → Did you conduct a follow-up interview? ○ Yes ○ No
[IF NO, GO DIRECTLY TO SECTION I.]

Discharge → → → Did you conduct a discharge interview? ○ Yes ○ No
[IF NO, GO DIRECTLY TO SECTION J.]

Interview Date |____|____| / |____|____| / |____|____|____|____|
Month Day Year

A. RECORD MANAGEMENT - DEMOGRAPHICS *[ASKED ONLY AT INTAKE/BASELINE.]*

1. What is your birth month and year?

|____|____| / |____|____|____|____|
Month Year

○ Refused

2. What do you consider yourself to be??

○ Male
○ Female
○ Transgender (Male to Female)
○ Transgender (Female to Male)
○ Gender non-conforming
○ Other (Specify)_____
○ Refused

3. Are you Hispanic, Latino/a, or Spanish origin?

○ Yes
○ No ***[SKIP TO QUESTION 4]***
○ Refused ***[SKIP TO QUESTION 4]***

[IF YES] **What ethnic group do you consider yourself? You may indicate more than one.**

○ Central American
○ Cuban
○ Dominican
○ Mexican
○ Puerto Rican
○ South American
○ Other (Specify)_____
○ Refused

4. What is your race? You may indicate more than one.

○ Black or African American
○ White
○ American Indian
○ Alaska Native
○ Asian Indian
○ Chinese
○ Filipino
○ Japanese
○ Korean
○ Vietnamese
○ Other Asian
○ Native Hawaiian
○ Guamanian or Chamorro
○ Samoan
○ Other Pacific Islander
○ Other (Specify)_____

○ Refused

5. Do you speak a language other than English at home?

○ Yes
○ No

IF YES, what is this language?

○ Spanish
○ Other _____

6. Do you think of yourself as…

○ Straight Or Heterosexual
○ Homosexual (Gay Or Lesbian)
○ Bisexual
○ Queer, Pansexual, And/Or Questioning
○ Asexual
○ Something Else? Please Specify _____
○ Refused

7. What is your relationship status?

○ Married
○ Single
○ Divorced
○ Separated
○ Widowed
○ In a relationship
○ In multiple relationships
○ Refused

8. *[IF NOT MALE]* Are you currently pregnant?

○ Yes
○ No
○ Do not know
○ Refused

9. Do you have children? [Refers to children both living and/or who may have died]

○ Yes
○ No ***[SKIP TO QUESTION 10]***
○ Refused ***[SKIP TO QUESTION 10]***

a. How many children under the age of 18 do you have?

|____|____| ○ Refused

b. Are any of your children, who are under the age of 18, living with someone else due to a court's intervention?

○ Yes Number of children removed from client's care |____|____|
○ No ***[SKIP TO QUESTION 10]***

○ Refused ***[SKIP TO QUESTION 10]***

c. Have you been reunited with any of your children, under the age of 18, who have been previously removed from your care? ***[THE VALUE IN ITEM C8c CANNOT EXCEED THE VALUE IN C8a.]***

○ Yes Number of children with whom the client has been reunited |____|____|
○ No
○ Refused

10. Have you ever served in the Armed Forces, in the Reserves, in the National Guard, or in other Uniformed Services? ***[IF SERVED]*** **What area, the Armed Forces, Reserves, National Guard, or other did you serve?**

○ No
○ Yes, In The Armed Forces
○ Yes, In The Reserves
○ Yes, In The National Guard
○ Yes, Other Uniformed Services *[Includes NOAA, USPHS]*
○ Refused

11. How long does it take you, on average, to travel to the location where you receive services provided by this grant?

○ Half an hour or less
○ Between half an hour and one hour
○ Between one hour and one and a half hours
○ Between one and a half hours and two hours
○ Two hours or more
○ Refused

B. SUBSTANCE USE AND PLANNED SERVICES

1. Using the table below, please indicate the following:

A. The number of days, in the past 30 days, that the client reports using a substance.

The client should be encouraged to list the substances on their own. If they are unsure, the list from the table below can be read to the client. Please note that not all substance use is considered harmful or illicit – it may be that a substance is prescribed by a licensed provider, or that the client uses the substance in accordance with official, national safety guidelines. In such instances, clarification from the client should be sought, but if the substance is only taken as prescribed or used on each occasion in accordance with official, national safety guidelines, then it is not considered misuse. If no use of a listed substance is reported, please enter a zero ('0') in the corresponding 'Number of Days Used' column.

B. The route by which the substance is used.

Mark one route only. But, if the client identifies more than one route, choose the corresponding route with the highest associated number value (numbers 1 – 6). Responses should capture the past 30 days of use.

During the past 30 days, how many days have you used any of the following, and how do you take the substance?

	Number of Days Used	**Route**
		1. Oral; **2.** Intranasal; **3.** Vaping
		4. Smoking; **5.** Non-IV Injection; **6.** Intravenous (IV) Injection
		0. Other
Alcohol		
Alcohol	|___|___|	|___|
Other (Specify)	|___|___|	|___|
Opioids		
Heroin	|___|___|	|___|
Morphine	|___|___|	|___|
Fentanyl (Prescription Diversion Or Illicit Source)	|___|___|	|___|
Dilaudid	|___|___|	|___|
Demerol	|___|___|	|___|
Percocet	|___|___|	|___|
Codeine	|___|___|	|___|
Tylenol 2, 3, 4	|___|___|	|___|
OxyContin/Oxycodone	|___|___|	|___|
Non-prescription methadone	|___|___|	|___|
Non-prescription buprenorphine	|___|___|	|___|
Other (Specify)	|___|___|	|___|
Cannabis		
Cannabis (Marijuana)	|___|___|	|___|
Synthetic Cannabinoids	|___|___|	|___|
Other (Specify)	|___|___|	|___|

