ATTACHMENT A

Form Approved
OMB No. 0930-0285
Expiration Date 02/28/2022

Substance Abuse and Mental Health Services Administration (SAMHSA)

Center for Mental Health Services (CMHS)

National Outcome Measures (NOMs) Client-Level Measures for Discretionary Programs Providing Direct Services

SERVICES TOOL

SAMHSA's Performance Accountability and Reporting System (SPARS)
May 2021

Table of Contents

[This page intentionally left blank]

RECORDS MANAGEMENT

Records Management information is collected by Grantee Staff at BASELINE, REASSESSMENT, and DISCHARGE, even when an assessment interview is not conducted.

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

Grant ID |____|____|____|____|____|____|____|____|____|____|____|____|

Site ID |____|____|____|____|____|____|____|____|____|____|____|

1. **Indicate Assessment Type:**

☐ **Baseline Assessment** **Enter the MONTH and YEAR when the consumer first received services under this grant for this episode of care.** |____|____| / |____|____|____|____| MONTH YEAR	☐ **Reassessment** (3-month or 6-month)	☐ **Clinical Discharge Assessment**

2. **Was the assessment interview conducted?**

☐ Yes **When?** |____|____| / |____|____| / |____|____|____|____| MONTH DAY YEAR	☐ No **Why not? Choose only one.** ☐ Not able to obtain consent from proxy ☐ Client/consumer was impaired or unable to provide consent ☐ Client/consumer refused this interview ☐ Client/consumer was not reached for interview ☐ Client/consumer refused all interviews

3. **For children, was the respondent the child or the caregiver**?

☐☐☐☐Child
☐☐☐☐Caregiver

DEMOGRAPHIC DATA

1. **What do you consider yourself to be? [Read choices.]**

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

2. **Do you think of yourself as…**

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

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

   ☐ Yes
   ☐ No *[GO TO 4.]*
   ☐ Refused *[GO TO 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.**

Race

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

5. **Do you speak a language other than English at home? (5 years old or older)**

○ Yes
○ No

IF YES, what is this language? (5 years old or older)

○ Spanish
○ Other _____

6. **What is your month and year of birth?**

|____|____| / |____|____|____|____|

Month **Year**

7. **[ADULT ONLY] Have you ever served in the Armed Forces, the Reserves, or the National Guard?**

○ Yes
○ No
○ Don't know
○ Not applicable

8. **[ADULT ONLY] Are you currently serving on active duty in the Armed Forces, the Reserves, or the National Guard?**

○ Yes
○ No
○ Refused
○ Don't Know

Stop here if a BASELINE ASSESSMENT interview was not conducted.

BEHAVIORAL HEALTH DIAGNOSES – This section should be completed by a licensed clinician

1. **Was the client/consumer screened or assessed by your program for trauma-related experiences:**

   - ○ Yes
   - ○ No
   - ○ Don't know

   If "no", please select why:

   - ○ No time during interview
   - ○ No training around trauma screening/disclosure
   - ○ No institutional/organizational policy around screening
   - ○ No referral network and/or infrastructure for trauma services currently available
   - ○ Other

   If screened/assessed, was the screen positive?

   - ○ Yes
   - ○ No
   - ○ Don't know

2. **Did the client/consumer have a positive suicidal screen?**
   - ○ Yes
   - ○ No
   - ○ Don't know

   If Yes, was a suicidal safety plan developed?
   - ○ Yes
   - ○ No
   - ○ Don't know

   If Yes, was access to lethal means assessed?
   - ○ Yes
   - ○ No
   - ○ Don't know

3. **Behavioral Health Diagnoses [This data is reported by Grantee Program Staff]**

Please indicate the client/consumer's current behavioral health diagnoses using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes listed below. Please note that some substance use disorder ICD-10-CM codes have been crosswalked to the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) descriptors. Select up to three mental health diagnoses. If there are any co-occurring disorders, you may select up to three substance use disorders.

