

Click to skip introduction

The following information is a quick reference for using the GPRA Collection Tool. For more complete guidance, please visit the COVID-19 Response Grant section of the Vermont Department of Health's website: <https://www.healthvermont.gov/alcohol-drug-abuse/grantees-contractors/reporting-forms-and-guidance-documents>, or visit the Department of Mental Health website: <https://mentalhealth.vermont.gov/samhsa-covid-19-emergency-services-grant>.

INTAKE/BASELINE INTERVIEW

Must be completed 1-3 calendar days after entering a residential program and 1-4 calendar days after entering a non-residential program.

Sections: Sections A1-A3 is completed by program staff, sections A4 & A5, B-G are client-report. **Rules:** Grantees are only required to administer the GPRA baseline one time per client. However, grantees may choose to administer a second (or third, fourth, etc.) baseline GPRA if the client leaves and is readmitted to treatment. In this case, the subsequent 6-month follow-up will be required from the latest baseline only.

Consent: If a client does not consent, create a client ID and complete section A1. If a client is unable to consent, follow the same process and provide clinical documentation in the text box provided.

6-MONTH FOLLOW UP INTERVIEW

Must be completed within the window of 1 month before and 2 months after the 6-month mark. The 6-month mark is in relation to the date of the latest intake interview.

Sections: Sections A1, A2, and I are completed by program staff, sections B-G are client-report. These questions must be asked and answered again in a new interview.

Administrative interview: If a client is not able to be reached, conduct an administrative follow up in which the program staff completes the first four questions in sections A1 and section I.

Rules: If the client discharges before the 6-month follow up, a complete 6-month follow up interview must still be conducted.

Consent: If a client withdraws consent, complete an administrative interview.

DISCHARGE INTERVIEW

If the client is present on the day of discharge, the GPRA discharge interview should be conducted on the day of discharge. If a client has not finished treatment, drops out, and is not present the day of discharge, the program will have 14 calendar days to find the client to conduct the in-person GPRA discharge interview.

Sections: Sections A1, A2, J and K are completed by program staff, sections B-G are client report. These questions must be asked and answered again in a new interview.

Administrative interview: If a client is unable to be reached for the discharge interview, program staff will complete the first four parts of section A1, and sections J and K.

Rules: If a client is discharged from your program within 7 calendar days of their GPRA intake interview, a face-to-face interview is not required, and program staff will complete the administrative discharge as above.

Consent: If a client withdraws consent, complete an administrative interview.

CLIENT ID FORMULATION

Each client should have their own unique client ID that is used at all three data collection points. The same unique ID is used each time, even if the client has more than one episode of care. For confidentiality reasons, do not use any portion of the client's date of birth, Social Security Number, or mother's maiden name in the Client ID.

CLIENT ID NAMING CONVENTION = COV + M/S + Provider ID + Unique Identifier		
Provider	Provider ID	Client ID + Unique Identifier*
Counseling Services of Addison County	01	COV + M/S + 01 + unique ID
Northwest Counseling and Support Services	02	COV + M/S + 02 + unique ID
Howard Center	03	COV + M/S + 03 + unique ID
Lamoille County Mental Health	04	COV + M/S + 04 + unique ID
Health Care & Rehabilitation Services of Southeast Vermont	05	COV + M/S + 05 + unique ID
Northeast Kingdom Mental Health Services	06	COV + M/S + 06 + unique ID
Clara Martin Center	07	COV + M/S + 07 + unique ID
Rutland Mental Health Services	08	COV + M/S + 08 + unique ID
United Counseling Services	09	COV + M/S + 09 + unique ID
Washington County Mental Health Services	10	COV + M/S + 10 + unique ID
Pathways	50	COV + M/S + 50 + unique ID
M = Mental Health programs (renovations, go bags, equipment, and vans) S = SUD programs (SUD emergency services/SUD specialists)		
Examples: COVM03GJS50 COVS056092G COVM09024969		
*Unique Identifier is created by the agency, it up to 9 numbers/letters, and cannot include any identifying information, including mother's maiden name, birthday, social security number. Each client should have their own unique client ID that is used at all three data collection points.		

