

Transformation Accountability (TRAC)
Center for Mental Health Services

**NOMs Client-Level Measures for Discretionary
Programs Providing Direct Services**

**SERVICES TOOL
For Adult Programs**



July 2016
Version 15

Public reporting burden for this collection of information is estimated to average 30 minutes per response if all items are asked of a consumer/participant; to the extent that providers already obtain much of this information as part of their ongoing consumer/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 SAMHSA Reports Clearance Officer, Room 7-1045, 1 Choke Cherry Road, 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 OMB control number. The control number for this project is 0930-0285.

RECORD MANAGEMENT

[RECORD MANAGEMENT IS REPORTED BY GRANTEE STAFF AT BASELINE, REASSESSMENT AND DISCHARGE REGARDLESS OF WHETHER AN INTERVIEW IS CONDUCTED.]

Consumer ID | 0 | 6 | 0 | 0 | | | | | | | | | Name _____

Grant ID (Grant/Contract/Cooperative Agreement) | S | M | 6 | 2 | 2 | 2 | 5 |

Site ID | C | O | I | D | S | Interviewer _____

1. Indicate Assessment Type:

<p><input type="radio"/> Baseline</p> <p>[ENTER THE MONTH AND YEAR WHEN THE CONSUMER FIRST RECEIVED SERVICES UNDER THE GRANT FOR THIS EPISODE OF CARE.]</p> <p> _ _ _ _ / _ _ _ _ _ _ _ _ _ MONTH YEAR</p>	<p><input type="radio"/> Reassessment</p> <p>Which 6-month reassessment?</p> <p> _ _ _ _ </p> <p>[ENTER 06 FOR A 6-MONTH, 12 FOR A 12-MONTH, 18 FOR AN 18-MONTH ASSESSMENT, ETC.]</p>	<p><input type="radio"/> Clinical Discharge</p>
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2. Was the interview conducted?

<p><input type="radio"/> Yes</p> <p>When?</p> <p> _ _ _ _ / _ _ _ _ / _ _ _ _ _ _ _ _ _ MONTH DAY YEAR</p>	<p><input type="radio"/> No</p> <p>Why not? Choose only one.</p> <ul style="list-style-type: none"> <input type="radio"/> Not able to obtain consent from proxy <input type="radio"/> Consumer was impaired or unable to provide consent <input type="radio"/> Consumer refused this interview only <input type="radio"/> Consumer was not reached for interview <input type="radio"/> Consumer refused all interviews
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[IF THIS IS A BASELINE, GO TO SECTION A.]

[FOR ALL REASSESSMENTS:

IF AN INTERVIEW WAS CONDUCTED, GO TO SECTION B.

IF AN INTERVIEW WAS NOT CONDUCTED, GO TO SECTION H (IF APPLICABLE), THEN SECTION I.]

[FOR A CLINICAL DISCHARGE:

IF AN INTERVIEW WAS CONDUCTED, GO TO SECTION B.

IF AN INTERVIEW WAS NOT CONDUCTED, GO TO SECTION H (IF APPLICABLE), THEN SECTION J.]

A. DEMOGRAPHIC DATA

[SECTION A IS ONLY COLLECTED AT BASELINE. IF THIS IS NOT A BASELINE, GO TO SECTION B.]

1. What is your gender?

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

2. Are you Hispanic or Latino?

- YES
- NO *[GO TO 3.]*
- REFUSED *[GO TO 3.]*

[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.

	YES	NO	REFUSED
Central American	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cuban	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dominican	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mexican	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Puerto Rican	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
South American	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
OTHER (SPECIFY) _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> <i>[IF YES, SPECIFY BELOW.]</i>

3. What race do you consider yourself? Please answer yes or no for each of the following. You may say yes to more than one.

	YES	NO	REFUSED
Black or African American	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asian	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Native Hawaiian or other Pacific Islander	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alaska Native	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
White	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
American Indian	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. What is your month and year of birth?

|_|_|/|_|_|_|_|
MONTH YEAR

REFUSED

A. DEMOGRAPHIC DATA (Continued)

5. Which one of the following do you consider yourself to be?

- Heterosexual, that is straight
- [IF FEMALE, THEN “Lesbian”] or Gay
- Bisexual
- OTHER (SPECIFY) _____
- REFUSED
- DON'T KNOW

[IF AN INTERVIEW WAS CONDUCTED CONTINUE TO SECTION B.]

[IF AN INTERVIEW WAS NOT CONDUCTED:

PRIMARY AND BEHAVIORAL HEALTH CARE INTEGRATION (PBHCI) GRANTEES: GO TO SECTION H.