If no mental health diagnosis, select reason:

- ○ No clinician assessment
- ○ High risk factors requiring intervention and not yet meeting criteria for a DSM/ICD diagnosis
- ○ Only met criteria for a "Z "code
- ☐ Other (please specify_____)

MENTAL HEALTH DIAGNOSES	Diagnosed?
Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	
F20 – Schizophrenia	☐
F21 – Schizotypal disorder	☐
F22 – Delusional disorder	☐
F23 – Brief psychotic disorder	☐
F24 – Shared psychotic disorder	☐
F25 – Schizoaffective disorders	☐
F28 – Other psychotic disorder not due to a substance or known physiological condition	☐
F29 – Unspecified psychosis not due to a substance or known physiological condition	☐
Mood [affective] disorders]	
F30 – Manic episode	☐
F31 – Bipolar disorder	☐
F32 – Major depressive disorder, single episode	☐
F33 – Major depressive disorder, recurrent	☐
F34 – Persistent mood [affective] disorders	☐
F39 – Unspecified mood [affective] disorder	☐
Phobic Anxiety and Other Anxiety Disorders	
F40 – Phobic anxiety disorders	☐
F40.00 – Agoraphobia, unspecified	☐
F40.01 – Agoraphobia with panic disorder	☐
F40.02 – Agoraphobia without panic disorder	☐
F40.1 – Social phobias (Social anxiety disorder)	☐
F40.10 – Social phobia, unspecified	☐
F40.11 – Social phobia, generalized	☐
F40.2 – Specific (isolated) phobias	☐
F41 – Other anxiety disorders	☐
F41.0 – Panic disorder	☐
F41.1 – Generalized anxiety disorder	☐
Obsessive-compulsive disorders	
F42 – Obsessive-compulsive disorder	☐
F42.2 – Obsessive-compulsive disorder with mixed obsessional thoughts and acts	☐
F42.3 – Hoarding disorder	☐
F42.4 – Excoriation (skin-picking) disorder	☐
F42.8 – Other obsessive-compulsive disorder	☐
F42.9 – Obsessive-compulsive disorder, unspecified	☐
Reaction to severe stress and adjustment disorders	
F43 – Acute stress disorder; reaction to severe stress, and adjustment disorders	☐
F43.10 – Post traumatic stress disorder, unspecified	☐
F43.2 – Adjustment disorders	☐
F44 – Dissociative and conversion disorders	☐
F44.81 – Dissociative identity disorder	☐
F45 – Somatoform disorders	☐
F45.22 – Body dysmorphic disorder	☐
F48 – Other non-psychotic mental disorders	☐
Behavioral syndromes associated with physiological	

disturbances and physical factors	
F50 – Eating disorders	☐
F51 – Sleep disorders not due to a substance or known physiological condition	☐
Disorders of adult personality and behavior	
F60.0 – Paranoid personality disorder	☐
F60.1 – Schizoid personality disorder	☐
F60.2 – Antisocial personality disorder	☐
F60.3 – Borderline personality disorder	☐
F60.4 – Histrionic personality disorder	☐
F60.5 – Obsessive-compulsive personality disorder	☐
F60.6 – Avoidant personality disorder	☐
F60.7 – Dependent personality disorder	☐
F60.8 – Other specific personality disorders	☐
F60.9 – Personality disorder, unspecified	☐
F63.3 – Trichotillomania	☐
F70–F79 – Intellectual disabilities	☐
F80–F89 – Pervasive and specific developmental disorders	☐
Behavioral and emotional disorders with onset usually occurring in childhood and adolescence	
F90 – Attention-deficit hyperactivity disorders	☐
F91 – Conduct disorders	☐
F93 – Emotional disorders with onset specific to childhood	☐
F93.0 – Separation anxiety disorder of childhood	☐
F94 – Disorders of social functioning with onset specific to childhood or adolescence	☐
F94.0 – Selective mutism	☐
F94.1 – Reactive attachment disorder of childhood	☐
F94.2 – Disinhibited attachment disorder of childhood	☐
F95 – Tic disorder	☐
F98 – Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence	☐
F99 – Unspecified mental disorder	☐
Z codes – Persons with potential health hazards related to socioeconomic and psychosocial circumstances	
Z55 – Problems related to education and literacy	☐
Z56 – Problems related to employment and unemployed	☐
Z57 – Occupational exposure to risk factors	☐
Z59 – Problems related to housing and economic circumstances	☐
Z60 – Problems related to social environment	☐
Z62 – Problems related to upbringing	☐
Z63 – Other problems related to primary support group, including family circumstances	☐
Z64 – Problems related to certain psychological circumstances	☐
Z65 – Problems related to other psychosocial circumstances	☐

