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?

O   <mark>Baseline</mark>

A1. What is the client's month and year of birth (MM/YYYY)

_____/_____

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

_____/_____/_____

A4. When did the client first receive services under this grant?

_____/_____

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

- O None

- O 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?

- O Yes – Behavioral health reasons, for example mental health or substance use disorder

- O Yes – Other health reasons, for example injury or illness

- O No

- O 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?

- O Yes – Behavioral health reasons, for example mental health or substance use disorder

- O Yes – Other health reasons, for example injury or illness

- O No

- O 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?

O   Yes

O   No

O   Not documented in records or not documented in records using this standard

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

O   Suicide risk

O   Other risk of harm to self or others (e.g. NSSI, homicidal thoughts)

O   Mental Health

O   Substance use other than overdose

O   Overdose

O   Other

O   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?

O   Yes

O   No

O   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?

O   Yes

O   No

O   Not applicable

O   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?

O   Yes

O   No

O   Not applicable

O   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?

O   Yes

O   No

O   Not applicable

O   Not documented in records or not documented in records using this standard

C. BEHAVIORAL HEALTH SCREENINGS

Please indicate the client's screening results, as <u>documented in an individual clinical or client record (whether paper or electronic).</u>

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

      O   Yes – Screening result was negative (no or low risk)

      O   Yes – Screening result was positive (at risk)

      O   No, not screened or assessed

      O   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?

      O   Yes – Screening result was negative (no or low risk for substance use disorder (SUD))

      O   Yes – Screening result was positive (at risk for SUD)

      O   No, not screened or assessed

      O   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	O	O	O	O
b.	Opioids	O	O	O	O
c.	Cannabis	O	O	O	O

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

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………	O	O	O	O
b.	Anxiety disorders…………	O	O	O	O
c.	Bipolar disorders…………	O	O	O	O
d.	Psychosis, psychotic disorders…………	O	O	O	O
e.	Trauma disorders, including PTSD……………	O	O	O	O

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), <u>as made by a clinician and documented in a clinical record.</u>

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

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

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

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

O No diagnosis

D2. Mental Health diagnosis (record up to 3)

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

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

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

O No diagnosis

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

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

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

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

O 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?

O   Yes

O   No

O   Not applicable

O   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?

O   Yes

O   No

O   Not applicable

O   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

O   Not applicable

O   Not documented in records, or not documented in records using this standard

F. DEMOGRAPHICS

Demographics is collected by grantee staff at Baseline **only** if the Client or Caregiver **declined** consent for the SUPRT-C

If the individual declined the Client or Caregiver SUPRT-C form at baseline, please provide demographic information below. This data can be pulled from other internal sources, however it should still come directly from clients, with the exact categories or response options as indicated below and not be assumed.

Did the client or caregiver complete the SUPRT-C form at Baseline?

O   Yes

O   No

IF "NO", ENTER THE DEMOGRAPHIC INFORMATION BELOW

F1. What is the client's race or ethnicicty? Select all that apply and enter additional details in the spaces below

☐ **White – Provide details below.**

    ☐   German

    ☐   Irish

    ☐   English

    ☐   Italian

    ☐   Polish

    ☐   French

    ☐   Enter, for example, Scottish, Norwegian, Dutch, etc.

    _____

☐ **Hispanic or Latino – Provide details below.**

    ☐   Mexican or Mexican American

    ☐   Puerto Rican

    ☐   Cuban

- ☐   Salvadoran

- ☐   Dominican

- ☐   Colombian

- ☐   Enter, for example, Guatemalan, Spaniard, Ecuadorian, etc.

       _____

- ☐ **Black or African American – Provide details below.**

  - ☐   African American

  - ☐   Jamaican

  - ☐   Haitian

  - ☐   Nigerian

  - ☐   Ethiopian

  - ☐   Somali

  - ☐   Enter, for example, Ghanaian, South African, Barbadian, etc.

         _____

- ☐ **Asian – Provide details below.**

  - ☐   Chinese

  - ☐   Filipino

  - ☐   Asian Indian

  - ☐   Vietnamese

  - ☐   Korean

  - ☐   Japanese

☐ Enter, for example, Pakistani, Cambodian, Hmong, etc.

_____

☐ **American Indian or Alaska Native – Provide details below.**

☐ Specify, for example. Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Tlingit, etc.

_____

☐ **Middle Eastern or North African – Provide details below.**

☐ Lebanese

☐ Iranian

☐ Egyptian

☐ Syrian

☐ Moroccan

☐ Israeli

☐ Enter, for example, Algerian, Iraqi, Kurdish, etc.

_____

☐ **Native Hawaiian or Pacific Islander – Provide details below.**

☐ Native Hawaiian

☐ Samoan

☐ Chamorro

☐ Tongan

☐ Fijian

☐ Marshallese

☐ Enter, for example, Palauan, Tahitian, Chuukese etc.

_____

O Race/ethnicity not captured in grantee records using detailed OMB categories

O Client/caregiver declined to provide race/ethnicity

F2. What is the individual's sex?

O Female

O Male