GRANTEES IN ALL OTHER PROGRAMS: STOP HERE.]

B. FUNCTIONING

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

- Excellent
- Very Good
- Good
- Fair
- Poor
- REFUSED
- DON'T KNOW

2. In order to provide the best possible mental health and related services, we need to know what you think about how well you were able to deal with your everyday life during the past 30 days. Please indicate your disagreement/agreement with each of the following statements.

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]

STATEMENT	RESPONSE OPTIONS						
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	REFUSED	NOT APPLICABLE
a. I deal effectively with daily problems.	<input type="radio"/>						
b. I am able to control my life.	<input type="radio"/>						
c. I am able to deal with crisis.	<input type="radio"/>						
d. I am getting along with my family.	<input type="radio"/>						
e. I do well in social situations.	<input type="radio"/>						
f. I do well in school and/or work.	<input type="radio"/>						
g. My housing situation is satisfactory.	<input type="radio"/>						
h. My symptoms are not bothering me.	<input type="radio"/>						

B. FUNCTIONING (Continued)

3. The following questions ask about how you have been feeling during the past 30 days. For each question, please indicate how often you had this feeling.

[READ EACH QUESTION FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]

QUESTION	RESPONSE OPTIONS						
During the past 30 days, about how often did you feel ...	All of the Time	Most of the Time	Some of the Time	A Little of the Time	None of the Time	REFUSED	DON'T KNOW
a. nervous?	○	○	○	○	○	○	○
b. hopeless?	○	○	○	○	○	○	○
c. restless or fidgety?	○	○	○	○	○	○	○
d. so depressed that nothing could cheer you up?	○	○	○	○	○	○	○
e. that everything was an effort?	○	○	○	○	○	○	○
f. worthless?	○	○	○	○	○	○	○

B. FUNCTIONING (Continued)

4. The following questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we'll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed.

[READ EACH QUESTION FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]

QUESTION	RESPONSE OPTIONS					
	Never	Once or Twice	Weekly	Daily or Almost Daily	REFUSED	DON'T KNOW
In the past 30 days, how often have you used...						
a. tobacco products (cigarettes, chewing tobacco, cigars, etc.)?	<input type="radio"/>					
b. alcoholic beverages (beer, wine, liquor, etc.)?	<input type="radio"/>					
b1. <i>[IF B >= ONCE OR TWICE, AND RESPONDENT MALE]</i> , How many times in the past 30 days have you had five or more drinks in a day? <i>[CLARIFY IF NEEDED: A standard drink (e.g., 12 oz beer, 5 oz wine, 1.5 oz liquor)]</i> .	<input type="radio"/>					
b2. <i>[IF B >= ONCE OR TWICE, AND RESPONDENT NOT MALE]</i> , How many times in the past 30 days have you had four or more drinks in a day? <i>[CLARIFY IF NEEDED: A standard drink (e.g., 12 oz beer, 5 oz wine, 1.5 oz liquor)]</i> .	<input type="radio"/>					
c. cannabis (marijuana, pot, grass, hash, etc.)?	<input type="radio"/>					
d. cocaine (coke, crack, etc.)?	<input type="radio"/>					
e. prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)?	<input type="radio"/>					
f. methamphetamine (speed, crystal meth, ice, etc.)?	<input type="radio"/>					
g. inhalants (nitrous oxide, glue, gas, paint thinner, etc.)?	<input type="radio"/>					
h. sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)?	<input type="radio"/>					
i. hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)?	<input type="radio"/>					
j. street opioids (heroin, opium, etc.)?	<input type="radio"/>					
k. prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)?	<input type="radio"/>					
l. other – specify (e-cigarettes, etc.):	<input type="radio"/>					

B. FUNCTIONING (Continued)

[OPTIONAL: GAF SCORE REPORTED BY GRANTEE STAFF AT PROJECT'S DISCRETION.]

DATE GAF WAS ADMINISTERED: |_|_|/|_|_|/|_|_|_|_|
 MONTH DAY YEAR

WHAT WAS THE CONSUMER'S SCORE? GAF = |_|_|_|_|

B. MILITARY FAMILY AND DEPLOYMENT

[QUESTIONS 5 THROUGH 8 ARE ONLY ASKED AT BASELINE. IF THIS IS NOT A BASELINE GO TO 9.]

5. Have you ever served in the Armed Forces, the Reserves, or the National Guard?

- YES
- NO *[GO TO 6.]*
- REFUSED *[GO TO 6.]*
- DON'T KNOW *[GO TO 6.]*

[IF YES] In which of the following have you ever served? Please answer for each of the following. You may say yes to more than one.