	Number of Days Used	Route				
		1. Oral	**2.** Intranasal		**3.** Vaping	
		4. Smoking	**5.** Non-IV Injection	**6.** Intravenous (IV) Injection		
		0. Other				
Sedative, Hypnotic, or Anxiolytics						
Sedatives	|___|___|	|___|				
Hypnotics	|___|___|	|___|				
Barbiturates	|___|___|	|___|				
Anxiolytics/Benzodiazepines	|___|___|	|___|				
Other (Specify)	|___|___|	|___|				
Cocaine						
Cocaine	|___|___|	|___|				
Crack	|___|___|	|___|				
Other (Specify)	|___|___|	|___|				
Other Stimulants						
Methamphetamine	|___|___|	|___|				
Stimulant medications	|___|___|	|___|				
Other (Specify)	|___|___|	|___|				
Hallucinogens & Psychedelics						
PCP	|___|___|	|___|				
MDMA	|___|___|	|___|				
LSD	|___|___|	|___|				
Mushrooms	|___|___|	|___|				
Mescaline	|___|___|	|___|				
Salvia	|___|___|	|___|				
DMT	|___|___|	|___|				
Other (Specify)	|___|___|	|___|				
Inhalants						
Inhalants	|___|___|	|___|				
Other (Specify)	|___|___|	|___|				
Other Psychoactive Substances						
Non-prescription GHB	|___|___|	|___|				
Ketamine	|___|___|	|___|				
MDPV/Bath Salts	|___|___|	|___|				
Kratom	|___|___|	|___|				
Khat	|___|___|	|___|				
Other tranquilizers	|___|___|	|___|				
Other downers	|___|___|	|___|				
Other sedatives	|___|___|	|___|				
Other hypnotics	|___|___|	|___|				
Other (Specify)	|___|___|	|___|				
Tobacco and Nicotine						
Tobacco	|___|___|	|___|				

	Number of Days Used	Route			
		1. Oral	**2.** Intranasal		**3.** Vaping
		4. Smoking	**5.** Non-IV Injection	**6.** Intravenous (IV) Injection	
		0. Other			
Nicotine (Including Vape Products)	|___|___|	|___|			
Other (Specify)	|___|___|	|___|			

2. If you have been diagnosed with an alcohol use disorder, which FDA-approved medication did you receive for the treatment of this alcohol use disorder in the past 30 days? [CHECK ALL THAT APPLY.]

- ○ Naltrexone ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Extended–release Naltrexone ***[IF RECEIVED]*** Specify how many doses received |___|___|
- ○ Disulfiram ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Acamprosate ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Did not receive an FDA-approved medication for a diagnosed alcohol use disorder
- ○ Client does not report such a diagnosis

3. If you have been diagnosed with an opioid use disorder, which FDA-approved medication did you receive for the treatment of this opioid use disorder in the past 30 days? [CHECK ALL THAT APPLY.]

- ○ Methadone ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Buprenorphine ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Naltrexone ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Extended–release Naltrexone ***[IF RECEIVED]*** Specify how many doses received |___|___|
- ○ Did not receive an FDA-approved medication for a diagnosed opioid use disorder
- ○ Client does not report such a diagnosis

4. If you have been diagnosed with a stimulant use disorder, which evidence-based interventions did you receive for the treatment of this disorder in the past 30 days?

- ○ Contingency Management ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Community Reinforcement ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Cognitive Behavioral Therapy ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Other evidence-based intervention ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Did not receive any intervention for a diagnosed stimulant use disorder
- ○ Client does not report such a diagnosis

5. If you have been diagnosed with a tobacco use disorder, which FDA-approved medication did you receive for the treatment of this tobacco use disorder in the past 30 days? [CHECK ALL THAT APPLY.]

- ○ Nicotine Replacement ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Bupropion ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Varenicline ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Did not receive an FDA-approved medication for a diagnosed tobacco use disorder
- ○ Client does not report such a diagnosis

6. In the past 30 days, did you experience an overdose or take too much of a substance that resulted in needing supervision or medical attention?

- ○ Yes ***[IF YES, SPECIFY BELOW, IN QUESTION 7]***
- ○ No ***[IF NO, MOVE TO QUESTION 8]***
- ○ Refused ***[MOVE TO QUESTION 8]***

7. In the past 30 days, after taking too much of a substance or overdosing, what intervention did you receive? You may indicate more than one.

- ○ Naloxone (Narcan)
- ○ Care in an Emergency Department
- ○ Care from a Primary Care Provider
- ○ Admission to a hospital
- ○ Supervision by someone else
- ○ Other (Specify) _____
- ○ Refused

8. Not including this current episode, how many times in your life have you been treated at an inpatient or outpatient facility for a substance use disorder?

- ○ One time
- ○ Two times
- ○ Three times
- ○ Four times
- ○ Five times
- ○ Six or more times
- ○ Never ***[SKIP TO QUESTION 10]***
- ○ Refused ***[SKIP TO QUESTION 10]***

9. Approximately when was the last time you received inpatient or outpatient treatment for a substance use disorder?

- ○ Less than 6 months ago
- ○ Between 6 months and one year ago
- ○ One to two years ago
- ○ Two to three years ago
- ○ Three to four years ago
- ○ Five or more years ago
- ○ Refused

10. Have you ever been diagnosed with a mental health illness by a health care professional?

- ○ Yes
- ○ No ***[SKIP TO QUESTION 11]***
- ○ Refused ***[SKIP TO QUESTION 11]***

a. *[IF YES]* Please ask the client to self-report their mental health illnesses as listed in the table below. The client should be encouraged to report their own mental health illnesses but if preferred, the list can be read to the client.

Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	
Brief psychotic disorder	☐
Delusional disorder	☐
Schizoaffective disorders	☐
Schizophrenia	☐
Schizotypal disorder	☐
Shared psychotic disorder	☐
Unspecified psychosis	☐
Mood [affective] disorders	

Bipolar disorder	☐
Major depressive disorder, recurrent	☐
Major depressive disorder, single episode	☐
Manic episode	☐
Persistent mood [affective] disorders	☐
Unspecified mood [affective] disorder	☐
Phobic Anxiety and Other Anxiety Disorders	
Agoraphobia without panic disorder	☐
Agoraphobia with panic disorder	☐
Agoraphobia, unspecified	☐
Generalized anxiety disorder	☐
Panic disorder	☐
Phobic anxiety disorders	☐
Social phobias (Social anxiety disorder)	☐
Specific (isolated) phobias	☐
Obsessive-compulsive disorders	
Excoriation (skin-picking) disorder	☐
Hoarding disorder	☐
Obsessive-compulsive disorder	☐
Obsessive-compulsive disorder with mixed obsessional thoughts and acts	☐
Reaction to severe stress and adjustment disorders	
Acute stress disorder; reaction to severe stress, and adjustment disorders	☐
Adjustment disorders	☐
Body dysmorphic disorder	☐
Dissociative and conversion disorders	☐
Dissociative identity disorder	☐
Post traumatic stress disorder	☐
Somatoform disorders	☐
Behavioral syndromes associated with physiological disturbances and physical factors	
Eating disorders	☐
Sleep disorders not due to a substance or known physiological condition	☐
Disorders of adult personality and behavior	
Antisocial personality disorder	☐
Avoidant personality disorder	☐
Borderline personality disorder	☐
Dependent personality disorder	☐
Histrionic personality disorder	☐
Intellectual disabilities	☐
Obsessive-compulsive personality disorder	☐
Other specific personality disorders	☐
Paranoid personality disorder	☐
Personality disorder, unspecified	☐

Pervasive and specific developmental disorders	□
Schizoid personality disorder	□

○ NONE OF THE ABOVE

[FOLLOW-UP AND DISCHARGE INTERVIEWS: SKIP TO SECTION C. AT INTAKE, CONTINUE WITH THE FOLLOWING QUESTIONS]

11. Was the client screened by your program, using an evidence-based tool or set of questions, for co-occurring mental health and/or substance use disorders?

