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 Reassessment in care at 6 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
- 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 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?

- 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), as made by a clinician and documented in a clinical record.

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

E. SERVICES RECEIVED

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

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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)*

O Yes

O No

O 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	O	O	O	O
b.	Person- or family-centered treatment planning	O	O	O	O
c.	Substance use psychoeducation	O	O	O	O
d.	Mental health psychoeducation	O	O	O	O
e.	Mental health therapy	O	O	O	O
f.	Co-occurring therapy (substance use & mental health)	O	O	O	O
g.	Group counseling	O	O	O	O
h.	Individual counseling	O	O	O	O

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

E2. [IF E1a_l = MEDICATION FOR SUBSTANCE USE DISORDER IS YES – PROVIDED] Indicate medication received:

		Yes – received	No – not received	Not documented in records/unknown
a.	Naltrexone……	O	O	O
b.	Extended-release Naltrexone……	O	O	O
c.	Disulfiram…….	O	O	O
d.	Acamprosate…..	O	O	O
e.	Methadone……	O	O	O
f.	Buprenorphine….	O	O	O
g.	Nicotine cessation therapy (e.g.	O	O	O

		Yes – received	No – not received	Not documented in records/unknown
	Nicotine patch, gum, lozenge)…...			
h.	Bupropion……	O	O	O
i.	Varenicline……	O	O	O
j.	Other……	O	O	O

CRISIS SERVICES

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

O Yes

O No

O 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…….	O	O	O	O
b.	Crisis response…...	O	O	O	O
c.	Crisis stabilization……	O	O	O	O
d.	Crisis follow-up……..	O	O	O	O

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)*

O Yes

O No

O 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…….	O	O	O	O
b.	Family support services, including family peer support…...	O	O	O	O
c.	Childcare……	O	O	O	O
d.	Transportation…..	O	O	O	O
e.	Education Support…….	O	O	O	O
f.	Housing support……..	O	O	O	O
g.	Recovery housing……..	O	O	O	O
h.	Spiritual, ceremonial, and/or traditional activities……..	O	O	O	O
i.	Mutual support groups……..	O	O	O	O
j.	Peer support specialist services, coaching, or mentoring……	O	O	O	O
k.	Respite care……	O	O	O	O
l.	Therapeutic foster care……	O	O	O	O

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)*

O Yes

O No

O 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…….	O	O	O	O
b.	Maternal health care or OB/GYN…...	O	O	O	O
c.	HIV testing……	O	O	O	O
d.	Viral hepatitis testing…..	O	O	O	O
e.	HIV treatment…….	O	O	O	O
f.	HIV pre-exposure prophylaxis (PrEP)……..	O	O	O	O
g.	Viral hepatitis treatment……..	O	O	O	O
h.	Other STI testing or treatment…..	O	O	O	O
i.	Dental care……..	O	O	O	O