CONTACTS

Julia Harrison, ADAP Emergency COVID-19 Grant Project Director

Julia.Harrison@vermont.gov

(802) 951-5791

Amy Guidice, DMH Emergency COVID-19 Grant Performance Manager

Amy.Guidice@partner.vermont.gov

(802) 598-1267

GPRA SUBMISSION LINK

<https://www.surveygizmo.com/s3/5391637/GPRA-Submission>

GPRA Tool

Client ID _____

Click here to reset form - be sure to **SAVE** prior to reset.

Click here to submit form.

A1. RECORDS MANAGEMENT

Reported by PROGRAM STAFF

Client ID: _ _ _ _ _

Client Type: Client in treatment

Interview Type:

- ☐ Intake/Baseline
- ☐ 6-month follow up
- ☐ Discharge

Did you conduct the 6-month follow-up interview? ☐ Yes ☐ No
(If no, go directly to section I)

Did you conduct the discharge interview? ☐ Yes ☐ No
(If no, go directly to section J)

Interview Date:**Did client consent to GPRA Interview?** Yes No

***If client does not consent, assign a Client ID, complete Section A1 and submit.**

If it is determined the client cannot consent, please submit clinical justification (including screening tool used) here:

A2. BEHAVIORAL HEALTH DIAGNOSES

Reported by PROGRAM STAFF

Please indicate the client's current behavioral health diagnoses using the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM) codes listed below. Please note that some substance use disorder ICD-10-CM codes have been crosswalked to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*, descriptors.

Select up to three diagnoses. For each diagnosis selected, please indicate whether it is primary, secondary, or tertiary, if known. Only one diagnosis can be primary, only one can be secondary, and only one can be tertiary.

