

A. RECORD MANAGEMENT

SUPRT-A forms should be completed ***independently*** by grantee staff using information from the client's Electronic Health Record or other client recordkeeping system.

Client ID: _____

Staff Name: _____

Staff's Email: _____

Agency Name: _____

Region/PIHP (If applicable: Region 1 – 10): _____

A3. Which assessment type?

- Annual (for clients in care for more than 12 months)

A2. What is the date of the assessment? (MM/DD/YYYY)?

_____/_____/_____

A5. When did the client most recently receive services under this grant

(MM/YYYY)?

_____/_____

B. BEHAVIORAL HEALTH HISTORY

B1. What insurance does the client or guarantor have? SELECT ALL THAT APPLY

- Medicare
- Medicaid
- Private Insurance or Employer Provided
- TRICARE, CHAMPUS, CHAMPVA or other veteran or military health care
- Indian Health Service Tribal Health Care
- An assistance program [for example, a medication assistance program]
- Any other type of health insurance or health coverage plan
- None
- Not documented in records or not documented in records using this standard

B2. In the past 30 days, was the client admitted to a hospital?

- Yes – Behavioral health reasons, for example mental health or substance use disorder
- Yes – Other health reasons, for example injury or illness
- No
- Not documented in records or not documented in records using this standard

B3. In the past 30 days, did the client visit an emergency department?

- Yes – Behavioral health reasons, for example mental health or substance use disorder
- Yes – Other health reasons, for example injury or illness
- No
- Not documented in records or not documented in records using this standard

B4. In the past 30 days, did the client experience a behavioral health crisis or request crisis response, for example from 988 or 911?

- Yes
- No
- Not documented in records or not documented in records using this standard

B4a. [IF QUESTION B4 IS YES] What is the primary crisis issue?

- Suicide risk
- Other risk of harm to self or others (e.g. NSSI, homicidal thoughts)
- Mental Health
- Substance use other than overdose
- Overdose
- Other
- Not documented in records or not documented in records using this standard

B5. In the past 30 days, did the client spend one or more nights at a residential behavioral health treatment facility, for example crisis stabilization or residential substance use disorder treatment facility, including for withdrawal management?

- Yes
- No
- Not documented in records or not documented in records using this standard

B6. In the past 90 days, was the client arrested, taken into custody, or detained?

- Yes
- No
- Not applicable
- Not documented in records or not documented in records using this standard

B7. In the past 90 days, did the client spend one or more nights in jail or a correctional facility?

- Yes
- No
- Not applicable
- Not documented in records or not documented in records using this standard

B8. In the past 90 days, has the client been on probation, parole, or intensive pretrial supervision for one or more days?

- Yes
- No
- Not applicable
- Not documented in records or not documented in records using this standard

C. BEHAVIORAL HEALTH SCREENINGS

Please indicate the client’s screening results, as documented in an individual clinical or client record (whether paper or electronic).

C1. Within the past 30 days, was the client screened or assessed by your program for risk of suicidality?

- Yes – Screening result was negative (no or low risk)
- Yes – Screening result was positive (at risk)
- No, not screened or assessed
- Not documented in records or not documented in records using this standard

C2. Within the past 30 days, was the client screened or assessed by your program for substance use?

- Yes – Screening result was negative (no or low risk for substance use disorder (SUD))
- Yes – Screening result was positive (at risk for SUD)
- No, not screened or assessed
- Not documented in records or not documented in records using this standard

C3. [IF QUESTION C2 IS “YES”] During the screening and assessment process, what was the reported use for the following substances?

		Recent use (Within the past 30 days)	Past use (greater than 30 days)	Never Used	Not documented
a.	Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b.	Opioids	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c.	Cannabis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

		Recent use (Within the past 30 days)	Past use (greater than 30 days)	Never Used	Not documented
d.	Sedative, hypnotic, or anxiolytics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e.	Cocaine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f.	Methamphetamine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g.	Other stimulants	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h.	Hallucinogens or psychedelics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i.	Inhalants	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j.	Other psychoactive substances	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k.	Tobacco or nicotine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

C4. Within the past 30 days, was the client screened or assessed by your program for the following disorders? (Please select one per disorder)

		Screened/assessed	Not screened	Not applicable	Not documented in records
a.	Depression, depressive disorders.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b.	Anxiety disorders.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c.	Bipolar disorders.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d.	Psychosis, psychotic disorders.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e.	Trauma disorders, including PTSD.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

D. BEHAVIORAL HEALTH DIAGNOSIS

Please indicate the client's current behavioral health diagnoses using the most current version of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes or corresponding Diagnostic Statistical Manual of Mental Disorders (e.g. DSM-5), as made by a clinician and documented in a clinical record.