SUBSTANCE USE DIAGNOSES	**Diagnosed?**
Alcohol related disorders	

F10.10 – Alcohol abuse, uncomplicated	☐
F10.11 – Alcohol abuse, in remission	☐
F10.20 – Alcohol dependence, uncomplicated	☐
F10.21 – Alcohol dependence, in remission	☐
F10.9 – Alcohol use, unspecified	☐
Opioid related disorders	
F11.10 – Opioid abuse, uncomplicated,	☐
F11.11 – Opioid abuse, in remission	☐
F11.20 – Opioid dependence, uncomplicated	☐
F11.21 – Opioid dependence, in remission	☐
F11.9 – Opioid use, unspecified	☐
Cannabis related disorders	
F12.10 – Cannabis abuse, uncomplicated	☐
F12.11 – Cannabis abuse, in remission	☐
F12.20 – Cannabis dependence, uncomplicated	☐
F12.21 – Cannabis dependence, in remission	☐
F12.9 – Cannabis use, unspecified	☐
Sedative, hypnotic, or anxiolytic related disorders	
F13.10 – Sedative, hypnotic, or anxiolytic abuse, uncomplicated	☐
F13.11 – Sedative, hypnotic, or anxiolytic abuse, in remission	☐
F13.20 – Sedative, hypnotic, or anxiolytic dependence, uncomplicated	☐
F13.21 – Sedative, hypnotic, or anxiolytic dependence, in remission	☐
F13.9 – Sedative, hypnotic, or anxiolytic-related use, unspecified	☐
Cocaine related disorders	
F14.10 – Cocaine abuse, uncomplicated	☐
F14.11 – Cocaine abuse, in remission	☐
F14.20 – Cocaine dependence, uncomplicated	☐
F14.21 – Cocaine dependence, in remission	☐
F14.9 – Cocaine use, unspecified	☐
Other stimulant related disorders	
F15.10 – Other stimulant abuse, uncomplicated	☐
F15.11 – Other stimulant abuse, in remission	☐
F15.20 – Other stimulant dependence, uncomplicated	☐
F15.21 – Other stimulant dependence, in remission	☐
F15.9 – Other stimulant use, unspecified	☐
Hallucinogen related disorders	
F16.10 – Hallucinogen abuse, uncomplicated	☐
F16.11 – Hallucinogen abuse, in remission	☐
F16.20 – Hallucinogen dependence, uncomplicated	☐
F16.21 – Hallucinogen dependence, in remission	☐
F16.9 – Hallucinogen use, unspecified	☐
Inhalant related disorders	
F18.10 – Inhalant abuse, uncomplicated	☐
F18.11 – Inhalant abuse, in remission	☐
F18.20 – Inhalant dependence, uncomplicated	☐

F18.21 – Inhalant dependence, in remission	☐
F18.9 – Inhalant use, unspecified	☐
Other psychoactive substance related disorders	
F19.10 – Other psychoactive substance abuse, uncomplicated	☐
F19.11 – Other psychoactive substance abuse, in remission	☐
F19.20 – Other psychoactive substance dependence, uncomplicated	☐
F19.21 – Other psychoactive substance dependence, in remission	☐
F19.9 – Other psychoactive substance use, unspecified	☐
Nicotine dependence	
F17.20 – Nicotine dependence, unspecified	☐
F17.21 – Nicotine dependence, cigarettes	☐

For BASELINE and REASSESSMENT:

- **If an interview WAS conducted, go to Section A.**
- **If an interview WAS NOT conducted go to Section H.**

For a CLINICAL DISCHARGE:

