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Substance Abuse and Mental Health Services Administration (SAMHSA)

Center for Substance Abuse Treatment (CSAT)

Government Performance and Results Act (GPRA) Client Outcome Measures for Discretionary Programs

SAMHSA's Performance Accountability and Reporting System (SPARS)
March 2019

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 the Substance Abuse and Mental Health Services Administration (SAMHSA) Reports Clearance Officer, Room 15E21B, 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 Office of Management and Budget (OMB) control number. The control number for this project is 0930-0208.

Table of Contents

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A. RECORD MANAGEMENT

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

Client Type:

- ○ Treatment client
- ○ Client in recovery

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

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

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

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

3-month follow-up ***[ADOLESCENT PORTFOLIO ONLY]***:
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. BEHAVIORAL HEALTH DIAGNOSES

[REPORTED BY PROGRAM STAFF.]

Please indicate the client'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, Fifth Edition* (DSM-5), descriptors. Select up to three diagnoses. For each diagnosis selected, please indicate whether it is primary, secondary, or tertiary, if known. Only one diagnosis can be primary, only one can be secondary, and only one can be tertiary.

Behavioral Health Diagnoses	Diagnosed?	For each diagnosis selected, please indicate whether the diagnosis is primary, secondary, or tertiary, if known		
	Select up to 3	Primary	Secondary	Tertiary
SUBSTANCE USE DISORDER DIAGNOSES				
Alcohol-related disorders				
F10.10 – Alcohol use disorder, uncomplicated, mild	☐	☐	☐	☐
F10.11 – Alcohol use disorder, mild, in remission	☐	☐	☐	☐
F10.20 – Alcohol use disorder, uncomplicated, moderate/severe	☐	☐	☐	☐
F10.21 – Alcohol use disorder, moderate/severe, in remission	☐	☐	☐	☐
F10.9 – Alcohol use, unspecified	☐	☐	☐	☐
Opioid-related disorders				
F11.10 – Opioid use disorder, uncomplicated, mild	☐	☐	☐	☐
F11.11 – Opioid use disorder, mild, in remission	☐	☐	☐	☐
F11.20 – Opioid use disorder, uncomplicated, moderate/severe	☐	☐	☐	☐
F11.21 – Opioid use disorder, moderate/severe, in remission	☐	☐	☐	☐
F11.9 – Opioid use, unspecified	☐	☐	☐	☐
Cannabis-related disorders				
F12.10 – Cannabis use disorder, uncomplicated, mild	☐	☐	☐	☐
F12.11 – Cannabis use disorder, mild, in remission	☐	☐	☐	☐
F12.20 – Cannabis use disorder, uncomplicated, moderate/severe	☐	☐	☐	☐
F12.21 – Cannabis use disorder, moderate/severe, in remission	☐	☐	☐	☐
F12.9 – Cannabis use, unspecified	☐	☐	☐	☐
Sedative-, hypnotic-, or anxiolytic-related disorders	■	■	■	■
F13.10 – Sedative, hypnotic, or anxiolytic use disorder, uncomplicated, mild	☐	☐	☐	☐
F13.11 – Sedative, hypnotic, or anxiolytic use disorder, mild, in remission	☐	☐	☐	☐

A. BEHAVIORAL HEALTH DIAGNOSES (CONTINUED)

Behavioral Health Diagnoses	Diagnosed?	For each diagnosis selected, please indicate whether diagnosis is primary, secondary, or tertiary, if known		
	Select up to 3	Primary	Secondary	Tertiary
F13.20 – Sedative, hypnotic, or anxiolytic use disorder, uncomplicated, moderate/severe	☐	☐	☐	☐
F13.21 – Sedative, hypnotic, or anxiolytic use disorder, moderate/severe, in remission	☐	☐	☐	☐
F13.9 – Sedative, hypnotic, or anxiolytic use, unspecified	☐	☐	☐	☐
Cocaine-related disorders	■	■	■	■
F14.10 – Cocaine use disorder, uncomplicated, mild	☐	☐	☐	☐
F14.11 – Cocaine use disorder, mild, in remission	☐	☐	☐	☐
F14.20 – Cocaine use disorder, uncomplicated, moderate/severe	☐	☐	☐	☐
F14.21 – Cocaine use disorder, moderate/severe, in remission	☐	☐	☐	☐
F14.9 – Cocaine use, unspecified	☐	☐	☐	☐
Other stimulant-related disorders	■	■	■	■
F15.10 – Other stimulant use disorder, uncomplicated, mild	☐	☐	☐	☐
F15.11 – Other stimulant use disorder, mild, in remission	☐	☐	☐	☐
F15.20 – Other stimulant use disorder, uncomplicated, moderate/severe	☐	☐	☐	☐
F15.21 – Other stimulant use disorder, moderate/severe, in remission	☐	☐	☐	☐
F15.9 – Other stimulant use, unspecified	☐	☐	☐	☐
Hallucinogen-related disorders	■	■	■	■
F16.10 – Hallucinogen use disorder, uncomplicated, mild	☐	☐	☐	☐
F16.11 – Hallucinogen use disorder, mild, in remission	☐	☐	☐	☐
F16.20 – Hallucinogen use disorder, uncomplicated, moderate/severe	☐	☐	☐	☐
F16.21 – Hallucinogen use disorder moderate/severe, in remission	☐	☐	☐	☐
F16.9 – Hallucinogen use, unspecified	☐	☐	☐	☐
Inhalant-related disorders	■	■	■	■
F18.10 – Inhalant use disorder, uncomplicated, mild	☐	☐	☐	☐
F18.11 – Inhalant use disorder, mild, in remission	☐	☐	☐	☐
F18.20 – Inhalant use disorder, uncomplicated, moderate/severe	☐	☐	☐	☐
F18.21 – Inhalant use disorder, moderate/severe, in remission	☐	☐	☐	☐
F18.9 – Inhalant use, unspecified	☐	☐	☐	☐