	YES	NO	REFUSED	DON'T KNOW
Armed Forces	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reserves	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
National Guard	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5a. Are you currently serving on active duty in the Armed Forces, the Reserves, or the National Guard?

- YES
- NO *[GO TO 5b.]*
- REFUSED *[GO TO 5b.]*
- DON'T KNOW *[GO TO 5b.]*

[IF YES] In which of the following are you currently serving? Please answer for each of the following. You may say yes to more than one.

	YES	NO	REFUSED	DON'T KNOW
Armed Forces	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reserves	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
National Guard	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5b. Have you ever been deployed to a combat zone?

- YES
- NO *[GO TO 6.]*
- REFUSED *[GO TO 6.]*
- DON'T KNOW *[GO TO 6.]*

[IF YES] To which of the following combat zones have you been deployed? Please answer for each of the following. You may say yes to more than one.

	YES	NO	REFUSED	DON'T KNOW
Iraq or Afghanistan (e.g., Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Persian Gulf (Operation Desert Shield or Desert Storm)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vietnam/Southeast Asia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Korea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
WWII	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Deployed to a combat zone not listed above (e.g., Somalia, Bosnia, Kosovo)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

B. MILITARY FAMILY AND DEPLOYMENT (Continued)

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

- Yes, only one person
- Yes, more than one person
- No
- REFUSED
- DON'T KNOW

B. VIOLENCE AND TRAUMA

7. 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 *[GO TO 9.]*
- REFUSED *[GO TO 9.]*
- DON'T KNOW *[GO TO 9.]*

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

	YES	NO	REFUSED	DON'T KNOW
8a. Have had nightmares about it or thought about it when you did not want to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8c. Were constantly on guard, watchful, or easily startled?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8d. Felt numb and detached from others, activities, or your surroundings?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

B. VIOLENCE AND TRAUMA (Continued)

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

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

C. STABILITY IN HOUSING

1. In the past 30 days how many ...	Number of Nights/ Times	REFUSED	DON'T KNOW
a. nights have you been homeless?	_ _ _	<input type="radio"/>	<input type="radio"/>
b. nights have you spent in a hospital for mental health care?	_ _ _	<input type="radio"/>	<input type="radio"/>
c. nights have you spent in a facility for detox/inpatient or residential substance abuse treatment?	_ _ _	<input type="radio"/>	<input type="radio"/>
d. nights have you spent in correctional facility including jail, or prison?	_ _ _	<input type="radio"/>	<input type="radio"/>
 <i>[ADD UP THE TOTAL NUMBER OF NIGHTS SPENT HOMELESS, IN HOSPITAL FOR MENTAL HEALTH CARE, IN DETOX/INPATIENT OR RESIDENTIAL SUBSTANCE ABUSE TREATMENT, OR IN A CORRECTIONAL FACILITY. (ITEMS A-D, CANNOT EXCEED 30 NIGHTS).]</i>			
	_ _ _		
e. times have you gone to an emergency room for a psychiatric or emotional problem?	_ _ _	<input type="radio"/>	<input type="radio"/>

[IF 1A, 1B, 1C, OR 1D IS 16 OR MORE NIGHTS, GO TO SECTION D.]

2. In the past 30 days, where have you been living most of the time?

[DO NOT READ RESPONSE OPTIONS TO THE CONSUMER. SELECT ONLY ONE.]

- OWNED OR RENTED HOUSE, APARTMENT, TRAILER, ROOM
- SOMEONE ELSE'S HOUSE, APARTMENT, TRAILER, ROOM
- HOMELESS (SHELTER, STREET/OUTDOORS, PARK)
- GROUP HOME
- ADULT FOSTER CARE
- TRANSITIONAL LIVING FACILITY
- HOSPITAL (MEDICAL)
- HOSPITAL (PSYCHIATRIC)
- DETOX/INPATIENT OR RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
- CORRECTIONAL FACILITY (JAIL/PRISON)
- NURSING HOME
- VA HOSPITAL
- VETERAN'S HOME
- MILITARY BASE
- OTHER HOUSED (SPECIFY) _____
- REFUSED
- DON'T KNOW

D. EDUCATION AND EMPLOYMENT

**1. Are you currently enrolled in school or a job training program?
[IF ENROLLED] Is that full time or part time?**

- 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?