- **If an interview WAS conducted, go to Section A.**
- **If an interview WAS NOT conducted, go to Section H.**

A. FUNCTIONING

1. How would you rate your [your child's] overall mental health right now?

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ No response/refused

2. To provide the best mental health and related services, we need to know how well you [your child] were able to deal with everyday life during the past thirty days. Please indicate your [your child's] response to each of the following statements:

During the past 30 days ….	**Yes**	**No**	**No Response/Refused**
2.a. I am [my child is] handling daily life.	☐	☐	☐
2.b. I am [my child is] able to deal with unexpected events in my life.	☐	☐	☐
2.c. I [my child does] get along with friends and other people.	☐	☐	☐
2.d. I [my child does] get along with family members.	☐	☐	☐
2.e. I [my child does] do well in social situations.	☐	☐	☐
2.f. I [my child does] do well in school and/or work.	☐	☐	☐
2.g. I do [my child does] have had a safe place to live.	☐	☐	☐

3. The following questions ask about how you [your child] has been feeling during the past 30 days. Please indicate your response to each question:

During the past 30 days, did you [your child] feel …	**Yes**	**No**	**No Response / Refused**
3.a. Nervous?	□	□	□
3.b. Hopeless?	□	□	□
3.c. Restless or fidgety?	□	□	□
	□	□	□
3.d. So depressed that nothing could cheer you [your child] up?	□	□	□
3.e. That everything was an effort?	□	□	□
3.f. Worthless?	□	□	□
3.g. Bothered by psychological or emotional problems?	□	□	□

B. STABILITY IN HOUSING

1. In the past 30 days, have you [your child] …	Yes	No	No Response/Refused
1. Been homeless	☐	☐	☐
2. Spent time in a hospital for mental health care	☐	☐	☐
3. Spent time in a facility for detox/inpatient treatment for a substance abuse disorder	☐	☐	☐
4. Spent time in a correctional facility (e.g., jail, prison, juvenile facility)	☐	☐	☐
5. Gone to an emergency room for a mental health or emotional problem.	☐	☐	☐
6. Been satisfied with the conditions of your living space.	☐	☐	☐

2. In the past 30 days, where have you been living most of the time?

[Do not read response options to the client. Select only one.]

- ○ Private residence
- ○ Foster home
- ○ Residential care
- ○ Crisis residence
- ○ Residential treatment center
- ○ Institutional setting
- ○ Jail/correctional facility
- ○ Homeless/shelter
- ○ Other (SPECIFY) _____

○ Don't know

C. EDUCATION AND EMPLOYMENT

1. Are you [your child] currently enrolled in school or a job training program?

- ○ Yes
- ○ No
- ○ No response/refused

2. [ADULT ONLY] - 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 (GED)
- ○ VOCATIONAL/TECHNICAL (VOC/TECH) DIPLOMA
- ○ SOME COLLEGE OR UNIVERSITY
- ○ BACHELOR'S DEGREE (BA, BS)
- ○ GRADUATE WORK/GRADUATE DEGREE
- ○ REFUSED
- ○ DON'T KNOW

3. [ADULT ONLY) - Are you currently employed?

- ○ Employed full-time (35+ HOURS per week)
- ○ 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
- ○ Don't know

4. In the past 30 days , did you …

Statement	Yes	No	No response or Refused
4.a. Have you enough money to meet your [your child's] needs?	□	□	□

[1] For information on federal minimum wage, go to https://www.dol.gov/general/topic/wages

D. CRIME AND CRIMINAL JUSTICE STATUS

1. [ADULT ONLY] In the past 30 days, have you …

Statement	Yes	No	No response/refused
D.1.a. Been arrested?	☐	☐	☐
D.1.b Spent time in jail or a correctional facility or on probation?	☐	☐	☐

2. [CHILD ONLY] In the past 30 days, have you

Statement	Yes	No	No response/refused
D.2.a. Been arrested?	☐	☐	☐
D.2.b Spent time in jail or been on juvenile probation?	☐	☐	☐

If this is a BASELINE assessment, go to Section F.