A. BEHAVIORAL HEALTH DIAGNOSES (CONTINUED)

Behavioral Health Diagnoses	Diagnosed?	For each diagnosis selected, please indicate whether diagnosis is primary, secondary, or tertiary, if known		
	Select up to 3	Primary	Secondary	Tertiary
Other psychoactive substance–related disorders	■	■	■	■
F19.10 – Other psychoactive substance use disorder, uncomplicated, mild	□	□	□	□
F19.11 – Other psychoactive substance use disorder, in remission	□	□	□	□
F19.20 – Other psychoactive substance use disorder, uncomplicated, moderate/severe	□	□	□	□
F19.21 – Other psychoactive substance use disorder, moderate/severe, in remission	□	□	□	□
F19.9 – Other psychoactive substance use, unspecified	□	□	□	□
Nicotine dependence	■	■	■	■
F17.20 – Tobacco use disorder, mild/moderate/severe	□	□	□	□
F17.21 – Tobacco use disorder, mild/moderate/severe, in remission	□	□	□	□
MENTAL HEALTH DIAGNOSES				
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	□	□	□	□
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	□	□	□	□
F40–F48 – Anxiety, dissociative, stress-related, somatoform, and other nonpsychotic mental disorders	□	□	□	□
F50 – Eating disorders	□	□	□	□
F51 – Sleep disorders not due to a substance or known physiological condition	□	□	□	□
F60.2 – Antisocial personality disorder	□	□	□	□
F60.3 – Borderline personality disorder	□	□	□	□

A. BEHAVIORAL HEALTH DIAGNOSES (CONTINUED)

Behavioral Health Diagnoses	Diagnosed?	For each diagnosis selected, please indicate whether diagnosis is primary, secondary, or tertiary, if known		
	Select up to 3	Primary	Secondary	Tertiary
F60.0, F60.1, F60.4–F69 – Other personality disorders	☐	☐	☐	☐
F70–F79 – Intellectual disabilities	☐	☐	☐	☐
F80–F89 – Pervasive and specific developmental disorders	☐	☐	☐	☐
F90 – Attention-deficit hyperactivity disorders	☐	☐	☐	☐
F91 – Conduct disorders	☐	☐	☐	☐
F93 – Emotional disorders with onset specific to childhood	☐	☐	☐	☐
F94 – Disorders of social functioning with onset specific to childhood or adolescence	☐	☐	☐	☐
F95 – Tic disorder	☐	☐	☐	☐
F98 – Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence	☐	☐	☐	☐
F99 – Unspecified mental disorder	☐	☐	☐	☐

- ○ Don't know
- ○ None of the above

A. BEHAVIORAL HEALTH DIAGNOSES (CONTINUED)

1. **In the past 30 days, was this client diagnosed with an opioid use disorder?**

   - ○ Yes
   - ○ No ***[SKIP TO 2.]***
   - ○ Don't know ***[SKIP TO 2.]***

   a. ***[IF YES]*** **In the past 30 days, which U.S. Food and Drug Administration (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 days received |___|___|
   - ○ Client did not receive an FDA-approved medication for an opioid use disorder
   - ○ Don't know

2. **In the past 30 days, was this client diagnosed with an alcohol use disorder?**

   - ○ Yes
   - ○ No ***[SKIP TO 3 IF INTAKE. SKIP TO SECTION B IF FOLLOW-UP OR DISCHARGE.]***
   - ○ Don't know ***[SKIP TO 3 IF INTAKE. SKIP TO SECTION B IF FOLLOW-UP OR DISCHARGE.]***

   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 days 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
   - ○ Don't know

[FOLLOW-UP AND DISCHARGE INTERVIEWS: SKIP TO SECTION B.]

3. Was the client screened by your program for co-occurring mental health and substance use disorders?

- ○ YES
- ○ NO ***[SKIP 3a.]***

3a. ***[IF YES]*** **Did the client screen positive for co-occurring mental health and substance use disorders?**

- ○ YES
- ○ NO

[SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT) GRANTS CONTINUE. ALL OTHERS GO TO SECTION A, "PLANNED SERVICES."]

A. BEHAVIORAL HEALTH DIAGNOSES (CONTINUED)

THIS SECTION FOR SBIRT GRANTS ONLY [ITEMS 4, 4A, AND 5 REPORTED ONLY AT INTAKE/BASELINE].

4. How did the client screen for your SBIRT?

- ○ NEGATIVE
- ○ POSITIVE

4a. What was his/her screening score?

Alcohol Use Disorders Identification Test (AUDIT)	=	|____|____|
CAGE	=	|____|____|
Drug Abuse Screening Test (DAST)	=	|____|____|
DAST-10	=	|____|____|
National Institute on Alcohol Abuse and Alcoholism (NIAAA) Guide	=	|____|____|
Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)/Alcohol Subscore	=	|____|____|
Other (Specify)	=	|____|____|

_____

_____

_____

5. Was he/she willing to continue his/her participation in the SBIRT program?

- ○ YES
- ○ NO

A. PLANNED SERVICES

[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. ***[SELECT "YES" OR "NO" FOR EACH ONE.]***

[SELECT AT LEAST ONE MODALITY.]

Modality	Yes	No
1. Case Management	○	○
2. Day Treatment	○	○
3. Inpatient/Hospital (Other Than Detox)	○	○
4. Outpatient	○	○
5. Outreach	○	○
6. Intensive Outpatient	○	○
7. Methadone	○	○
8. Residential/Rehabilitation	○	○
9. Detoxification (Select Only One)		
A. Hospital Inpatient	○	○
B. Free-Standing Residential	○	○
C. Ambulatory Detoxification	○	○
10. After Care	○	○
11. Recovery Support	○	○
12. Other (Specify)	○	○

[SELECT AT LEAST ONE SERVICE.]