○ Yes
○ No ***[SKIP TO QUESTION 12]***

11a. ***[IF YES]*** **Did the client screen positive for co-occurring mental health and substance use disorders?**

○ Yes
○ No

11b. ***[IF YES]*** **Was the client referred for further assessment for a co-occurring mental health and substance use disorder?**

○ Yes
○ No

B 12. PLANNED SERVICES PROVIDED UNDER GRANT FUNDING *[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT INTAKE/BASELINE.]*

Identify the services you plan to provide to the client during the client's course of treatment/recovery. ***[MARK ONLY THE CIRCLE CORRESPONDING TO THE PLANNED SERVICE THAT WILL BE PROVIDED UNDER THE CURRENT GRANT. MARK ALL THAT APPLY IN EACH SECTION.]***

Modality
[SELECT AT LEAST ONE MODALITY.]

1. Case Management ○
2. Intensive Outpatient Treatment ○
3. Inpatient/Hospital (Other Than Withdrawal Management) ○
4. Outpatient Therapy ○
5. Outreach ○
6. Medication
   - A. Methadone ○
   - B. Buprenorphine ○
   - C. Naltrexone – Short Acting ○
   - D. Naltrexone – Long Acting ○
   - E. Disulfiram ○
   - F. Acamprosate ○
   - G. Nicotine Replacement ○
   - H. Bupropion ○
   - I. Varenicline ○
7. Residential/Rehabilitation ○
8. Withdrawal Management (Select Only One)
   - A. Hospital Inpatient ○
   - B. Free Standing Residential ○
   - C. Ambulatory Detoxification ○
9. After Care ○
10. Recovery Support ○
11. Other (Specify)_____ ○

[SELECT AT LEAST ONE SERVICE.]

Treatment Services
[SBIRT GRANTS: YOU MUST PROVIDE AT LEAST ONE OF THE TREATMENT SERVICES NUMBERED 1 THROUGH 4.]

1. Screening ○
2. Brief Intervention ○
3. Brief Treatment ○
4. Referral to Treatment ○
5. Assessment ○
6. Treatment Planning ○
7. Recovery Planning ○
8. Individual Counseling ○
9. Group Counseling ○
10. Contingency Management ○
11. Community Reinforcement ○
12. Cognitive Behavioral Therapy ○
13. Family/Marriage Counseling ○
14. Co-Occurring Treatment Services ○
15. Pharmacological Interventions ○
16. HIV/AIDS Counseling ○
17. Cultural Interventions/Activities ○
18. Other Clinical Services (Specify)_____ ○

Case Management Services
1. Family Services (E.g. Marriage Education, Parenting, Child Development Services) ○
2. Child Care ○
3. Employment Service
   - A. Pre-Employment ○
   - B. Employment Coaching ○
4. Individual Services Coordination ○
5. Transportation ○
6. HIV/AIDS Services
   - A. If HIV Neg, Pre-Exposure Prophylaxis ○
   - B. If HIV Neg, Post-Exposure Prophylaxis ○
   - C. If HIV Positive, HIV Treatment ○
7. Transitional Drug-Free Housing Services ○
8. Housing Support ○
9. Health Insurance Enrollment ○
10. Other Case Management Services (Specify)_____ ○

Medical Services
1. Medical Care ○
2. Alcohol/Drug Testing ○
3. OB/GYN Services ○
4. HIV/AIDS Medical Support & Testing ○
5. Dental Care ○
6. Viral Hepatitis Medical Support & Testing ○
7. Other STI Support & Testing ○
8. Other Medical Services (Specify)_____ ○

After Care Services
1. Continuing Care ○
2. Relapse Prevention ○
3. Recovery Coaching ○
4. Self-Help and Mutual Support Groups ○
5. Spiritual Support ○
6. Other After Care Services (Specify)_____ ○

Education Services
1. Substance Use Education ○
2. HIV/AIDS Education ○
3. Naloxone Training ○
4. Fentanyl Test Strip Training ○
5. Viral Hepatitis Education ○
6. Other STI Education Services ○
7. Other Education Services (Specify)_____ ○

Recovery Support Services
1. Peer Coaching or Mentoring ○
2. Vocational Services ○
3. Recovery Housing ○
4. Recovery Planning ○
5. Case Management Services to Specifically Support Recovery ○
6. Alcohol- and Drug-Free Social Activities ○
7. Information and Referral ○
8. Other Recovery Support Services (Specify)_____ ○
9. Other Peer-to-Peer Recovery Support Services (Specify)_____ ○

C. LIVING CONDITIONS

1. In the past 30 days, where have you been living most of the time? ***[DO NOT READ RESPONSE OPTIONS TO CLIENT.]***

- ○ Shelter (Safe Havens, Transitional Living Center [TLC], Low-Demand Facilities, Reception Centers, Other Temporary Day or Evening Facility)
- ○ Street/Outdoors (Sidewalk, Doorway, Park, Public Or Abandoned Building)
- ○ Institution (Hospital, Nursing Home, Jail/Prison)
- ○ Housed: ***[IF HOUSED, CHECK APPROPRIATE SUBCATEGORY:]***
  - ○ Own/Rental Apartment, Room, Trailer, Or House
  - ○ Someone Else's Apartment, Room, Trailer, Or House (including couch surfing)
  - ○ Dormitory/College Residence
  - ○ Halfway House or Transitional Housing
  - ○ Residential Treatment
  - ○ Recovery Residence/Sober Living
  - ○ Other Housed (Specify)
- ○ Refused

2. Do you currently live with any person who, over the past 30 days, has regularly used alcohol or other substances?

- ○ Yes
- ○ No
- ○ No, lives alone
- ○ Refused

D. EDUCATION, EMPLOYMENT, AND INCOME

1. Are you currently enrolled in school or a job training program? *[IF ENROLLED]* Is that full time or part time? *[IF CLIENT IS INCARCERATED, CODE D1 AS "NOT ENROLLED."]*