If this is a REASSESSMENT or a CLINICAL DISCHARGE assessment, go to Section E.

E. PERCEPTION OF CARE

Go to Section F if this is a BASELINE assessment

Section E data is collected only for the REASSESSMENT interview and the CLINICAL DISCHARGE assessment.

1. **In order to provide the best possible mental health and related services, we need to know what you [your child] thinks about the services you received during the past 30 days, the people who provided it, and the results. Please indicate your disagreement/agreement with each of the following statements.**

   [Read each statement to the client/consumer, followed by the response options]

Statement	yes	No	No response / Refused
a. Staff here believe that I [my child] can grow, change, and recover.	☐	☐	☐
b. I [my child] felt free to complain.	☐	☐	☐
c. I [my child] was given information about my rights.	☐	☐	☐
d. Staff encouraged me [my child] to take responsibility for how I live my life.	☐	☐	☐
e. Staff told me [my child] what side effects to watch out for.	☐	☐	☐
f. Staff respected my [my child's] wishes about who is and who is not to be given information about my treatment.	☐	☐	☐
g. Staff were sensitive to my [my child's] cultural background (e.g., race, religion, language).	☐	☐	☐
h. Staff helped me [my child] obtain the information I [my child] needed so that I [my child] could take charge of managing my [his/her] illness.	☐	☐	☐
i. I [my child] was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	☐	☐	☐
j. I [my child] felt comfortable asking questions about my treatment and medication.	☐	☐	☐
k. I, not staff, decided my treatment goals.	☐	☐	☐
l. I [my child] like[s] the services received here.	☐	☐	☐

Statement	yes	No	No response / Refused
m. I [my child] would still get services from this agency if there were other choices.	☐	☐	☐
n. I would recommend this agency to a friend or family member.	☐	☐	☐

Indicate who administered Section F to the client/consumer for this interview:

☐ Administrative staff
○ Care coordinator
○ Case manager
○ Clinician providing direct services
○ Clinician not providing direct services
○ Consumer/peer
○ Data collector/evaluator
○ Family advocate
○ Other (SPECIFY) _____

F. SOCIAL CONNECTEDNESS

1. Please indicate YES or NO for each of the following statements. Please answer for relationships with persons other than your mental health provider(s) over the past 30 days.

[Read each statement to the client/consumer, followed by the response options]

STATEMENT	Yes	No	No response / Refused
a. I [my child is] am happy with my [their] friendships.	☐	☐	☐
b. I have [my child has] people with whom I [they] can do enjoyable things.	☐	☐	☐
c. I feel [my child feels] that I [they] belong in the community.	☐	☐	☐
d. In a crisis, I [my child] would have the support needed from family or friends.	☐	☐	☐
e. I have [my child has] family or friends that are supportive of my [my child's] recovery.	☐	☐	☐
f. I [my child] generally accomplishes what I [they] set out to do.	☐	☐	☐

IF YOUR PROGRAM DOES NOT REQUIRE SECTION G and this is a …

1. **BASELINE ASSESSMENT, stop now – the interview is completed**
2. **REASSESSMENT interview – go to Section H.**
3. **CLINICAL DISCHARGE interview assessments go to Section H.**

IF YOUR PROGRAM DOES REQUIRE SECTION G, and this is a …

1. **BASELINE interview – go to Section G and then stop. The interview has been completed.**
2. **REASSESSMENT interview: go to Section G, and then to Section H.**
3. **CLINICAL DISCHARGE interview – go to Section G, and then Section H.**

G. PROGRAM-SPECIFIC QUESTIONS

You are not responsible for collecting data on all Section G questions. Your GPO will provide guidance on which specific Section G questions you are to complete. If you have any questions, please contact your GPO.

G1. PROGRAM-SPECIFIC QUESTIONS: ASSISTED OUTPATIENT TREATMENT

Question 1 should be asked of the client/consumer at BASELINE, REASSESSMENT, and CLINICAL DISCHARGE.