Treatment Services	Yes	No
[SBIRT GRANTS: YOU MUST SELECT "YES" FOR AT LEAST ONE OF THE TREATMENT SERVICES NUMBERED 1–4.]		
1. Screening	○	○
2. Brief Intervention	○	○
3. Brief Treatment	○	○
4. Referral to Treatment	○	○
5. Assessment	○	○
6. Treatment/Recovery Planning	○	○
7. Individual Counseling	○	○
8. Group Counseling	○	○
9. Family/Marriage Counseling	○	○
10. Co-Occurring Treatment/ Recovery Services	○	○
11. Pharmacological Interventions	○	○
12. HIV/AIDS Counseling	○	○
13. Other Clinical Services (Specify)	○	○

Case Management Services	Yes	No
1. Family Services (Including 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 Service	○	○
7. Supportive Transitional Drug-Free Housing Services	○	○
8. Other Case Management Services (Specify)	○	○

Medical Services	Yes	No
1. Medical Care	○	○
2. Alcohol/Drug Testing	○	○
3. HIV/AIDS Medical Support and Testing	○	○
4. Other Medical Services (Specify)	○	○

After Care Services	Yes	No
1. Continuing Care	○	○
2. Relapse Prevention	○	○
3. Recovery Coaching	○	○
4. Self-Help and Support Groups	○	○
5. Spiritual Support	○	○
6. Other After Care Services (Specify)	○	○

Education Services	Yes	No
1. Substance Abuse Education	○	○
2. HIV/AIDS Education	○	○
3. Other Education Services (Specify)	○	○

Peer-to-Peer Recovery Support Services	Yes	No
1. Peer Coaching or Mentoring	○	○
2. Housing Support	○	○
3. Alcohol- and Drug-Free Social Activities	○	○
4. Information and Referral	○	○
5. Other Peer-to-Peer Recovery Support Services (Specify)	○	○

A. DEMOGRAPHICS

[ASKED ONLY AT INTAKE/BASELINE.]

1. **What is your gender?**

- ○ MALE
- ○ FEMALE
- ○ TRANSGENDER
- ○ OTHER (SPECIFY)
- ○ REFUSED

2. **Are you Hispanic or Latino?**

- ○ YES
- ○ NO
- ○ REFUSED

***[IF YES]* What ethnic group do you consider yourself? Please answer yes or no for each of the following. You may say yes to more than one.**

Ethnic Group	**Yes**	**No**	**Refused**	
Central American	○	○	○	
Cuban	○	○	○	
Dominican	○	○	○	
Mexican	○	○	○	
Puerto Rican	○	○	○	
South American	○	○	○	
Other	○	○	○	***[IF YES, SPECIFY BELOW.]***

(SPECIFY) _____

3. **What is your race? Please answer yes or no for each of the following. You may say yes to more than one.**

Race	**Yes**	**No**	**Refused**
Black or African American	○	○	○
Asian	○	○	○
Native Hawaiian or other Pacific Islander	○	○	○
Alaska Native	○	○	○
White	○	○	○
American Indian	○	○	○

4. **What is your date of birth?***

|____|____| / |____|____| ***[*THE SYSTEM WILL ONLY SAVE MONTH AND YEAR. TO MAINTAIN CONFIDENTIALITY, DAY IS NOT SAVED.]***
Month Day

|____|____|____|____|
Year

- ○ REFUSED

A. MILITARY FAMILY AND DEPLOYMENT

5. **Have you ever served in the Armed Forces, in the Reserves, or in the National Guard? *[IF SERVED]* In which area, the Armed Forces, Reserves, or National Guard did you serve?**

- ○ NO
- ○ YES, IN THE ARMED FORCES
- ○ YES, IN THE RESERVES
- ○ YES, IN THE NATIONAL GUARD
- ○ REFUSED
- ○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO QUESTION A6.]

5a. Are you currently on active duty in the Armed Forces, in the Reserves, or in the National Guard? *[IF ACTIVE]* In which area, the Armed Forces, Reserves, or National Guard?

- ○ NO, SEPARATED OR RETIRED FROM THE ARMED FORCES, RESERVES, OR NATIONAL GUARD
- ○ YES, IN THE ARMED FORCES
- ○ YES, IN THE RESERVES
- ○ YES, IN THE NATIONAL GUARD
- ○ REFUSED
- ○ DON'T KNOW

5b. Have you ever been deployed to a combat zone? *[CHECK ALL THAT APPLY.]*

- ○ NEVER DEPLOYED
- ○ IRAQ OR AFGHANISTAN (E.G., Operation Enduring Freedom [OEF]/ Operation Iraqi Freedom [OIF]/ Operation New Dawn [OND])
- ○ PERSIAN GULF (OPERATION DESERT SHIELD/DESERT STORM)
- ○ VIETNAM/SOUTHEAST ASIA
- ○ KOREA
- ○ WWII
- ○ DEPLOYED TO A COMBAT ZONE NOT LISTED ABOVE (E.G., BOSNIA/SOMALIA)
- ○ REFUSED
- ○ DON'T KNOW

[SBIRT GRANTEES: FOR CLIENTS WHO SCREENED NEGATIVE, THE INTAKE INTERVIEW IS NOW COMPLETE.]

A. MILITARY FAMILY AND DEPLOYMENT (CONTINUED)

6. **Is anyone in your family or someone close to you on active duty in the Armed Forces, in the Reserves, or in the National Guard or separated or retired from the Armed Forces, Reserves, or National Guard?**

- ○ NO
- ○ YES, ONLY ONE
- ○ YES, MORE THAN ONE
- ○ REFUSED
- ○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO SECTION B.]