- ○ Not Enrolled
- ○ Enrolled, Full Time
- ○ Enrolled, Part Time

- ○ Refused

2. What is the highest level of education you have finished, whether or not you received a degree?

- ○ Less than 12th Grade
- ○ 12th Grade/High School Diploma/Equivalent
- ○ Vocational/Technical (Voc/Tech) Diploma
- ○ Some College or University
- ○ Bachelor's Degree (For example: BA, BS)
- ○ Graduate Work/Graduate Degree
- ○ Other (Specify)_____
- ○ Refused
  Don't Know

3. Are you currently employed? *[CLARIFY BY FOCUSING ON STATUS DURING MOST OF THE PREVIOUS WEEK, DETERMINING WHETHER CLIENT WORKED AT ALL OR HAD A REGULAR JOB BUT WAS OFF WORK.] [IF CLIENT IS INCARCERATED AND HAS NO WORK OUTSIDE OF JAIL, CODE D3 AS "NOT LOOKING FOR WORK."]*

- ○ Employed, Full Time (35+ Hours Per Week, Or Would Be, If Not For Leave or An Excused Absence)
- ○ Employed, Part Time
- ○ Unemployed—But Looking For Work
- ○ Not Employed, NOT Looking For Work
- ○ Not working due to a disability
- ○ Retired, not working
- ○ Other (Specify)_____
- ○ Refused

4. Do you, individually, have enough money to pay for the following living expenses? Choose all that apply.

- ○ Food
- ○ Clothing
- ○ Transportation
- ○ Rent/Housing
- ○ Utilities (Gas/Water/Electric)
- ○ Telephone Connection (Cell or Landline)
- ○ Childcare
- ○ Health Insurance
- ○ Refused

5. What is your personal annual income, meaning the total pre-tax income from all sources, earned in the past year?

- ○ $0 to $9,999
- ○ $10,000 to $14,999
- ○ $15,000 to $19,999
- ○ $20,000 to $34,999
- ○ $35,000 to $49,999
- ○ $50,000 to $74,999
- ○ $75,000 to $99,999
- ○ $100,000 to $199,999
- ○ $200,000 or more
- ○ Refused

E. LEGAL

1. **In the past 30 days, how many times have you been arrested?** ***[IF THE CLIENT INDICATES NO ARRESTS IN THE PAST 30 DAYS, BUT IS INCARCERATED AT THE TIME OF THE INTERVIEW, MARK CURRENTLY INCARCERATED]***

|____|____| TIMES ○ Refused ○ Currently Incarcerated

2. Are you currently awaiting charges, trial, or sentencing?

○ Yes
○ No
○ Refused

3. Are you currently on parole or probation or intensive pretrial supervision?

○ Probation
○ Parole
○ Intensive Pretrial Supervision
○ No
○ Refused

4. Do you currently participate in a drug court program or are you in a deferred prosecution agreement?

○ Drug court program
○ Deferred prosecution agreement
○ No, neither of these
○ Refused

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY

1. How would you rate your quality of life over the past 30 days?

- ○ Very poor
- ○ Poor
- ○ Neither poor nor good
- ○ Good
- ○ Very good
- ○ Refused

2. In the past 30 days, how many days have you *[ENTER 'O' IN DAYS FOR NO RESPONSE]*:

	Days	**Refused**
a.	Experienced serious depression ○	|____|____|
b.	Experienced serious anxiety or tension ○	|____|____|
c.	Experienced hallucinations ○	|____|____|
d.	Experienced trouble understanding, concentrating, or remembering ○	|____|____|
e.	Experienced trouble controlling violent behavior ○	|____|____|
f.	Attempted suicide ○	|____|____|
g.	Been prescribed medication for psychological/emotional problem ○	|____|____|

[IF CLIENT REPORTS 1 OR MORE DAY TO ANY QUESTION IN #2, PLEASE ENSURE THAT THEY ARE SEEN BY A LICENSED PROFESSIONAL AS SOON AS POSSIBLE.]

3. How much have you been bothered by these psychological or emotional problems in the past 30 days?

- ○ Not at all
- ○ Slightly
- ○ Moderately
- ○ Considerably
- ○ Extremely
- ○ Refused
- ○ No reported mental health complaints in the past 30 days

4. In the past 30 days, where have you gone to receive medical care? You may select more than one response.

- ○ Primary Care Provider
- ○ Urgent Care
- ○ The Emergency Department
- ○ A specialist doctor
- ○ No care was sought

○ Other _____

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (continued)

5. Do you currently have medical/health insurance?

○ Yes
○ No ***[SKIP TO NEXT SECTION]***
○ Refused

5a. *[IF YES]* What type of insurance do you have (Select all that apply)?

○ Medicare
○ Medicaid
○ Private Insurance or Employer Provided
○ TRICARE or other military health care
○ An assistance program [for example, a medication assistance program]
○ Any other type of health insurance or health coverage plan (Specify)_____
○ Refused

G. SOCIAL CONNECTEDNESS

1. In the past 30 days, did you attend any voluntary mutual support groups for recovery? In other words, did you participate in a non-professional, peer-operated organization that assists individuals who have addiction-related problems such as: Alcoholics Anonymous, Narcotics Anonymous, Secular Organization for Sobriety, Women for Sobriety, religious/faith-affiliated recovery mutual support groups, etc.? Attendance could have been in person or virtual.

- ○ Yes ***[IF YES]*** Specify How Many Times |____|____| ○ Refused
- ○ No
- ○ Refused

2. In the past 30 days, did you have interaction with family and/or friends that are supportive of your recovery?

- ○ Yes
- ○ No
- ○ Refused

3. How satisfied are you with your personal relationships?

- ○ Very Dissatisfied
- ○ Dissatisfied
- ○ Neither Satisfied nor Dissatisfied
- ○ Satisfied
- ○ Very Satisfied
- ○ Refused

4. In the past 30 days did you realize that you need to change those social connections or places that negatively impact your recovery?

- ○ Yes
- ○ No
- ○ Refused

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

H1. PROGRAM SPECIFIC QUESTIONS

[QUESTION 1 SHOULD BE REPORTED BY GRANTEE STAFF AT FOLLOW-UP AND DISCHARGE]

1. Which of the following occurred for the client, subsequent to receiving treatment? ***[CHECK ALL THAT APPLY]***

- ○ Client was reunited with child (or children)
  - *[IF YES]* With Agency Supervision ○
  - *[OR]* Without Agency Supervision ○
- ○ Client avoided out of home placement for child (or children)
- ○ None of the above

H2. PROGRAM SPECIFIC QUESTIONS

[QUESTION 1 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE]

1. Did the [insert grantee name] help you obtain any of the following benefits? ***[CHECK ALL THAT APPLY]***

- ○ Private Health Insurance
- ○ Medicaid
- ○ Medicare
- ○ SSI/SSDI
- ○ TANF
- ○ SNAP

○ Other (Specify)

○ None Of The Above

○ Refused

H3. PROGRAM SPECIFIC QUESTIONS

[QUESTION 1 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE.]