- LESS THAN 12TH GRADE
- 12TH GRADE/HIGH SCHOOL DIPLOMA/EQUIVALENT (GED)
- VOC/TECH DIPLOMA
- SOME COLLEGE OR UNIVERSITY
- BACHELOR'S DEGREE (BA, BS)
- GRADUATE WORK/GRADUATE DEGREE
- REFUSED
- DON'T KNOW

3. Are you currently employed? [CLARIFY BY FOCUSING ON STATUS DURING MOST OF THE PREVIOUS WEEK, DETERMINING WHETHER CONSUMER WORKED AT ALL OR HAD A REGULAR JOB BUT WAS OFF 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

3a. [IF EMPLOYED]

- | | Yes | No | REFUSED | DON'T KNOW |
|--|-----------------------|-----------------------|-----------------------|-----------------------|
| • Are you paid at or above the minimum wage ¹ ? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| • Are your wages paid directly to you by your employer? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| • Could anyone have applied for this job? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

¹ For information on Federal minimum wage go to <http://www.dol.gov/dol/topic/wages/>.

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 THIS IS A BASELINE, GO TO SECTION G. OTHERWISE, GO TO SECTION F.]

F. PERCEPTION OF CARE

[SECTION F IS NOT COLLECTED AT BASELINE. FOR BASELINE INTERVIEWS, GO TO SECTION G.]

1. In order to provide the best possible mental health and related services, we need to know what you think about the services you received during the past 30 days, the people who provided it, and the results. Please indicate your disagreement/agreement with each of the following statements.

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]

STATEMENT	RESPONSE OPTIONS						
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	REFUSED	NOT APPLICABLE
a. Staff here believe that I can grow, change and recover.							
b. I felt free to complain.							
c. I was given information about my rights.							
d. Staff encouraged me to take responsibility for how I live my life.	○						
e. Staff told me what side effects to watch out for.	○	○					
f. Staff respected my wishes about who is and who is not to be given information about my treatment.	○	○	○				
g. Staff were sensitive to my cultural background (race, religion, language, etc.).	○	○	○	○			
h. Staff helped me obtain the information I needed so that I could take charge of managing my illness.	○	○	○	○			
i. I was encouraged to use consumer run programs (support groups, drop-in centers, crisis phone line, etc.).	○	○	○	○	○		
j. I felt comfortable asking questions about my treatment and medication.	○	○	○	○	○	○	○
k. I, not staff, decided my treatment goals.	○	○	○	○	○	○	
l. I like the services I received here.	○	○	○	○	○	○	
m. If I had other choices, I would still get services from this agency.	○	○	○	○	○	○	
n. I would recommend this agency to a friend or family member.	○	○	○	○	○	○	

F. PERCEPTION OF CARE (Continued)

2. [INDICATE WHO ADMINISTERED SECTION F - PERCEPTION OF CARE TO THE RESPONDENT FOR THIS INTERVIEW.]

- ADMINISTRATIVE STAFF
- CARE COORDINATOR
- CASE MANAGER
- CLINICIAN PROVIDING DIRECT SERVICES
- CLINICIAN NOT PROVIDING SERVICES
- CONSUMER PEER
- DATA COLLECTOR
- EVALUATOR
- FAMILY ADVOCATE
- RESEARCH ASSISTANT STAFF
- SELF-ADMINISTERED
- OTHER (SPECIFY) _____

G. SOCIAL CONNECTEDNESS

1. Please indicate your disagreement/agreement with each of the following statements. Please answer for relationships with persons other than your mental health provider(s) over the past 30 days.

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]

STATEMENT	RESPONSE OPTIONS					
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	REFUSED
a. I am happy with the friendships I have.	<input type="radio"/>					
b. I have people with whom I can do enjoyable things.	<input type="radio"/>					
c. I feel I belong in my community.	<input type="radio"/>					
d. In a crisis, I would have the support I need from family or friends.	<input type="radio"/>					

[IF YOUR PROGRAM DOES NOT REQUIRE SECTION H:

IF THIS IS A BASELINE INTERVIEW, STOP NOW. THE INTERVIEW IS COMPLETE.]

IF THIS IS A REASSESSMENT INTERVIEW, PLEASE GO TO SECTION I THEN K.]

IF THIS IS A CLINICAL DISCHARGE INTERVIEW, PLEASE GO TO SECTION J THEN K.]

[IF YOUR PROGRAM DOES REQUIRE SECTION H:

IF THIS IS A BASELINE INTERVIEW, PLEASE PROCEED TO SECTION H THEN STOP. THE INTERVIEW WILL BE COMPLETE.]

IF THIS IS A REASSESSMENT INTERVIEW, PROCEED TO SECTION H, THEN I AND K.]

IF THIS IS A CLINICAL DISCHARGE INTERVIEW, PROCEED TO SECTION H, THEN J AND K.]