Don't know None

Behavioral Health Diagnoses	Diagnosed?	For each diagnosis selected, please indicate whether the diagnosis is primary, secondary, or tertiary, if known		
	Select up to 3	Primary	Secondary	Tertiary
<u>SUBSTANCE USE DISORDER DIAGNOSES</u>				
<u>Alcohol-related disorders</u>				
F10.10 – Alcohol use disorder, uncomplicated, mild	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F10.11 – Alcohol use disorder, mild, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F10.20 – Alcohol use disorder, uncomplicated, moderate/severe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Behavioral Health Diagnoses	Diagnosed?	For each diagnosis selected, please indicate whether the diagnosis is primary, secondary, or tertiary, if known		
	Select up to 3	Primary	Secondary	Tertiary
F10.21 – Alcohol use disorder, moderate/severe, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F10.9 – Alcohol use, unspecified	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>Opioid-related disorders</u>				
F11.10 – Opioid use disorder, uncomplicated, mild	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F11.11 – Opioid use disorder, mild, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F11.20 – Opioid use disorder, uncomplicated, moderate/severe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F11.21 – Opioid use disorder, moderate/severe, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F11.9 – Opioid use, unspecified	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>Cannabis-related disorders</u>				
F12.10 – Cannabis use disorder, uncomplicated, mild	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F12.11 – Cannabis use disorder, mild, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F12.20 – Cannabis use disorder, uncomplicated, moderate/severe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F12.21 – Cannabis use disorder, moderate/severe, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F12.9 – Cannabis use, unspecified	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>Sedative-, hypnotic-, or anxiolytic-related disorders</u>				
F13.10 – Sedative, hypnotic, or anxiolytic use disorder, uncomplicated, mild	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F13.11 – Sedative, hypnotic, or anxiolytic use disorder, mild, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F13.20 – Sedative, hypnotic, or anxiolytic use disorder, uncomplicated, moderate/severe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F13.21 – Sedative, hypnotic, or anxiolytic use disorder, moderate/severe, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F13.9 – Sedative, hypnotic, or anxiolytic use, unspecified	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>Cocaine-related disorders</u>				
F14.10 – Cocaine use disorder, uncomplicated, mild	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Behavioral Health Diagnoses	Diagnosed?	For each diagnosis selected, please indicate whether the diagnosis is primary, secondary, or tertiary, if known		
	Select up to 3	Primary	Secondary	Tertiary
F14.11 – Cocaine use disorder, mild, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F14.20 – Cocaine use disorder, uncomplicated, moderate/severe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F14.21 – Cocaine use disorder, moderate/severe, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F14.9 – Cocaine use, unspecified	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>Other stimulant-related disorders</u>				
F15.10 – Other stimulant use disorder, uncomplicated, mild	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F15.11 – Other stimulant use disorder, mild, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F15.20 – Other stimulant use disorder, uncomplicated, moderate/severe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F15.21 – Other stimulant use disorder, moderate/severe, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F15.9 – Other stimulant use, unspecified	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>Hallucinogen-related disorders</u>				
F16.10 – Hallucinogen use disorder, uncomplicated, mild	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F16.11 – Hallucinogen use disorder, mild, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F16.20 – Hallucinogen use disorder, uncomplicated, moderate/severe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F16.21 – Hallucinogen use disorder moderate/severe, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F16.9 – Hallucinogen use, unspecified	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>Inhalant-related disorders</u>				
F18.10 – Inhalant use disorder, uncomplicated, mild	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F18.11 – Inhalant use disorder, mild, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F18.20 – Inhalant use disorder, uncomplicated, moderate/severe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F18.21 – Inhalant use disorder, moderate/severe, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F18.9 – Inhalant use, unspecified	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>Other psychoactive substance-related disorders</u>				
F19.10 – Other psychoactive substance use disorder, uncomplicated, mild	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Behavioral Health Diagnoses	Diagnosed?	For each diagnosis selected, please indicate whether the diagnosis is primary, secondary, or tertiary, if known		
	Select up to 3	Primary	Secondary	Tertiary
F19.11 – Other psychoactive substance use disorder, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F19.20 – Other psychoactive substance use disorder, uncomplicated, moderate/severe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F19.21 – Other psychoactive substance use disorder, moderate/severe, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F19.9 – Other psychoactive substance use, unspecified	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>Nicotine dependence</u>				
F17.20 – Tobacco use disorder, mild/moderate/severe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F17.21 – Tobacco use disorder, mild/moderate/severe, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>MENTAL HEALTH DIAGNOSES</u>				
F20 – Schizophrenia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F21 – Schizotypal disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F22 – Delusional disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F23 – Brief psychotic disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F24 – Shared psychotic disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F25 – Schizoaffective disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F28 – Other psychotic disorder not due to a substance or known physiological condition	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F29 – Unspecified psychosis not due to a substance or known physiological condition	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F30 – Manic episode	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F31 – Bipolar disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F32 – Major depressive disorder, single episode	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F33 – Major depressive disorder, recurrent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F34 – Persistent mood [affective] disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F39 – Unspecified mood [affective] disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F40–F48 – Anxiety, dissociative, stress-related, somatoform, and other nonpsychotic mental disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F50 – Eating disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F51 – Sleep disorders not due to a substance or known physiological condition	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F60.2 – Antisocial personality disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Behavioral Health Diagnoses	Diagnosed?	For each diagnosis selected, please indicate whether the diagnosis is primary, secondary, or tertiary, if known		
	Select up to 3	Primary	Secondary	Tertiary
F60.3 – Borderline personality disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F60.0, F60.1, F60.4–F69 – Other personality disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F70–F79 – Intellectual disabilities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F80–F89 – Pervasive and specific developmental disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F90 – Attention-deficit hyperactivity disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F91 – Conduct disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F93 – Emotional disorders with onset specific to childhood	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F94 – Disorders of social functioning with onset specific to childhood or adolescence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F95 – Tic disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F98 – Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F99 – Unspecified mental disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

1. In the past 30 days, was this client diagnosed with an opioid use disorder?

☐ Yes ☐ No ☐ Don't know

1a. In the past 30 days, which U.S. Food and Drug Administration (FDA)-approved medication did the client receive for the treatment of an opioid use disorder?

☐ Methadone **[IF RECEIVED]** Specify how many days received |__|__|

☐ Buprenorphine **[IF RECEIVED]** Specify how many days received |__|__|

☐ Naltrexone **[IF RECEIVED]** Specify how many days received |__|__|

☐ Extended-release naltrexone **[IF RECEIVED]** Specify how many days received |__|__|

☐ Client was diagnosed with an opioid use disorder, but did not receive an FDA-approved medication for an opioid use disorder

☐ Client was not diagnosed with an opioid use disorder and did not receive an FDA-approved medication for an opioid use disorder

☐ Don't know

2. In the past 30 days, was this client diagnosed with an alcohol use disorder?

☐ Yes ☐ No ☐ Don't know

2a. In the past 30 days, which FDA-approved medication did the client receive for the treatment of an alcohol use disorder?