[IF YES, ANSWER FOR UP TO 6 PEOPLE.] **What is the relationship of that person (Service Member) to you?** ***[WRITE RELATIONSHIP IN COLUMN HEADING.]***

1 = Mother 2 = Father
3 = Brother 4 = Sister
5 = Spouse 6 = Partner
7 = Child 8 = Other (Specify) _____

Has the Service Member experienced any of the following? ***[CHECK ANSWER IN APPROPRIATE COLUMN FOR ALL THAT APPLY.]***	_____ **(Relationship) 1.**	_____ **(Relationship) 2.**	_____ **(Relationship) 3.**	_____ **(Relationship) 4.**	_____ **(Relationship) 5.**	_____ **(Relationship) 6.**
6a. Deployed in support of combat operations (e.g., Iraq or Afghanistan)?	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO REFUSED DON'T KNOW
6b. Was physically injured during combat operations?	YES NO REFUSED DON'T KNOW	YES NO REFUSED DON'T KNOW	YES NO REFUSED DON'T KNOW	YES NO REFUSED DON'T KNOW	YES NO REFUSED DON'T KNOW	YES NO REFUSED DON'T KNOW
6c. Developed combat stress symptoms/difficulties adjusting following deployment, including post-traumatic stress disorder (PTSD), depression, or suicidal thoughts?	YES NO REFUSED DON'T KNOW	YES NO REFUSED DON'T KNOW	YES NO REFUSED DON'T KNOW	YES NO REFUSED DON'T KNOW	YES NO REFUSED DON'T KNOW	YES NO REFUSED DON'T KNOW
6d. Died or was killed?	YES NO REFUSED DON'T KNOW	YES NO REFUSED DON'T KNOW	YES NO REFUSED DON'T KNOW	YES NO REFUSED DON'T KNOW	YES NO REFUSED DON'T KNOW	YES NO REFUSED DON'T KNOW

B. DRUG AND ALCOHOL USE

	Number of Days	REFUSED	DON'T KNOW
1. During the past 30 days, how many days have you used the following:			
a. Any alcohol ***[IF ZERO, SKIP TO ITEM B1c.]***	|____|____|		
b1. Alcohol to intoxication (5+ drinks in one sitting)	|____|____|		
b2. Alcohol to intoxication (4 or fewer drinks in one sitting and felt high)	|____|____|		
c. Illegal drugs ***[IF B1a <u>OR</u> B1c = 0, REFUSED (RF), DON'T KNOW (DK), THEN SKIP TO ITEM B2.]***	|____|____|		
d. Both alcohol and drugs (on the same day)	|____|____|		

Route of Administration Types:
1. Oral 2. Nasal 3. Smoking 4. Non-intravenous (IV) injection 5. IV
*NOTE THE USUAL ROUTE. FOR MORE THAN ONE ROUTE, CHOOSE THE MOST SEVERE. THE ROUTES ARE LISTED FROM LEAST SEVERE (1) TO MOST SEVERE (5).

	Number of Days	RF	DK	Route*	RF	DK
2. During the past 30 days, how many days have you used any of the following: *[IF THE VALUE IN ANY ITEM B2a–B2i > 0, THEN THE VALUE IN B1c MUST BE > 0.]*						
a. Cocaine/Crack	|____|____|					
	|____|					
b. Marijuana/Hashish (Pot, Joints, Blunts, Chronic, Weed, Mary Jane)	|____|____|					
	|____|					

c. Opiates:

1. Heroin (Smack, H, Junk, Skag) |____|____|

|____|

2. Morphine |____|____|

|____|

3. Dilaudid |____|____|

|____|

4. Demerol |____|____|

|____|

5. Percocet |____|____|

|____|

6. Darvon |____|____|

|____|

7. Codeine |____|____|

|____|

8. Tylenol 2, 3, 4 |____|____|

|____|

9. OxyContin/Oxycodone |____|____|

|____|

d. Non-prescription methadone |____|____|

|____|

e. Hallucinogens/psychedelics, PCP (Angel Dust, Ozone, Wack, Rocket Fuel), MDMA (Ecstasy, XTC, X, Adam), LSD (Acid, Boomers, Yellow Sunshine), Mushrooms, or Mescaline
|____|____|

|____|

f. Methamphetamine or other amphetamines (Meth, Uppers, Speed, Ice, Chalk, Crystal, Glass, Fire, Crank) |____|____|

|____|

B. DRUG AND ALCOHOL USE (CONTINUED)

Route of Administration Types:
1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV
*NOTE THE USUAL ROUTE. FOR MORE THAN ONE ROUTE, CHOOSE THE MOST SEVERE. THE ROUTES ARE LISTED FROM LEAST SEVERE (1) TO MOST SEVERE (5).

2. During the past 30 days, how many days have you used any of the following: *[IF THE VALUE IN ANY ITEM B2a–B2i > 0, THEN THE VALUE IN B1c MUST BE > 0.]*

	Number of Days	RF	DK	Route*	RF	DK
g. 1. Benzodiazepines: Diazepam (Valium); Alprazolam (Xanax); Triazolam (Halcion); and Estasolam (Prosom and Rohypnol, also known as roofies, roche, and cope)	|___|___|		|___|___|		

|____|

2. Barbiturates: Mephobarbital (Mebacut) and pentobarbital sodium (Nembutal) |____|____|

|____|

3. Non-prescription GHB (known as Grievous Bodily Harm, Liquid Ecstasy, and Georgia Home Boy) |____|____|

|____|

4. Ketamine (known as Special K or Vitamin K) |____|____|

|____|

5. Other tranquilizers, downers, sedatives, or hypnotics |____|____|

|____|

h. Inhalants (poppers, snappers, rush, whippets) |____|____|

|____|

i. Other illegal drugs (Specify) |____|____|

|____|

3. In the past 30 days, have you injected drugs? ***[IF ANY ROUTE OF ADMINISTRATION IN B2a–B2i = 4 or 5, THEN B3 MUST = YES.]***

YES
NO
REFUSED
DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO SECTION C.]