**H. PBHCI
PHYSICAL HEALTH ITEMS**

Questions H1-H3
OMB No. 0990-0371
Expiration Date 03/31/2019

1. Health measurements:

- a. Systolic blood pressure
- b. Diastolic blood pressure
- c. Weight
- d. Height
- e. Waist circumference
- f. Breath CO - for smoking status

Note: Enter lbs and in., press Tab to convert

<input type="text"/>	mmHg
<input type="text"/>	mmHg
<input type="text"/>	kg
<input type="text"/>	cm
<input type="text"/>	cm
<input type="text"/>	ppm

2. Did patient successfully fast for 8 hours prior to providing the blood sample?

3. Blood test results (required only once a year):

a. Date of blood draw: / /
MONTH DAY YEAR

[FOR 3b AND 3c: ENTER ONE OR THE OTHER, NOT BOTH.]

b. Fasting plasma glucose	<input type="text"/>	mg/dL	<input type="text"/>
c. HgBA1c	<input type="text"/>	%	<input type="text"/>
d. Total Cholesterol	<input type="text"/>	mg/dL	<input type="text"/>
e. HDL Cholesterol	<input type="text"/>	mg/dL	<input type="text"/>
f. LDL Cholesterol	<input type="text"/>	mg/dL	<input type="text"/>
g. Triglycerides	<input type="text"/>	mg/dL	<input type="text"/>

[IF THIS IS A BASELINE, STOP HERE.]

[IF THIS IS A REASSESSMENT, GO TO SECTION I.]

[IF THIS IS A CLINICAL DISCHARGE, GO TO SECTION J.]

Public reporting burden for this collection of information is estimated to be approximately 5 additional minutes for the individual entering data into TRAC for an average of 200 clients per site at all 60 PBHCI sites. Send comments regarding this burden estimate or any other aspect of this collection of information to SAMHSA Reports Clearance Officer, Room 7-1045, 1 Choke Cherry Road, 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 OMB control number. The control number for this project is 0990-0371.

I. REASSESSMENT STATUS

[SECTION I IS REPORTED BY GRANTEE STAFF AT REASSESSMENT.]

1. Have you or other grant staff had contact with the consumer within 90 days of the last encounter?

Yes

No

2. Is the consumer still receiving services from your project?

Yes

No

[GO TO SECTION K.]

J. CLINICAL DISCHARGE STATUS

[SECTION J IS REPORTED BY GRANTEE STAFF ABOUT THE CONSUMER AT CLINICAL DISCHARGE.]

1. On what date was the consumer discharged?

|_|_|_| / |_|_|_|_|_|_|
MONTH YEAR

2. What is the consumer's discharge status?

- Mutually agreed cessation of treatment
- Withdrew from/refused treatment
- No contact within 90 days of last encounter
- Clinically referred out
- Death
- Other (Specify) _____

[GO TO SECTION K.]

K. SERVICES RECEIVED

[SECTION K IS REPORTED BY GRANTEE STAFF AT REASSESSMENT AND DISCHARGE UNLESS THE CONSUMER REFUSED THIS INTERVIEW OR ALL INTERVIEWS, IN WHICH CASE IT IS OPTIONAL.]

1. On what date did the consumer last receive services?

/
 MONTH YEAR

[IDENTIFY ALL OF THE SERVICES YOUR PROJECT PROVIDED TO THE CONSUMER SINCE HIS/HER LAST NOMS INTERVIEW; THIS INCLUDES CMHS-FUNDED AND NON-FUNDED SERVICES.]

Core Services	<u>Provided</u>		UNKNOWN	SERVICE NOT AVAILABLE
	Yes	No		
1. Screening				
2. Assessment				
3. Treatment Planning or Review				
4. Psychopharmacological Services				
5. Mental Health Services				

[IF THE ANSWER TO 5 'MENTAL HEALTH SERVICES' IS YES, PLEASE ESTIMATE HOW FREQUENTLY MENTAL HEALTH SERVICES WERE DELIVERED.]

Number of times _____ per
 Day UNKNOWN
 Week
 Month
 Year

	<u>Provided</u>		UNKNOWN	SERVICE NOT AVAILABLE
	Yes	No		
6. Co-Occurring Services				
7. Case Management				
8. Trauma-specific Services				
9. Was the Consumer referred to another provider for any of the above core services?				

Support Services	<u>Provided</u>		UNKNOWN	SERVICE NOT AVAILABLE
	Yes	No		
1. Medical Care				
2. Employment Services				
3. Family Services				
4. Child Care				
5. Transportation				
6. Education Services				
7. Housing Support				
8. Social Recreational Activities				
9. Consumer Operated Services				
10. HIV Testing				
11. Was the Consumer referred to another provider for any of the above support services?				