1. Have you achieved any of the following since you began receiving services or supports from [insert grantee name]? If yes, do you believe that the services you received from [insert grantee name] helped you with this achievement?

	Achieved?	If yes, do you believe that the services you received from [insert grantee name] helped you with this achievement?
1a. Enrolled in school	○ Yes ○ No ○ Refused	○ Yes ○ No ○ Refused
1b. Enrolled in vocational training	○ Yes ○ No ○ Refused	○ Yes ○ No ○ Refused
1c. Currently employed	○ Yes ○ No ○ Refused	○ Yes ○ No ○ Refused
1d. Living in stable housing	○ Yes ○ No ○ Refused	○ Yes ○ No ○ Refused

H4. PROGRAM SPECIFIC QUESTIONS

[QUESTION 1 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE]

1. **Please indicate the degree to which you agree or disagree with the following statements:**

a. Receiving treatment in a non-residential setting has enabled me to maintain parenting and family responsibilities while receiving treatment.

- ○ Strongly disagree
- ○ Disagree
- ○ Undecided
- ○ Agree
- ○ Strongly Agree
- ○ Refused

b. As a result of treatment, I feel I now have the skills and support to balance parenting and managing my recovery.

- ○ Strongly disagree
- ○ Disagree
- ○ Undecided
- ○ Agree
- ○ Strongly Agree
- ○ Refused

H5. PROGRAM SPECIFIC QUESTIONS

[QUESTION 1 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE]

1. Please indicate the degree to which you agree or disagree with the following statements:

a. Receiving treatment in a residential setting without my child (or children) has enabled me to focus on my treatment without distractions of parenting and family responsibilities.

- ○ Strongly disagree
- ○ Disagree
- ○ Undecided
- ○ Agree
- ○ Strongly Agree
- ○ Refused

b. As a result of treatment, I feel I now have the skills and support to balance parenting and managing my recovery.

- ○ Strongly disagree
- ○ Disagree
- ○ Undecided
- ○ Agree
- ○ Strongly Agree
- ○ Refused

H6. PROGRAM SPECIFIC QUESTIONS

[QUESTION 1 SHOULD BE REPORTED BY GRANTEE STAFF AT INTAKE/BASELINE, FOLLOW-UP, AND DISCHARGE].

1. Please indicate which type of funding was/will be used to pay for the SBIRT services provided to this client. ***[CHECK ALL THAT APPLY.]***

- ○ Current SAMHSA grant funding
- ○ Other federal grant funding
- ○ State funding
- ○ Client's private insurance
- ○ Medicaid/Medicare
- ○ TRICARE
- ○ Other (Specify)_____

[IF FOLLOW-UP OR DISCHARGE INTERVIEW, SKIP TO H3.]

[QUESTION 2 SHOULD BE REPORTED BY GRANTEE STAFF ONLY AT INTAKE/BASELINE]

2. If the client screened positive for substance misuse or a substance use disorder, was the client assigned to the following types of services? ***[IF CLIENT SCREENED NEGATIVE, SELECT "NO" FOR EACH SERVICE BELOW]***

	Yes	**No**
Brief Intervention	Y	N
Brief Treatment	Y	N
Referral to Treatment	Y	N

[QUESTION 3 SHOULD BE REPORTED BY GRANTEE STAFF AT INTAKE, BASELINE, FOLLOW-UP AND DISCHARGE]

3. Did the client receive the following types of services?

	Yes	**No**
Brief Intervention	Y	N
Brief Treatment	Y	N
Referral to Treatment	Y	N

H7. PROGRAM SPECIFIC QUESTIONS

[QUESTION 1 SHOULD BE ANSWERED BY THE CLIENT AT INTAKE/BASELINE, FOLLOW-UP AND DISCHARGE]

1. In the past 30 days, have you been sexually active?

- ○ Yes
- ○ No *[SKIP TO QUESTION 2.]*
- ○ Not Permitted To Ask *[SKIP TO QUESTION 2.]*
- ○ Refused *[SKIP TO QUESTION 2.]*

[IF YES] **Altogether, in the past 30 days, how many:**	**Response**	**Refused**
a. Sexual partners did you have?	Number: |____|____|____|	○

b. Did you engage in unprotected/condomless sex?

- ○ Yes
- ○ No → *[SKIP TO QUESTION 2.]*

c. *[If yes]* Were any of your partners:

1. Living with HIV and not taking HIV medications	○ Yes ○ No	○
2. A person who injects drugs	○ Yes ○ No	○
3. High on one or more substances	○ Yes ○ No	○

2. Are you currently taking Pre-Exposure Prophylaxis (PrEP) for HIV prevention, or are you taking medication for the treatment of HIV?

- ○ PrEP
- ○ Treatment for HIV
- ○ Neither
- ○ Refused

3. Did the program provide access to the following?

A1. An HIV test?

- ○ Yes
- ○ No *[SKIP TO 3B.1]*
- ○ Refused *[SKIP TO 3B.1]*

A2. ***[IF YES]*** **Was this the first time that you had been tested for HIV?**

- ○ Yes
- ○ No *[SKIP TO QUESTION A5]*
- ○ Refused *[SKIP TO QUESTION A5]*

A3. ***[IF YES]*** **Was HIV testing performed on-site or were you referred out for testing?**

- ○ On-site *[SKIP TO QUESTION A5]*

○ Referred out
○ Refused ***[SKIP TO QUESTION A5]***

A4. ***[IF REFFERED OUT FOR TESTING]*** **Where was testing performed?**

○ Primary Care Provider's office
○ Dedicated clinic
○ VA Medical Center
○ Health Center or Community Clinic
○ Local Health Department
○ Specialty Addiction Treatment Program
○ Sexual Health Center
○ A mobile testing service
○ Other _____

A5. What was the result?

○ Positive
○ Negative ***[SKIP TO A12]***
○ Indeterminate
○ Refused ***[SKIP TO 3B.1]***

A6. ***[IF POSITIVE OR INDETERMINATE]*** **Did you receive confirmatory testing?**

○ Yes
○ No ***[SKIP TO QUESTION A8]***
○ Refused ***[SKIP TO QUESTION A8]***

A7. [IF YES] **What was the result?**

○ Positive
○ Negative
○ Indeterminate
○ Refused

A8. Were you connected to HIV treatment services within 30 days of the positive test result?