1. **In the past 30 days, have you taken your psychiatric medication(s) as prescribed to you?**

   - ○ Yes
   - ○ No
   - ○ Refused
   - ○ Not applicable

Question 2 should be answered by grantee staff at REASSESSMENT and CLINICAL DISCHARGE.

2. **In the past 30 days, have you followed your treatment plan?**

   - ○ Yes
   - ○ No
   - ○ Refused
   - ○ Not applicable

If this is a BASELINE assessment, stop here.

If this is a REASSESSMENT, go to Sections H.

If this is a CLINICAL DISCHARGE assessment, go to Section H.

G2. PROGRAM-SPECIFIC QUESTIONS: LAW ENFORCEMENT AND BEHAVIORAL HEALTH PARNTERSHIPS FOR EARLY DIVERSION

Questions 1 and 2 should be answered by grantee at BASELINE, REASSESSMENT, and CLINICAL DISCHARGE.

1. Was the consumer referred to mental health services?

YES	NO
☐	☐

a. *[IF YES]* Did they receive mental health services?

YES	NO	OTHER
☐	☐☐☐☐☐☐☐	

2. Was the consumer referred to substance use disorder services?

YES	NO
☐	☐

a. *[IF YES]* Did they receive substance use disorder services?

YES	NO	OTHER
☐	☐☐☐☐☐☐☐	

Question 3 should be answered by the client/consumer only at REASSESSMENT and CLINICAL DISCHARGE.

3. Has this program helped you avoid further contact with the police and criminal justice system?

- ○ Yes
- ○ No
- ○ No response
- ○ Refused

If this is a BASELINE assessment, stop here.

If this is a REASSESSMENT, go to Section H.

If this is a CLINICAL DISCHARGE assessment, go to Section H.

G3. PROGRAM-SPECIFIC QUESTIONS: PROMOTING THE INTEGRATION OF PRIMARY AND BEHAVIORAL HEALTH CARE

Questions should be answered by the client/consumer at BASELINE, REASSESSMENT, and CLINICAL DISCHARGE.

1. In the past 30 days, have you ….	**Yes**	**No**	**Refused**
a. Been to the emergency room for a physical healthcare problem?	☐	☐	☐
b. Been hospitalized overnight for a physical healthcare problem?	☐	☐	☐

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

Program-Specific Health Items

1. Health measurements (Report Quarterly)

a.	Systolic blood pressure		mmHg
b.	Diastolic blood pressure		mmHg
c.	Weight		kg
d.	Height		cm
f.	Breath CO for smoking status		ppm

2. Blood test results (Report at Baseline, Reassessment, & Clinical Discharge). For b or c, please choose one only.

a. Date of blood draw: |____|____| / |____|____| / |____|____|____|____|
MONTH DAY YEAR

b.	Fasting plasma glucose		mg/dL
c.	HgBA1c		%
d.	Total Cholesterol		mg/dL
e.	LDL Cholesterol	-	mg/dL

If this is a BASELINE assessment, stop here.

If this is a REASSESSMENT, go to Section H.

If this is a CLINICAL DISCHARGE assessment, go to Section H.

G4. PROGRAM-SPECIFIC QUESTIONS: MINORITY AIDS – SERVICE INTEGRATION

Questions should be asked by grantee staff at BASELINE, REASSESSMENT, and CLINICAL DISCHARGE

1a. Did the program provide an HIV test?

- ○ Yes
- ○ No ***[SKIP TO G1b.]***
- ○ REFUSED ***[SKIP TO G1b.]***
- ○ DON'T KNOW ***[SKIP TO G1b.]***

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

- ○ Positive
- ○ Negative ***[SKIP TO G1b.]***
- ○ Indeterminate ***[SKIP TO G1b.]***
- ○ REFUSED ***[SKIP TO G1b.]***
- ○ DON'T KNOW ***[SKIP TO G1b.]***

[IF CONSUMER SCREENED POSITIVE] **Were you connected to HIV treatment services?**

- ○ Yes
- ○ No
- ○ REFUSED
- ○ DON'T KNOW

1b. Did the program provide a Hepatitis B (HBV) test?