4. In the past 30 days, how often did you use a syringe/needle, cooker, cotton, or water that someone else used?

Always
More than half the time
Half the time
Less than half the time
Never
REFUSED
DON'T KNOW

C. FAMILY AND 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/RENT APARTMENT, ROOM, OR HOUSE
- SOMEONE ELSE'S APARTMENT, ROOM, OR HOUSE
- DORMITORY/COLLEGE RESIDENCE
- HALFWAY HOUSE
- RESIDENTIAL TREATMENT
- OTHER HOUSED (SPECIFY)

REFUSED
DON'T KNOW

2. **How satisfied are you with the conditions of your living space?**

Very dissatisfied
Dissatisfied
Neither satisfied nor dissatisfied
Satisfied
Very satisfied
REFUSED
DON'T KNOW

3. **During the past 30 days, how stressful have things been for you because of your use of alcohol or other drugs?** ***[IF B1a <u>OR</u> B1c > 0, THEN C3 CANNOT = "NOT APPLICABLE."]***

Not at all
Somewhat
Considerably
Extremely
NOT APPLICABLE ***[USE ONLY IF B1A <u>AND</u> B1C = 0.]***

REFUSED
DON'T KNOW

4. **During the past 30 days, has your use of alcohol or other drugs caused you to reduce or give up important activities?** ***[IF B1a <u>OR</u> B1c > 0, THEN C4 CANNOT = "NOT APPLICABLE."]***

Not at all
Somewhat
Considerably
Extremely
NOT APPLICABLE ***[USE ONLY IF B1A <u>AND</u> B1C = 0.]***
REFUSED
DON'T KNOW

C. FAMILY AND LIVING CONDITIONS (CONTINUED)

5. **During the past 30 days, has your use of alcohol or other drugs caused you to have emotional problems?** ***[IF B1a OR B1c > 0, THEN C5 CANNOT = "NOT APPLICABLE."]***

Not at all
Somewhat
Considerably
Extremely
NOT APPLICABLE ***[USE ONLY IF B1a AND B1c = 0.]***
REFUSED
DON'T KNOW

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

YES
NO
REFUSED
DON'T KNOW

7. **Do you have children?**

YES
NO
REFUSED
DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO SECTION D.]

a. How many children do you have? ***[IF C7 = YES, THEN THE VALUE IN C7a MUST BE > 0.]***

|____|____| REFUSED DON'T KNOW

b. Are any of your children living with someone else due to a child protection court order?

YES
NO
REFUSED
DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO ITEM C7D.]

c. ***[IF YES]*** **How many of your children are living with someone else due to a child protection court order?** ***[THE VALUE IN C7c CANNOT EXCEED THE VALUE IN C7a.]***

|____|____| REFUSED DON'T KNOW

d. **For how many of your children have you lost parental rights?** ***[THE CLIENT'S PARENTAL RIGHTS WERE TERMINATED.] [THE VALUE IN ITEM C7d CANNOT EXCEED THE VALUE IN C7a.]***

|___|___| REFUSED DON'T KNOW

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
OTHER (SPECIFY)
REFUSED
DON'T KNOW

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

NEVER ATTENDED
1ST GRADE
2ND GRADE
3RD GRADE
4TH GRADE
5TH GRADE
6TH GRADE
7TH GRADE
8TH GRADE
9TH GRADE
10TH GRADE
11TH GRADE
12TH GRADE/HIGH SCHOOL DIPLOMA/EQUIVALENT
COLLEGE OR UNIVERSITY/1ST YEAR COMPLETED
COLLEGE OR UNIVERSITY/2ND YEAR COMPLETED/ASSOCIATE'S DEGREE (AA, AS)
COLLEGE OR UNIVERSITY/3RD YEAR COMPLETED
BACHELOR'S DEGREE (BA, BS) OR HIGHER
VOCATIONAL/TECHNICAL (VOC/TECH) PROGRAM AFTER HIGH SCHOOL BUT NO VOC/TECH DIPLOMA
VOC/TECH DIPLOMA AFTER HIGH SCHOOL
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 "ENROLLED, FULL TIME" IN D1 AND INDICATES "EMPLOYED, FULL TIME" IN D3, ASK FOR CLARIFICATION. IF CLIENT IS INCARCERATED AND HAS NO WORK OUTSIDE OF JAIL, CODE D3 AS "UNEMPLOYED, NOT LOOKING FOR WORK."]***

EMPLOYED, FULL TIME (35+ HOURS PER WEEK, OR WOULD HAVE BEEN)
EMPLOYED, PART TIME

UNEMPLOYED, LOOKING FOR WORK
UNEMPLOYED, DISABLED
UNEMPLOYED, VOLUNTEER WORK
UNEMPLOYED, RETIRED
UNEMPLOYED, NOT LOOKING FOR WORK
OTHER (SPECIFY)
REFUSED
DON'T KNOW

D. EDUCATION, EMPLOYMENT, AND INCOME (CONTINUED)

4. **Approximately, how much money did YOU receive (pre-tax individual income) in the past 30 days from …** ***[IF D3 DOES NOT = "EMPLOYED" AND THE VALUE IN D4a IS GREATER THAN ZERO, PROBE. IF D3 = "UNEMPLOYED, LOOKING FOR WORK" AND THE VALUE IN D4b = 0, PROBE. IF D3 = "UNEMPLOYED, RETIRED" AND THE VALUE IN D4c = 0, PROBE. IF D3 = "UNEMPLOYED, DISABLED" AND THE VALUE IN D4d = 0, PROBE.]***