- ☐ Naltrexone **[IF RECEIVED]** Specify how many days received |__|__|
- ☐ Extended-release naltrexone **[IF RECEIVED]** Specify how many days received |__|__|
- ☐ Disulfiram **[IF RECEIVED]** Specify how many days received |__|__|
- ☐ Acamprosate **[IF RECEIVED]** Specify how many days received |__|__|
- ☐ Client was diagnosed with an alcohol use disorder, but did not receive an FDA-approved medication for an alcohol use disorder
- ☐ Client was not diagnosed with an alcohol use disorder and did not receive an FDA-approved medication for an alcohol use disorder
- ☐ Don't know

[FOLLOW-UP AND DISCHARGE INTERVIEWS: SKIP TO SECTION B.]

3. Was the client screened by your program for co-occurring mental health and substance use disorders?

- ☐ Yes ☐ No **[SKIP 3a.]**

3a. [IF YES] Did the client screen positive for co-occurring mental health and substance use disorders?

- ☐ Yes ☐ No

A3. PLANNED SERVICES

Reported by PROGRAM STAFF only at intake/baseline interview

Identify the services you plan to provide to the client during the client's course of treatment/recovery.

[SELECT "YES" OR "NO" FOR EACH ONE.]

Modality [SELECT AT LEAST ONE MODALITY.]	YesNo	Treatment Services [SELECT AT LEAST ONE SERVICE.]	YesNo
1. Case Management	<input type="radio"/> <input type="radio"/>	1. Screening	<input type="radio"/> <input type="radio"/>
2. Day Treatment	<input type="radio"/> <input type="radio"/>	2. Brief Intervention	<input type="radio"/> <input type="radio"/>
3. Inpatient/Hospital (Other Than Detox)	<input type="radio"/> <input type="radio"/>	3. Brief Treatment	<input type="radio"/> <input type="radio"/>
4. Outpatient	<input type="radio"/> <input type="radio"/>	4. Referral to Treatment	<input type="radio"/> <input type="radio"/>
5. Outreach	<input type="radio"/> <input type="radio"/>	5. Assessment	<input type="radio"/> <input type="radio"/>
6. Intensive Outpatient	<input type="radio"/> <input type="radio"/>	6. Treatment/Recovery Planning	<input type="radio"/> <input type="radio"/>
7. Methadone	<input type="radio"/> <input type="radio"/>	7. Individual Counseling	<input type="radio"/> <input type="radio"/>
8. Residential/Rehabilitation	<input type="radio"/> <input type="radio"/>	8. Group Counseling	<input type="radio"/> <input type="radio"/>
9. Detoxification (Select Only One)	<input type="radio"/> <input type="radio"/>	9. Family/Marriage Counseling	<input type="radio"/> <input type="radio"/>
A. Hospital Inpatient	<input type="radio"/> <input type="radio"/>	10. Co-Occurring Treatment/Recovery Services	<input type="radio"/> <input type="radio"/>
B. Free-Standing Residential	<input type="radio"/> <input type="radio"/>	11. Pharmacological Interventions	<input type="radio"/> <input type="radio"/>
C. Ambulatory Detoxification	<input type="radio"/> <input type="radio"/>	12. HIV/AIDS Counseling	<input type="radio"/> <input type="radio"/>
10. After Care	<input type="radio"/> <input type="radio"/>	13. Other Clinical Services	<input type="radio"/> <input type="radio"/>
11. Recovery Support	<input type="radio"/> <input type="radio"/>	(Specify) _____	<input type="radio"/> <input type="radio"/>
12. Other (Specify) _____	<input type="radio"/> <input type="radio"/>		

