CSAT GPRA Client Outcome  
Measures for Discretionary Programs

FINAL DRAFT

Public reporting burden for this collection of information is estimated to average 36 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information, if all items are asked of a client/participant; to the extent that providers already obtain much of this information as part of their ongoing client/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 15E57A, 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 0930-0208.

# 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

1. What do you consider yourself to be??

Male

Female

Transgender (Male to Female)

Transgender (Female to Male)

Gender non-conforming

Other (Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Refused

1. 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

1. 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

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

* Yes
* No

IF YES, what is this language?

* Spanish
* Other \_\_\_\_\_\_\_\_\_\_\_

1. 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

1. What is your relationship status?

Married

Single

Divorced

Separated

Widowed

In a relationship

In multiple relationships

Refused

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

Yes

No

Do not know

Refused

1. 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

1. 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:**

1. **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.

1. **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) | |\_\_\_|\_\_\_| | |\_\_\_| | | | |
|  |  |  | | | |
| **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 | |\_\_\_|\_\_\_| | |\_\_\_| | | | |
| Nicotine (Including Vape  Products) | |\_\_\_|\_\_\_| | |\_\_\_| | | | |
| Other (Specify) | |\_\_\_|\_\_\_| | |\_\_\_| | | | |
|  |  |  | | | |

1. **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

1. **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

1. **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

1. **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

1. **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]***

1. **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

1. **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]***

1. **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

1. **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]***

1. ***[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

1. 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

1. 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

1. 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

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

Yes

No

Refused

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

Probation

Parole

Intensive Pretrial Supervision

No

Refused

1. 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

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

Yes

No

Refused

1. How satisfied are you with your personal relationships?

Very Dissatisfied

Dissatisfied

Neither Satisfied nor Dissatisfied

Satisfied

Very Satisfied

Refused

1. 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

1. **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:**
2. **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

1. **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]**

1. **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]**

1. **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

1. **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 |

1. **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]**

1. **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]**

1. **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

1. 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)

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

Yes **[SKIP TO QUESTION 5.]**

No **[GO TO J4.]**

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

Yes

No

1. 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

1. 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) |\_\_\_|\_\_\_|\_\_\_|

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

Yes

No

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

Yes

No

1. 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

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

Yes

No

1. 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

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

Yes

No

1. 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

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

Yes

No

1. 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

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

Yes

No