			RF	**DK**
a.	Wages	$ |__|__|__| , |__|__|__|		
b.	Public assistance	$ |__|__|__| , |__|__|__|		
c.	Retirement	$ |__|__|__| , |__|__|__|		
d.	Disability	$ |__|__|__| , |__|__|__|		
e.	Non-legal income	$ |__|__|__| , |__|__|__|		
f.	Family and/or friends	$ |__|__|__| , |__|__|__|		
g.	Other (Specify) _____	$ |__|__|__| , |__|__|__|		

5. Have you enough money to meet your needs?

Not at all
A little
Moderately
Mostly
Completely
REFUSED
DON'T KNOW

E. CRIME AND CRIMINAL JUSTICE STATUS

1. **In the past 30 days, how many times have you been arrested?**

|____|____| TIMES REFUSED DON'T KNOW

[IF NO ARRESTS, SKIP TO ITEM E3.]

2. **In the past 30 days, how many times have you been arrested for drug-related offenses?** ***[THE VALUE IN E2 CANNOT BE GREATER THAN THE VALUE IN E1.]***

|____|____| TIMES REFUSED DON'T KNOW

3. **In the past 30 days, how many nights have you spent in jail/prison?** ***[IF THE VALUE IN E3 IS GREATER THAN 15, THEN C1 MUST = INSTITUTION (JAIL/PRISON). IF C1 = INSTITUTION (JAIL/PRISON), THEN THE VALUE IN E3 MUST BE GREATER THAN OR EQUAL TO 15.]***

|____|____| NIGHTS REFUSED DON'T KNOW

4. **In the past 30 days, how many times have you committed a crime?** ***[CHECK NUMBER OF DAYS USED ILLEGAL DRUGS IN ITEM B1c. ANSWER HERE IN E4 SHOULD BE EQUAL TO OR GREATER THAN NUMBER IN B1c BECAUSE USING ILLEGAL DRUGS IS A CRIME.]***

|____|____|____| TIMES REFUSED DON'T KNOW

5. **Are you currently awaiting charges, trial, or sentencing?**

YES
NO
REFUSED
DON'T KNOW

6. **Are you currently on parole or probation?**

YES
NO
REFUSED
DON'T KNOW

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY

1. **How would you rate your overall health right now?**

Excellent
Very good
Good
Fair
Poor
REFUSED
DON'T KNOW

2. **During the past 30 days, did you receive:**

a. Inpatient treatment for:	**YES**	***[IF YES]*** **Altogether for how many nights**	**NO**	**RF**	**DK**
i. Physical complaint		nights			
ii. Mental or emotional difficulties		nights			
iii. Alcohol or substance abuse		nights			

b. Outpatient treatment for:	**YES**	***[IF YES]*** **Altogether for how many times**	**NO**	**RF**	**DK**

i. Physical complaint times
ii. Mental or emotional difficulties times
iii. Alcohol or substance abuse times

c. Emergency room treatment for:

	YES	*[IF YES]* Altogether for how many times	NO	RF	DK
i. Physical complaint		times			
ii. Mental or emotional difficulties		times			
iii. Alcohol or substance abuse		times			

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

3. **During the past 30 days, did you engage in sexual activity?**

Yes
No ***[SKIP TO F4.]***
NOT PERMITTED TO ASK ***[SKIP TO F4.]***
REFUSED ***[SKIP TO F4.]***
DON'T KNOW ***[SKIP TO F4.]***

[IF YES] **Altogether, how many:**

	Contacts	RF	DK
a. Sexual contacts (vaginal, oral, or anal) did you have? |____|____|			
b. Unprotected sexual contacts did you have? ***[THE VALUE IN F3b SHOULD NOT BE GREATER THAN THE VALUE IN F3a.] [IF ZERO, SKIP TO F4.]*** |____|____|____|			

c. Unprotected sexual contacts were with an individual who is or was ***[NONE OF THE VALUES IN F3c1–F3c3 CAN BE GREATER THAN THE VALUE IN F3b.]***

1. HIV positive or has AIDS |____|____|____|
2. An injection drug user |____|____|____|
3. High on some substance |____|____|____|

4. **Have you ever been tested for HIV?**

Yes ***[GO TO F4a.]***

No ***[SKIP TO F5.]***
REFUSED ***[SKIP TO F5.]***
DON'T KNOW ***[SKIP TO F5.]***

a. Do you know the results of your HIV testing?

Yes
No

5. **How would you rate your quality of life?**

Very poor
Poor
Neither poor nor good
Good
Very good
REFUSED
DON'T KNOW

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

6. **How satisfied are you with your health?**

Very dissatisfied
Dissatisfied
Neither satisfied nor dissatisfied
Satisfied
Very satisfied
REFUSED
DON'T KNOW

7. **Do you have enough energy for everyday life?**

Not at all
A little
Moderately
Mostly
Completely
REFUSED
DON'T KNOW

8. **How satisfied are you with your ability to perform your daily activities?**

Very dissatisfied
Dissatisfied
Neither satisfied nor dissatisfied
Satisfied
Very satisfied
REFUSED
DON'T KNOW

9. **How satisfied are you with yourself?**

Very dissatisfied
Dissatisfied
Neither satisfied nor dissatisfied
Satisfied
Very satisfied
REFUSED
DON'T KNOW

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

10. **In the past 30 days, not due to your use of alcohol or drugs, how many days have you:**

		Days	RF	DK
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 ZERO DAYS, RF, OR DK TO <u>ALL</u> ITEMS IN QUESTION F10, SKIP TO ITEM F12.]