- ○ Yes
- ○ No ***[SKIP TO G1c.]***
- ○ REFUSED ***[SKIP TO G1c.]***
- ○ DON'T KNOW ***[SKIP TO G1c.]***

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

- ○ Positive
- ○ Negative ***[SKIP TO G1c.]***
- ○ Indeterminate ***[SKIP TO G1c.]***
- ○ REFUSED ***[SKIP TO G1c.]***
- ○ DON'T KNOW ***[SKIP TO G1c.]***

[IF CONSUMER SCREENED POSITIVE] **Were you connected to HBV treatment services?**

- ○ Yes
- ○ No
- ○ REFUSED
- ○ DON'T KNOW

1c. Did the program provide a Hepatitis C (HCV) test?

- ○ Yes
- ○ No ***[SKIP TO G2a.]***
- ○ REFUSED ***[SKIP TO G2a.]***

- DON'T KNOW ***[SKIP TO G2a.]***

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

- Positive
- Negative ***[SKIP TO G2a.]***
- Indeterminate ***[SKIP TO G2a.]***
- REFUSED ***[SKIP TO G2a.]***
- DON'T KNOW ***[SKIP TO G2a.]***

[IF CONSUMER SCREENED POSITIVE] **Were you connected to HCV treatment services?**

- Yes
- No
- REFUSED
- DON'T KNOW

2a. ***[If HIV STATUS IS POSITIVE]*** **Did you receive a referral form from** ***[INSERT GRANTEE NAME]*** **to medical care?**

- Yes
- No
- REFUSED
- DON'T KNOW

2b. Have you been prescribed an Antiretroviral Medication (ART)?

- Yes
- No
- REFUSED
- DON'T KNOW

[FOR CONSUMERS WHO REPORT BEING PRESCRIBED AN ART] **In the past 30 days, how often have you taken your ART as prescribed to you?**

- Always
- Usually
- Sometimes
- Rarely
- Never
- Refused
- DON'T KNOW
- NOT APPLICABLE

[IF THE PRESCRIPTION WAS GIVEN FOR THE FIRST TIME AT THIS APPOINTMENT, SELECT NOT APPLICABLE.]

If this is a BASELINE assessment, stop here.

If this is a REASSESSMENT, go to Section H.

If this is a CLINICAL DISCHARGE assessment, go to Section H.

G5. PROGRAM-SPECIFIC QUESTIONS: HEALTHY TRANSITIONS

Questions should be answered by grantee staff at BASELINE, REASSESSMENT and CLINICAL DISCHARGE.

1. Was the consumer referred to mental health services?

YES NO
☐ ☐

a. *[IF YES]* Did they receive mental health services?

YES NO OTHER
☐ ☐☐☐☐☐☐☐

2. Was the consumer referred to substance use disorder services?

YES NO
☐ ☐

***a. [IF YES]* Did they receive substance use disorder services?**

YES NO OTHER
☐ ☐☐☐☐☐☐☐

If this is a BASELINE assessment, stop here.

If this is a REASSESSMENT, go to Section H.

If this is a CLINICAL DISCHARGE assessment, go to Section H.

G6. PROGRAM-SPECIFIC QUESTIONS: ASSERTIVE COMMUNITY TREATMENT

Questions 1 and 2 should be answered by the consumer/client at REASSESSMENT and CLINICAL DISCHARGE

1. How often does a member of your team interact with you?

- ○ At least daily
- ○ At least weekly
- ○ At least monthly
- ○ Never
- ○ REFUSED
- ○ DON'T KNOW

2. If I need to talk with someone on my team, I know who to call.

- ○ Yes
- ○ No
- ○ Refused
- ○ Not applicable

If this is a BASELINE assessment, stop here.

If this is a REASSESSMENT, go to Section H.

If this is a CLINICAL DISCHARGE assessment, go to Section H.

G7. PROGRAM-SPECIFIC QUESTIONS: CLINICAL HIGH RISK FOR PSYCHOSIS

Question 1 should be answered by grantee staff at REASSESSMENT and CLINICAL DISCHARGE.