○ Yes
○ No ***[SKIP TO QUESTION A10]***
○ Refused ***[SKIP TO QUESTION A10]***

A9. ***[IF YES]*** **Where were you referred for ongoing treatment?**

○ Primary Care Provider's office
○ Dedicated clinic
○ VA Medical Center
○ Health Center or Community Clinic
○ Local Health Department
○ Specialty Addiction Treatment Program
○ Sexual Health Center
○ Other _____

A10. Was rapid HIV testing offered to your substance-using and/or sexual partners?

- Yes
- No *[SKIP TO QUESTION 3B.1]*
- Refused *[SKIP TO QUESTION 3B.1]*

A11. ***[IF YES]*** **What was the number of drug-using and/or sexual partners offered HIV testing?**

- 1
- 2
- 3
- 4 or more
- Refused

A12. ***[IF NEGATIVE]*** **Were you referred for Pre-Exposure Prophylaxis (PrEP) or Post-Exposure Prophylaxis (PEP), and/or were you referred for counseling about these interventions? (Select all that apply)**

- PrEP
- PEP
- Received Counseling
- Did not receive medications
- Did not receive counseling
- Refused

B1. Did you receive a Rapid Hepatitis C (HCV) test

- Yes
- No [***SKIP TO 3C.1]***
- Refused [***SKIP TO 3C.1]***

B2. ***[IF YES]*** **Was this followed up with confirmatory Hepatitis C (HCV RNA) testing?**

- Yes
- No ***[SKIP TO QUESTION B4]***

B3. ***[IF YES]*** **What was the result?**

- Positive
- Negative [***SKIP TO 3C.1]***
- Indeterminate
- Refused [***SKIP TO 3C.1]***

B4. ***[IF SCREENED POSITIVE OR INDETERMINATE]*** **Were you connected to Hepatitis C treatment services?**

- Yes
- No
- Refused

C1. Hepatitis B (HBV) test?

- Yes
- No ***[SKIP TO 3D.1]***
- Refused ***[SKIP TO 3D.1]***

C2. ***[IF YES]*** **What was the result?**

- ○ Positive
- ○ Negative ***[SKIP TO 3D.1]***
- ○ Indeterminate
- ○ Refused ***[SKIP TO 3D.1]***

C3. ***[IF SCREENED POSITIVE OR INDETERMINATE]*** **Were you connected to Hepatitis B treatment services?**

- ○ Yes
- ○ No
- ○ Refused

D1. Was the client offered a Hepatitis A and B Vaccination?

- ○ Yes ***[SKIP TO SECTION I OR J/K]***
- ○ No
- ○ Refused ***[SKIP TO SECTION I OR J/K]***

D2. ***[IF NO]*** **Was the client referred out for vaccination?**

- ○ Yes
- ○ No
- ○ Refused

H8. PROGRAM SPECIFIC QUESTIONS [QUESTIONS 1 AND 2 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE]

1. Is peer support available at this program?

○ Yes **[COMPLETE QUESTIONS 2 AND 3]**

○ No **[SKIP TO NEXT SECTION]**

2. [IF YES] Have you achieved any of the following since you began receiving peer services from [insert grantee name]? If yes, do you believe that the services you received from [insert grantee name] helped you with this achievement?

	Achieved?	If yes, do you believe that the services you received from [insert grantee name] helped you with this achievement?
1a. Enrolled in school	○ Yes ○ No ○ Refused	○ Yes ○ No ○ Refused
1b. Enrolled in vocational training	○ Yes ○ No ○ Refused	○ Yes ○ No ○ Refused
1c. Currently employed	○ Yes ○ No ○ Refused	○ Yes ○ No ○ Refused
1d. Living in stable housing	○ Yes ○ No ○ Refused	○ Yes ○ No ○ Refused

3. To what extent has this program improved your quality of life?

○ To a great extent

○ Somewhat
○ Very little
○ Not at all
○ Refused

H9. PROGRAM SPECIFIC QUESTIONS

[QUESTION 1 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE]

1. Please indicate the degree to which you agree or disagree with the following statements:

i. The use of technology accessed through [insert grantee name] has helped me communicate with my provider.

- ○ Strongly disagree
- ○ Disagree
- ○ Undecided
- ○ Agree
- ○ Strongly Agree
- ○ Not Applicable
- ○ Refused

ii. The use of technology accessed through [insert grantee name] has helped me reduce my substance use.

- ○ Strongly disagree
- ○ Disagree
- ○ Undecided
- ○ Agree
- ○ Strongly Agree
- ○ Not Applicable
- ○ Refused

iii. The use of technology accessed through [insert grantee name] has helped me manage my mental health symptoms.

- ○ Strongly disagree
- ○ Disagree
- ○ Undecided
- ○ Agree
- ○ Strongly Agree
- ○ Not Applicable
- ○ Refused

iv. The use of technology accessed through [insert grantee name] has helped me support my recovery.

- ○ Strongly disagree
- ○ Disagree
- ○ Undecided
- ○ Agree
- ○ Strongly Agree
- ○ Not Applicable
- ○ Refused

H10. PROGRAM SPECIFIC QUESTIONS

[QUESTIONS 1 AND 1A SHOULD BE REPORTED BY GRANTEE STAFF AT INTAKE/BASELINE, FOLLOW-UP, AND DISCHARGE]
[QUESTION 1B SHOULD BE REPORTED BY GRANTEE STAFF AT FOLLOW-UP/DISCHARGE IF THE CLIENT HAS BEEN REFERRED FOR SERVICES]

1. Did the client screen positive for, or have a history of, a mental health disorder?

- ○ Client screened positive
- ○ Client screened negative ***[SKIP TO QUESTION 2.]***
- ○ Client was not screened ***[SKIP TO QUESTION 2.]***
- ○ Client has a positive history

a. ***[IF POSITIVE]*** **Was the client referred to mental health services?**

- ○ Yes
- ○ No ***[SKIP TO H2.]***

b. ***[IF YES]*** **Did the client receive mental health services?**

- ○ Yes
- ○ No

[QUESTIONS 2 AND 2A SHOULD BE REPORTED BY GRANTEE STAFF AT INTAKE/BASELINE, FOLLOW-UP, AND DISCHARGE]
[QUESTION 2B SHOULD BE REPORTED BY GRANTEE STAFF AT FOLLOW-UP/DISCHARGE IF THE CLIENT HAS BEEN REFERRED FOR SERVICES]

2. Did the client screen positive for, or have a history of, substance use disorder(s)?

- ○ Client screened positive
- ○ Client screened negative
- ○ Client was not screened
- ○ Client has a positive history