11. **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
DON'T KNOW

F. VIOLENCE AND TRAUMA

12. **Have you ever experienced violence or trauma in any setting (including community or school violence; domestic violence; physical, psychological, or sexual maltreatment/assault within or outside of the family; natural disaster; terrorism; neglect; or traumatic grief)?**

YES
NO
REFUSED
DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO ITEM F13.]

Did any of these experiences feel so frightening, horrible, or upsetting that, in the past and/or the present, you:

12a. Have had nightmares about it or thought about it when you did not want to?

YES
NO
REFUSED
DON'T KNOW

F. VIOLENCE AND TRAUMA (CONTINUED)

12b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?

YES
NO
REFUSED
DON'T KNOW

12c. Were constantly on guard, watchful, or easily startled?

YES
NO
REFUSED
DON'T KNOW

12d. Felt numb and detached from others, activities, or your surroundings?

YES
NO
REFUSED
DON'T KNOW

13. **In the past 30 days, how often have you been hit, kicked, slapped, or otherwise physically hurt?**

Never
A few times
More than a few times
REFUSED
DON'T KNOW

G. SOCIAL CONNECTEDNESS

1. **In the past 30 days, did you attend any voluntary self-help groups for recovery that were not affiliated with a religious or faith-based organization? In other words, did you participate in a nonprofessional, peer-operated organization that is devoted to helping individuals who have addiction-related problems, such as Alcoholics Anonymous, Narcotics Anonymous, Oxford House, Secular Organization for Sobriety, or Women for Sobriety, etc.?**

YES
|____|____|
NO
REFUSED
DON'T KNOW

[IF YES] SPECIFY HOW MANY TIMES
REFUSED DON'T KNOW

2. **In the past 30 days, did you attend any religious/faith-affiliated recovery self-help groups?**

YES
|____|____|
NO
REFUSED
DON'T KNOW

[IF YES] SPECIFY HOW MANY TIMES
REFUSED DON'T KNOW

3. **In the past 30 days, did you attend meetings of organizations that support recovery other than the organizations described above?**

YES
|____|____|
NO
REFUSED
DON'T KNOW

[IF YES] SPECIFY HOW MANY TIMES
REFUSED DON'T KNOW

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

YES
NO
REFUSED
DON'T KNOW

5. **To whom do you turn when you are having trouble? *[SELECT ONLY ONE.]***

NO ONE
CLERGY MEMBER
FAMILY MEMBER
FRIENDS
REFUSED
DON'T KNOW
OTHER (SPECIFY)

6. **How satisfied are you with your personal relationships?**

Very dissatisfied

Dissatisfied
Neither satisfied nor dissatisfied
Satisfied
Very satisfied
REFUSED
DON'T KNOW

H. PROGRAM-SPECIFIC QUESTIONS

YOU ARE NOT RESPONSIBLE FOR COLLECTING DATA ON ALL SECTION H QUESTIONS. YOUR GOVERNMENT PROJECT OFFICER (GPO) HAS PROVIDED 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)
   Client avoided out-of-home placement for child (or children)
   None of the above
   Don't know

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
Supplemental Security Income (SSI)/ Social Security disability insurance (SSDI)
Temporary Assistance for Needy Families (TANF)
Supplemental Nutrition Assistance Program (SNAP)
Other (Specify) _____
NONE OF THE ABOVE
REFUSED
DON'T KNOW

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?

Status	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 □ DON'T KNOW □ REFUSED	□ Yes □ No □ DON'T KNOW □ REFUSED
1b. Enrolled in vocational training	□ Yes □ No □ DON'T KNOW □ REFUSED	□ Yes □ No □ DON'T KNOW □ REFUSED
1c. Currently employed	□ Yes □ No □ DON'T KNOW □ REFUSED	□ Yes □ No □ DON'T KNOW □ REFUSED
1d. Living in stable housing	□ Yes □ No □ DON'T KNOW □ REFUSED	□ Yes □ No □ DON'T KNOW □ 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 nonresidential setting has enabled me to maintain parenting and family responsibilities while receiving treatment.

Strongly disagree
Disagree
Undecided
Agree
Strongly agree
REFUSED
DON'T KNOW

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
DON'T KNOW

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 with 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
DON'T KNOW

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
DON'T KNOW

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
Other (Specify) _____
Don't know

[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	Don't Know
Brief Intervention			
Brief Treatment			
Referral to Treatment			

[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	Don't Know
Brief Intervention			
Brief Treatment			
Referral to Treatment			

H7. PROGRAM-SPECIFIC QUESTIONS

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

1. Did the program provide the following?

a. HIV test

YES
NO ***[SKIP TO H1b.]***
REFUSED ***[SKIP TO H1b.]***
DON'T KNOW ***[SKIP TO H1b.]***

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

Positive
Negative ***[SKIP TO H1b.]***
Indeterminate ***[SKIP TO H1b.]***
REFUSED ***[SKIP TO H1b.]***
DON'T KNOW ***[SKIP TO H1b.]***

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

- Yes
- No
- REFUSED
- DON'T KNOW

b. Hepatitis B (HBV) test

YES
NO ***[SKIP TO H1c.]***
REFUSED ***[SKIP TO H1c.]***
DON'T KNOW ***[SKIP TO H1c.]***

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

Positive
Negative [***SKIP TO H1c.]***
Indeterminate [***SKIP TO H1c.]***
REFUSED [***SKIP TO H1c.]***
DON'T KNOW [***SKIP TO H1c.]***