Case Management Services

- | | Yes | No |
|--|-----------------------|-----------------------|
| 1. Family Services (Including Marriage Education, Parenting, Child Development Services) | <input type="radio"/> | <input type="radio"/> |
| 2. Child Care | <input type="radio"/> | <input type="radio"/> |
| 3. Employment Service | | |
| A. Pre-Employment | <input type="radio"/> | <input type="radio"/> |
| B. Employment Coaching | <input type="radio"/> | <input type="radio"/> |
| 4. Individual Services Coordination | <input type="radio"/> | <input type="radio"/> |
| 5. Transportation | <input type="radio"/> | <input type="radio"/> |
| 6. HIV/AIDS Service | <input type="radio"/> | <input type="radio"/> |
| 7. Supportive Housing Services | <input type="radio"/> | <input type="radio"/> |
| 8. Other Case Management Services (Specify) _____ | <input type="radio"/> | <input type="radio"/> |

Medical Services

- | | Yes | No |
|---|-----------------------|-----------------------|
| 1. Medical Care | <input type="radio"/> | <input type="radio"/> |
| 2. Alcohol/Drug Testing | <input type="radio"/> | <input type="radio"/> |
| 3. HIV/AIDS Medical Support and Testing | <input type="radio"/> | <input type="radio"/> |
| 4. Other Medical Services (Specify) _____ | <input type="radio"/> | <input type="radio"/> |

After Care Services

- | | Yes | No |
|--|-----------------------|-----------------------|
| 1. Continuing Care | <input type="radio"/> | <input type="radio"/> |
| 2. Relapse Prevention | <input type="radio"/> | <input type="radio"/> |
| 3. Recovery Coaching | <input type="radio"/> | <input type="radio"/> |
| 4. Self-Help and Support Groups | <input type="radio"/> | <input type="radio"/> |
| 5. Spiritual Support | <input type="radio"/> | <input type="radio"/> |
| 6. Other After Care Services (Specify) _____ | <input type="radio"/> | <input type="radio"/> |

Education Services

- | | Yes | No |
|---|-----------------------|-----------------------|
| 1. Substance Abuse Education | <input type="radio"/> | <input type="radio"/> |
| 2. HIV/AIDS Education | <input type="radio"/> | <input type="radio"/> |
| 3. Other Education Services (Specify) _____ | <input type="radio"/> | <input type="radio"/> |

Peer-to-Peer Recovery Support Services

- | | Yes | No |
|---|-----------------------|-----------------------|
| 1. Peer Coaching or Mentoring | <input type="radio"/> | <input type="radio"/> |
| 2. Housing Support | <input type="radio"/> | <input type="radio"/> |
| 3. Alcohol- and Drug-Free Social Activities | <input type="radio"/> | <input type="radio"/> |
| 4. Information and Referral | <input type="radio"/> | <input type="radio"/> |
| 5. Other Peer-to-Peer Recovery Support Services (Specify) _____ | <input type="radio"/> | <input type="radio"/> |

A4. DEMOGRAPHICSReported **BY CLIENT** only at intake/baseline interview**1. What is your gender?**

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Male | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Female | <input type="checkbox"/> Refused |
| <input type="checkbox"/> Transgender | |

2. Are you Hispanic or Latino?

- | | | |
|------------------------------|-----------------------------|----------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Refused |
|------------------------------|-----------------------------|----------------------------------|

[IF YES] What ethnic group do you consider yourself? Please answer Yes or No for each of the following. You may answer Yes to more than one option.

Ethnic Group	Yes	No	Refused
Central American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cuban	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dominican	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mexican	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Puerto Rican	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
South American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify) _____			

3. What is your race? Please answer Yes or No for each of the following. You may answer Yes to more than one option.

Race	Yes	No	Refused
Black or African American			
Asian			
Native Hawaiian or other Pacific Islander			
Alaska Native			
White			
American Indian			

4. What is your date of birth?*

_ _	_ _	/	_ _	_ _	_ _	_ _	_ _	_ _	_ _
Month		Day		Year					

☐ Refused

*The system will only save month and year to maintain confidentiality. Day will not be saved but is needed and kept confidentially for records management.

A5. MILITARY FAMILY AND DEPLOYMENT

Reported **BY CLIENT**

5. Have you ever served in the Armed Forces, in the Reserves, or in the National Guard? [IF SERVED] In which area, the Armed Forces, Reserves, or National Guard did you serve?