1. Has the consumer experienced an episode of psychosis since their last interview?

- ○ Yes
- ○ No
- ○ DON'T KNOW

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

|___|___| / |___|___|___|___|
MONTH YEAR

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

- ○ Yes
- ○ No
- ○ DON'T KNOW

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

|___|___| / |___|___|___|___| DON'T KNOW
MONTH YEAR □

If this is a BASELINE assessment, stop here.

If this is a REASSESSMENT, go to Section H.

If this is a CLINICAL DISCHARGE assessment, go to Section H.

G8 PROGRAM-SPECIFIC QUESTIONS: CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

Program specific health items are reported by Grantee Staff about the client/consumer at BASELINE, REASSESSMENT, and CLINICAL DISCHARGE.

1. During the past 30 days, did the client/consumer receive the following services?

• Crisis mental health services	_____ Yes	_____ No
• Screening, assessment, diagnosis	_____ Yes	_____ No
• Patient-centered treatment planning	_____ Yes	_____ No
• Outpatient mental health services	_____ Yes	_____ No
• Physical health screening/monitoring	_____ Yes	_____ No
• Targeted case management	_____ Yes	_____ No
• Psychiatric rehabilitation services	_____ Yes	_____ No
• Peer support services	_____ Yes	_____ No
• Family psychoeducation and support	_____ Yes	_____ No
• Services for veterans and military members	_____ Yes	_____ No

2. Health measurements: (Report quarterly)

a.	Systolic blood pressure		mmHg
b.	Diastolic blood pressure		mmHg
c.	Weight		kg
d.	Height		cm

If this is a BASELINE assessment, stop here.

If this is a REASSESSMENT, go to Section H.

If this is a CLINICAL DISCHARGE assessment, go to Section H.

G9 PROGRAM-SPECIFIC QUESTIONS: NATIONAL CHILD TRAUMATIC STRESS INITIATIVE – CATEGORY 3

Questions should be answered by the client/consumer or caregiver REASSESSMENT, and CLINICAL DISCHARGE.

Read each statement below to the client/consumer or caregiver and note the responses.

STATEMENT	Yes	No	No response	Not applicable
1. As a result of treatment and services received, my [my child's] trauma and/or loss experiences were identified and addressed.	□	□	□	□
2. As a result of treatment and services received for trauma and/or loss experiences, my [my child's] problem behaviors/symptoms have decreased.	□	□	□	□

If this is a REASSESSMENT, go to Section H.

If this is a CLINICAL DISCHARGE assessment, go to Section H.

H. SERVICES RECEIVED AND CLINICAL DISCHARGE STATUS

Question 1 is reported by Grantee Staff about the client/consumer at REASSESSMENT and CLINICAL DISCHARGE only.

1. On what date did the consumer last receive services?

|___|___| / |___|___|___|___|

MONTH YEAR

Identify all the services your grant project provided to the client/consumer during their participation in the program. This includes grant-funded and non-grant funded services.

Core Services	**Provided**		**UNKNOWN**	**SERVICE NOT AVAILABLE**
	Yes	**No**		
1. Screening	☐	☐	☐	☐
2. Assessment	☐	☐	☐	☐
3. Treatment Planning or Review	☐	☐	☐	☐
4. Psychopharmacological Services	☐	☐	☐	☐
5. Mental Health Services	☐	☐	☐	☐☐☐
6. Co-occurring Services	☐	☐	☐	☐
7. Case Management	☐	☐	☐	☐
8. Trauma-specific Services	☐	☐	☐	☐
9. Was the consumer referred to another provider for any of the above core services?	☐	☐	☐	☐

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

Questions 2 and 3 are reported by Grantee Staff about the client/consumer at CLINICAL DISCHARGE only

2. On what date was the consumer discharged?

|___|___| / |___|___|___|___|
MONTH YEAR

3. What is the consumer's discharge status?

- ☐ Mutually agreed cessation of treatment
- ○ Withdrew from/refused treatment
- ☐ No contact within 90 days of last encounter
- ☐ Clinically referred out
- ☐ Death
- ☐ Other (Specify) _____