[IF THIS IS AN INTAKE/BASELINE AND THE RESPONSE IS NEGATIVE, NOT SCREENED, OR DON'T KNOW, SECTION H IS DONE. IF THIS IS A FOLLOW-UP OR DISCHARGE AND THE RESPONSE IS NEGATIVE, NOT SCREENED, OR DON'T KNOW, SKIP TO QUESTION 3]

a. ***[IF POSITIVE]*** **Was the client referred to substance use disorder services?**

- ○ Yes
- ○ No

b. ***[IF YES]*** **Did the client receive substance use disorder services?**

- ○ Yes
- ○ No

[IF THIS IS AN INTAKE/BASELINE, SECTION H IS DONE. IF THIS IS A FOLLOW-UP OR DISCHARGE AND THE RESPONSE IS NO OR DON'T KNOW, SKIP TO QUESTION 3]

H10. PROGRAM SPECIFIC QUESTIONS (continued)

[QUESTION 3 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE]

3. **Please indicate the degree to which you agree or disagree with the following statement: Receiving community-based services through [insert grantee name] has helped me to avoid further contact with the police and the criminal justice system.**

- ○ Strongly disagree
- ○ Disagree
- ○ Undecided
- ○ Agree
- ○ Strongly Agree
- ○ Refused

H11. PROGRAM SPECIFIC QUESTIONS (continued)

THIS SECTION FOR SBIRT GRANTS ONLY [ITEMS TO BE REPORTED AT INTAKE/BASELINE].

1. When the SBIRT was administered, how did the client screen?

○ Negative
○ Positive

2. What was his/her screening score? AUDIT = |____|____|
CAGE = |____|____|
DAST = |____|____|
DAST-10 = |____|____|
NIAAA Guide = |____|____|
ASSIST/Alcohol Subscore = |____|____|
Other (Specify) = |____|____|
_____
_____
_____

3. Was he/she willing to continue his/her participation in SBIRT services?

○ Yes
○ No

I. FOLLOW-UP STATUS

[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT FOLLOW-UP.]

1. Was the client able to be contacted for follow-up?

- ○ Yes
- ○ No

2. What is the follow-up status of the client? ***[THIS IS A REQUIRED FIELD: NA, REFUSED, DON'T KNOW, AND MISSING WILL NOT BE ACCEPTED.]***

- ○ 01 = Deceased at time of due date
- ○ 11 = Completed interview within specified window
- ○ 12 = Completed interview outside specified window
- ○ 21 = Located, but refused, unspecified
- ○ 22 = Located, but unable to gain institutional access
- ○ 23 = Located, but otherwise unable to gain access
- ○ 24 = Located, but withdrawn from project
- ○ 31 = Unable to locate, moved
- ○ 32 = Unable to locate, other (Specify) _____

3. Is the client still receiving services from your program?

- ○ Yes
- ○ No

Please complete Sections B, C, D, E, F, G and those sections of Section H assigned to your program.

[IF THIS IS A FOLLOW-UP INTERVIEW, STOP NOW; THE INTERVIEW IS COMPLETE.]

J. DISCHARGE STATUS

[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT DISCHARGE.]

1. On what date was the client discharged?

|____|____| / |____|____| / |____|____|____|____|
MONTH DAY YEAR

2. What is the client's discharge status?

- ○ 01 = Completion/Graduate
- ○ 02 = Termination

If the client was terminated, what was the reason for termination? ***[SELECT ONE RESPONSE.]***

- ○ 01 = Left on own against staff advice with satisfactory progress
- ○ 02 = Left on own against staff advice without satisfactory progress
- ○ 03 = Involuntarily discharged due to nonparticipation
- ○ 04 = Involuntarily discharged due to violation of rules
- ○ 05 = Referred to another program or other services with satisfactory progress
- ○ 06 = Referred to another program or other services with unsatisfactory progress
- ○ 07 = Incarcerated due to offense committed while in treatment/recovery with satisfactory progress
- ○ 08 = Incarcerated due to offense committed while in treatment/recovery with unsatisfactory progress
- ○ 09 = Incarcerated due to old warrant or charged from before entering treatment/recovery with satisfactory progress
- ○ 10 = Incarcerated due to old warrant or charged from before entering treatment/recovery with unsatisfactory progress
- ○ 11 = Transferred to another facility for health reasons
- ○ 12 = Death
- ○ 13 = Other (Specify)_____

3. Did the program order an HIV test for this this client?

- ○ Yes **[SKIP TO QUESTION 5.]**
- ○ No **[GO TO J4.]**

4. ***[IF NO]*** **Did the program refer this client for HIV testing with another provider?**

- ○ Yes
- ○ No

5. Did the program provide Naloxone and/or Fentanyl Test Strips to this client at any time during their involvement in grant funded services?

- ○ Naloxone
- ○ Fentanyl Test Strips
- ○ Both Naloxone and Fentanyl Test Strips
- ○ Neither

6. Is the client fully vaccinated against the virus that causes COVID-19?

- ○ Yes
- ○ No, partially vaccinated with plans to receive the subsequent vaccination on time
- ○ No, partially vaccinated with no plan to receive the subsequent vaccination

○ No, client refused vaccination
○ Refused to answer

K.1 SERVICES RECEIVED UNDER GRANT FUNDING *[REPORTED BY PROGRAM STAFF ONLY AT DISCHARGE]*

Identify the number of DAYS of services provided to the client during the client's course of treatment/recovery. ***[ENTER ZERO IF NO SERVICES PROVIDED.]***

Modality	Days
1. Case Management	|___|___|___|
2. Intensive Outpatient Treatment	|___|___|___|
3. Inpatient/Hospital (Other Than Withdrawal Management)	|___|___|___|
4. Outpatient Therapy	|___|___|___|
5. Outreach	|___|___|___|
6. Medication	
A. Methadone	|___|___|___|
B. Buprenorphine	|___|___|___|
C. Naltrexone – Short Acting	|___|___|___|
D. Naltrexone – Long Acting (Report 28 days for each one injection)	|___|___|___|
E. Disulfiram	|___|___|___|
F. Acamprosate	|___|___|___|
G. Nicotine Replacement	|___|___|___|
H. Bupropion	|___|___|___|
I. Varenicline	|___|___|___|
7. Residential/Rehabilitation	|___|___|___|
8. Withdrawal Management (Select Only 1):	
A. Hospital Inpatient	|___|___|___|
B. Free Standing Residential	|___|___|___|
C. Ambulatory Detoxification	|___|___|___|
9. After Care	|___|___|___|
10. Recovery Support	|___|___|___|
11. Other (Specify)_____	|___|___|___|