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

- Yes
- No
- REFUSED
- DON'T KNOW

H7. PROGRAM-SPECIFIC QUESTIONS (CONTINUED)

c. Hepatitis C (HCV) test

YES
NO ***[SKIP TO SECTION I OR J/K.]***
REFUSED ***[SKIP TO SECTION I OR J/K.]***
DON'T KNOW ***[SKIP TO SECTION I OR J/K.]***

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

Positive
Negative ***[SKIP TO SECTION I OR J/K.]***
Indeterminate ***[SKIP TO SECTION I OR J/K.]***
REFUSED ***[SKIP TO SECTION I OR J/K.]***
DON'T KNOW ***[SKIP TO SECTION I OR J/K.]***

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

- Yes
- No
- REFUSED
- DON'T KNOW

H8. PROGRAM-SPECIFIC QUESTIONS

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

1. **Have you achieved any of the following since you began receiving peer services through *[INSERT GRANTEE NAME]*? If yes, do you believe that the peer services you received from *[INSERT GRANTEE NAME]* helped you with this achievement?**

Status	Achieved?	If yes, do you believe that the peer services you received from *[INSERT GRANTEE NAME]* helped you with this achievement?
1a. Enrolled in school	☐ Yes ☐ No ☐ DON'T KNOW ☐ REFUSED	☐ Yes ☐ No ☐ DON'T KNOW ☐ REFUSED
1b. Enrolled in vocational training	☐ Yes ☐ No ☐ DON'T KNOW ☐ REFUSED	☐ Yes ☐ No ☐ DON'T KNOW ☐ REFUSED
1c. Currently employed	☐ Yes ☐ No ☐ DON'T KNOW ☐ REFUSED	☐ Yes ☐ No ☐ DON'T KNOW ☐ REFUSED
1d. Living in stable housing	☐ Yes ☐ No ☐ DON'T KNOW ☐ REFUSED	☐ Yes ☐ No ☐ DON'T KNOW ☐ REFUSED

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

   To a great extent
   Somewhat
   Very little
   Not at all
   REFUSED
   DON'T KNOW

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
DON'T KNOW

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
DON'T KNOW

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
DON'T KNOW

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
DON’T KNOW

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 a mental health disorder?

Client screened positive
Client screened negative ***[SKIP TO H2.]***
Client was not screened ***[SKIP TO H2.]***
Don't know ***[SKIP TO H2.]***

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

Yes
No ***[SKIP TO H2.]***
Don't know ***[SKIP TO H2.]***

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

Yes
No
Don't know

[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 a substance use disorder?

Client screened positive
Client screened negative
Client was not screened
Don't know

[IF THIS IS AT INTAKE/BASELINE AND THE RESPONSE IS NEGATIVE, NOT SCREENED, OR DON'T KNOW, SECTION H IS DONE. IF THIS IS AT 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
Don't know

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

H10. PROGRAM-SPECIFIC QUESTIONS (CONTINUED)

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

Yes
No
Don't know

[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
DON'T KNOW

I. FOLLOW-UP STATUS

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

1. **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) _____

2. **Is the client still receiving services from your program?**

Yes
No

[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)

J. DISCHARGE STATUS (CONTINUED)

3. **Did the program test this client for HIV?**

Yes ***[SKIP TO SECTION K.]***
No ***[GO TO J4.]***

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

Yes
No

K. SERVICES RECEIVED

[REPORTED BY PROGRAM STAFF ABOUT CLIENT 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. YOU SHOULD HAVE AT LEAST ONE DAY FOR MODALITY.]***

Modality **Days**

1. Case Management |___|___|___|
2. Day Treatment |___|___|___|
3. Inpatient/Hospital (Other Than Detox) |___|___|___|
4. Outpatient |___|___|___|
5. Outreach |___|___|___|
6. Intensive Outpatient |___|___|___|
7. Methadone |___|___|___|
8. Residential/Rehabilitation |___|___|___|
9. Detoxification (Select Only One):

A. Hospital Inpatient |___|___|___|
B. Free-Standing Residential |___|___|___|
C. Ambulatory Detoxification |___|___|___|

10. After Care |___|___|___|
11. Recovery Support |___|___|___|
12. 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 1–4.]

1. Screening |___|___|___|
2. Brief Intervention |___|___|___|
3. Brief Treatment |___|___|___|
4. Referral to Treatment |___|___|___|
5. Assessment |___|___|___|
6. Treatment/Recovery Planning |___|___|___|
7. Individual Counseling |___|___|___|
8. Group Counseling |___|___|___|
9. Family/Marriage Counseling |___|___|___|
10. Co-Occurring Treatment/Recovery Services |___|___|___|
11. Pharmacological Interventions |___|___|___|
12. HIV/AIDS Counseling |___|___|___|
13. Other Clinical Services (Specify) |___|___|___|

Case Management Services **Sessions**

1. Family Services (Including 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 Service |___|___|___|
7. Supportive Transitional Drug-Free Housing Services |___|___|___|
8. Other Case Management Services (Specify) |___|___|___|

Medical Services **Sessions**

1. Medical Care |___|___|___|
2. Alcohol/Drug Testing |___|___|___|
3. HIV/AIDS Medical Support and Testing |___|___|___|
4. Other Medical Services (Specify) |___|___|___|

After Care Services **Sessions**

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

Education Services **Sessions**

1. Substance Abuse Education |___|___|___|
2. HIV/AIDS Education |___|___|___|
3. Other Education Services (Specify) |___|___|___|

Peer-to-Peer Recovery Support Services Sessions

1. Peer Coaching or Mentoring |___|___|___|
2. Housing Support |___|___|___|
3. Alcohol- and Drug-Free Social Activities |___|___|___|
4. Information and Referral |___|___|___|
5. Other Peer-to-Peer Recovery Support Services (Specify) |___|___|___|

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