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 Record Closeout

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)?

_____/_____

A6. Why are you closing out this client's record?

- O Completed the program
- O No contact
- O Withdrew from/Refused treatment
- O Referred out
- O Transferred to a different grant program
- O Incarceration
- O Moved
- O Death
- O Other

A6a. [IF QUESTION A6 IS DEATH] What is the cause of death?

- O Suicide
- O Overdose
- O Other behavioral health cause
- O Other cause
- O Not documented in record

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)*

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

		Yes – Provided	Referred to service	No – not provided or referred	Not documented in records/unknown
h.	Individual counseling	O	O	O	O
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

		Yes – received	No – not received	Not documented in records/unknown
g.	Nicotine cessation therapy (e.g. Nicotine patch, gum, lozenge)…...	O	O	O
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

		Yes – Provided	Referred to service	No – not provided or referred	Not documented in records/unknown
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