Identify the number of SESSIONS provided to the client during the client's course of treatment/recovery. ***[ENTER ZERO IF NO SERVICES PROVIDED.]***

Treatment Services	Sessions
[SBIRT GRANTS: YOU MUST HAVE AT LEAST ONE SESSION FOR ONE OF THE TREATMENT SERVICES NUMBERED 1 THROUGH 4.]	
1. Screening	|___|___|___|
2. Brief Intervention	|___|___|___|
3. Brief Treatment	|___|___|___|
4. Referral to Treatment	|___|___|___|
5. Assessment	|___|___|___|
6. Treatment Planning	|___|___|___|
7. Recovery Planning	|___|___|___|
8. Individual Counseling	|___|___|___|
9. Group Counseling	|___|___|___|
10. Contingency Management	|___|___|___|
11. Community Reinforcement	|___|___|___|
12. Cognitive Behavioral Therapy	|___|___|___|
13. Family/Marriage Counseling	|___|___|___|
14. Co-Occurring Treatment Services	|___|___|___|
15. Pharmacological Interventions	|___|___|___|
16. HIV/AIDS Counseling	|___|___|___|
17. Cultural Interventions/Activities	|___|___|___|
18. Other Clinical Services (Specify)_____	|___|___|___|

Case Management Services **Sessions**

1. Family Services (E.g Marriage Education, Parenting, Child Development Services) |___|___|___|
2. Child Care |___|___|___|
3. Employment Service
   A. Pre-Employment |___|___|___|
   B. Employment Coaching |___|___|___|
4. Individual Services Coordination |___|___|___|
5. Transportation |___|___|___|
6. HIV/AIDS Services & Counseling |___|___|___|
7. Transitional Drug-Free Housing Services |___|___|___|
8. Housing Support |___|___|___|
9. Health Insurance Enrollment |___|___|___|
10. Other Case Management Services (Specify)_ |___|___|___|

Medical Services **Sessions**

1. Medical Care |___|___|___|
2. Alcohol/Drug Testing |___|___|___|
3. OB/GYN Services |___|___|___|
4. HIV/ AIDS Medical Support & Testing |___|___|___|
5. Hepatitis Medical Support & Testing |___|___|___|
6. Other STI Support and Testing |___|___|___|
7. Dental Care |___|___|___|
8. Other Medical Services (Specify)_____ |___|___|___|

After Care Services **Sessions**

1. Continuing Care |___|___|___|
2. Relapse Prevention |___|___|___|
3. Recovery Coaching |___|___|___|
4. Mutual Support Groups |___|___|___|
5. Spiritual Support |___|___|___|
6. Other After Care Services (Specify)_____ |___|___|___|

Education Services **Sessions**

1. Substance Misuse Education |___|___|___|
2. HIV/AIDS Education |___|___|___|
3. Hepatitis Education |___|___|___|
4. Other STI Education Services |___|___|___|
5. Naloxone Training |___|___|___|
6. Fentanyl Test Strip Training |___|___|___|
7. Other Education Services (Specify)_____ |___|___|___|

Recovery Support Services **Sessions**

1. Peer Coaching or Mentoring |___|___|___|
2. Vocational Services |___|___|___|
3. Recovery Housing |___|___|___|
4. Recovery Planning |___|___|___|
5. Case Management Services to Specifically Support Recovery |___|___|___|
6. Alcohol- and Drug-Free Social Activities |___|___|___|
7. Information and Referral |___|___|___|
8. Other Recovery Support Services (Specify) _____ |___|___|___|
9. Other Peer-to-Peer Recovery Support Services (Specify)_____ |___|___|___|

2. Has this client attended 60% or more of their planned services?

○ Yes
○ No

3. Did this client receive any services via telehealth or a virtual platform?

○ Yes
○ No

4. Has this client previously been diagnosed with an opioid use disorder?

○ Yes
○ No ***[SKIP TO 5]***

a. *[IF YES]* In the past 30 days, which FDA-approved medication did the client receive for the treatment of this opioid use disorder? *[CHECK ALL THAT APPLY.]*

○ Methadone ***[IF RECEIVED]*** Specify how many days received |___|___|
○ Buprenorphine ***[IF RECEIVED]*** Specify how many days received |___|___|
○ Naltrexone ***[IF RECEIVED]*** Specify how many days received |___|___|
○ Extended–release Naltrexone ***[IF RECEIVED]*** Specify how many doses received |___|___|
○ Client did not receive an FDA-approved medication for an opioid use disorder

b. ***[IF YES]*** **Has this client taken the medication as prescribed?**

- ○ Yes
- ○ No

5. Has this client previously been diagnosed with an alcohol use disorder?

- ○ Yes
- ○ No ***[SKIP TO 6]***

a. ***[IF YES]*** **In the past 30 days, which FDA-approved medication did the client receive for the treatment of this alcohol use disorder?** ***[CHECK ALL THAT APPLY.]***

- ○ Naltrexone ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Extended–release Naltrexone ***[IF RECEIVED]*** Specify how many doses received |___|___|
- ○ Disulfiram ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Acamprosate ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Client did not receive an FDA-approved medication for an alcohol use disorder

c. ***[IF YES]*** **Has this client taken the medication as prescribed?**

- ○ Yes
- ○ No

6. Has this client previously been diagnosed with a stimulant use disorder?

- ○ Yes
- ○ No ***[SKIP TO 7]***

a. ***[IF YES]*** **In the past 30 days, which evidence-based interventions did the client receive for the treatment of this stimulant use disorder?** ***[CHECK ALL THAT APPLY.]***

- ○ Contingency Management ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Community Reinforcement ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Cognitive Behavioral Therapy ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Other Treatment Approach ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Client did not receive any intervention

d. ***[IF YES]*** **Has this client attended and participated in evidence-based interventions for stimulant use disorder?**

- ○ Yes
- ○ No

7. Has this client previously been diagnosed with a tobacco use disorder?

- ○ Yes
- ○ No ***[SKIP TO REMAINING DISCHARGE QUESTIONS.]***

a. ***[IF YES]*** **In the past 30 days, which FDA-approved medication did the client receive for the treatment of this tobacco use disorder?** ***[CHECK ALL THAT APPLY.]***

○ Nicotine Replacement ***[IF RECEIVED]*** Specify how many days received
|___|___|

○ Bupropion ***[IF RECEIVED]*** Specify how many days received
|___|___|

○ Varenicline ***[IF RECEIVED]*** Specify how many days received
|___|___|

○ Client did not receive an FDA-approved medication for a tobacco use disorder

e. ***[IF YES]*** **Has this client taken the medication as prescribed?**

○ Yes
○ No