D1. Substance use disorder diagnosis (record up to 3)

Enter ICD-10-CM/DSM-5 code F10-F19- or indicate no diagnosis

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Enter ICD-10-CM/DSM-5 code F10-F19- or indicate no diagnosis

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Enter ICD-10-CM/DSM-5 code F10-F19- or indicate no diagnosis

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No diagnosis

D2. Mental Health diagnosis (record up to 3)

Enter ICD-10-CM/DSM-5 code F20-F99- or indicate no diagnosis

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Enter ICD-10-CM/DSM-5 code F20-F99 - or indicate no diagnosis

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Enter ICD-10-CM/DSM-5 code F20-F99 - or indicate no diagnosis

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No diagnosis

D3. Other factors influencing health status (record up to 3)

Enter ICD-10-CM/DSM-5 code Z55-Z65 or Z69-Z76- or indicate no diagnosis

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Enter ICD-10-CM/DSM-5 code Z55-Z65 or Z69-Z76- or indicate no diagnosis

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Enter ICD-10-CM/DSM-5 code Z55-Z65 or Z69-Z76- or indicate no diagnosis

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No diagnosis

OTHER HEALTH STATUS QUESTIONS

Please indicate additional health status information as applicable and as documented in a clinical record.

D4. Is the client currently pregnant?

- Yes
- No
- Not applicable
- Not documented in records or not documented in records using this standard

D6. In the previous 30 days, did the client experience an overdose or take too much of a substance that resulted in needing supervision or medical attention?

- Yes
- No
- Not applicable
- Not documented in records or not documented in records using this standard

D6a. [IF QUESTION D6 IS YES] After taking too much of a substance or overdosing, what intervention(s) did the client receive?

- Naloxone (Narcan) or other opioid reversal medication
- Care in an emergency department
- Care from a primary care provider
- Admission to a hospital
- Supervision by someone else
- Other
- Not applicable
- Not documented in records, or not documented in records using this standard

E. SERVICES RECEIVED

Services received is collected by grantee staff at Reassessment, Annual Assessment, and Closeout

Identify all the services your grant project provided to the client since their previous assessment.

E1. Since the previous administrative assessment, did the project provide or refer the client for one or more behavioral health services? (e.g., Case management, substance use psychoeducation, group counseling, medication for substance use disorders)

- Yes
- No
- Not documented in records

E1a. [IF QUESTION E1 IS “YES”], Please indicate which:

		Yes – Provided	Referred to service	No – not provided or referred	Not documented in records/unknown
a.	Case or care management or coordination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b.	Person- or family-centered treatment planning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c.	Substance use psychoeducation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d.	Mental health psychoeducation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e.	Mental health therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f.	Co-occurring therapy (substance use & mental health)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g.	Group counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h.	Individual counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

		Yes – Provided	Referred to service	No – not provided or referred	Not documented in records/unknown
i.	Family counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j.	Psychiatric rehabilitation services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k.	Prescription medication for mental health disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l.	Medication for substance use disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m.	Intensive day treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
n.	Withdrawal management (whether in hospital, residential, or ambulatory)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
o.	After care planning and referrals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
p.	Co-occurring disorders (including developmental or neurologic)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

E2. [IF E1a_1 = MEDICATION FOR SUBSTANCE USE DISORDER IS YES – PROVIDED] Indicate medication received:

		Yes – received	No – not received	Not documented in records/unknown
a.	Naltrexone.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b.	Extended-release Naltrexone.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c.	Disulfiram.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d.	Acamprosate.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e.	Methadone.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f.	Buprenorphine....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g.	Nicotine cessation therapy (e.g.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

		Yes – received	No – not received	Not documented in records/unknown
	Nicotine patch, gum, lozenge).....			
h.	Bupropion.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i.	Varenicline.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j.	Other.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

CRISIS SERVICES

E3. Since the previous administrative assessment, did the project provide or refer the client for one or more crisis services?

- Yes
- No
- Not documented in records

E3a. [IF QUESTION E3 IS “YES”] Please indicate which:

		Yes – Provided	Referred to service	No – not provided or referred	Not documented in records/unknown
a.	Crisis response planning.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b.	Crisis response.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c.	Crisis stabilization.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d.	Crisis follow-up.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

E4. Since the previous administrative assessment, did the project provide or refer the client for one or more recovery support services? (e.g., Transportation, peer support services, or recovery housing)

- Yes
- No
- Not documented in records

E4a. [IF QUESTION E4 IS “YES”] Please indicate which:

		Yes – Provided	Referred to service	No – not provided or referred	Not documented in records/unknown
a.	Employment support.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b.	Family support services, including family peer support.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c.	Childcare.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d.	Transportation.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e.	Education Support.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f.	Housing support.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g.	Recovery housing.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h.	Spiritual, ceremonial, and/or traditional activities.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i.	Mutual support groups.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j.	Peer support specialist services, coaching, or mentoring.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k.	Respite care.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l.	Therapeutic foster care.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

INTEGRATED SERVICES

E5. Since the previous administrative assessment, did the project provide or refer the client for one or more integrated services? (e.g., Primary health care, dental care, STI testing)

- Yes
- No
- Not documented in records

E5a. [IF QUESTION E5 IS “YES”] Please indicate which:

		Yes – Provided	Referred to service	No – not provided or referred	Not documented in records/unknown
a.	Primary health care.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b.	Maternal health care or OB/GYN.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c.	HIV testing.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d.	Viral hepatitis testing.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e.	HIV treatment.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f.	HIV pre-exposure prophylaxis (PrEP).....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g.	Viral hepatitis treatment.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h.	Other STI testing or treatment.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i.	Dental care.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>