<input type="checkbox"/> No	<input type="checkbox"/> Yes, in the National Guard
<input type="checkbox"/> Yes, in the Armed Forces	<input type="checkbox"/> Refused
<input type="checkbox"/> Yes, in the Reserves	<input type="checkbox"/> Don't know

[NO, REFUSED, OR DON'T KNOW, SKIP TO QUESTION A6.]

5a. Are you currently on active duty in the Armed Forces, in the Reserves, or in the National Guard? [IF ACTIVE] In which area, the Armed Forces, Reserves, or National Guard?

<input type="checkbox"/> No, separated or retired from the Armed Forces, Reserves or National Guard	<input type="checkbox"/> Yes, in the National Guard
<input type="checkbox"/> Yes, in the Armed Forces	<input type="checkbox"/> Refused
<input type="checkbox"/> Yes, in the Reserves	<input type="checkbox"/> Don't know

5b. Have you ever been deployed to a combat zone? [CHECK ALL THAT APPLY.]

☐ Never deployed

☐ Iraq or Afghanistan (e.g., Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND))

☐ Persian Gulf (Operation Desert Shield/Desert Storm)

☐ Vietnam/Southeast Asia

☐ Korea

☐ WWII

☐ Deployed to a combat zone not listed above (e.g., Bosnia/Somalia)

☐ Refused

☐ Don't know

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

- ☐ No
 ☐ Yes, more than one
 ☐ Don't know
☐ Yes, only one
 ☐ Refused

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO SECTION B.]

[IF YES, ANSWER FOR UP TO 6 PEOPLE.] What is the relationship of that person (Service Member) to you?
[WRITE RELATIONSHIP IN COLUMN HEADING.]

1 = Mother 2 = Father
 3 = Brother 4 = Sister
 5 = Spouse 6 = Partner
 7 = Child 8 = Other (Specify) _____

Has the Service Member experienced any of the following? [CHECK ANSWER IN APPROPRIATE COLUMN FOR ALL THAT APPLY.]	_____ (Relationship) 1.	_____ (Relationship) 2.	_____ (Relationship) 3.	_____ (Relationship) 4.	_____ (Relationship) 5.	_____ (Relationship) 6.
Deployed in support of combat operations (e.g., Iraq or Afghanistan)?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFUSED <input type="checkbox"/> DON'T KNOW	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFUSED <input type="checkbox"/> DON'T KNOW	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFUSED <input type="checkbox"/> DON'T KNOW	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFUSED <input type="checkbox"/> DON'T KNOW	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFUSED <input type="checkbox"/> DON'T KNOW	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFUSED <input type="checkbox"/> DON'T KNOW
Was physically injured during combat operations?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFUSED <input type="checkbox"/> DON'T KNOW	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFUSED <input type="checkbox"/> DON'T KNOW	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFUSED <input type="checkbox"/> DON'T KNOW	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFUSED <input type="checkbox"/> DON'T KNOW	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFUSED <input type="checkbox"/> DON'T KNOW	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFUSED <input type="checkbox"/> DON'T KNOW

Developed combat stress symptoms/difficulties adjusting following deployment, including post-traumatic stress disorder (PTSD), depression, or suicidal thoughts?	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES
	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO
	<input type="checkbox"/> REFUSED	<input type="checkbox"/> REFUSED	<input type="checkbox"/> REFUSED	<input type="checkbox"/> REFUSED	<input type="checkbox"/> REFUSED	<input type="checkbox"/> REFUSED
	<input type="checkbox"/> DON'T KNOW	<input type="checkbox"/> DON'T KNOW	<input type="checkbox"/> DON'T KNOW	<input type="checkbox"/> DON'T KNOW	<input type="checkbox"/> DON'T KNOW	<input type="checkbox"/> DON'T KNOW
Died or was killed?	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES
	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO
	<input type="checkbox"/> REFUSED	<input type="checkbox"/> REFUSED	<input type="checkbox"/> REFUSED	<input type="checkbox"/> REFUSED	<input type="checkbox"/> REFUSED	<input type="checkbox"/> REFUSED
	<input type="checkbox"/> DON'T KNOW	<input type="checkbox"/> DON'T KNOW	<input type="checkbox"/> DON'T KNOW	<input type="checkbox"/> DON'T KNOW	<input type="checkbox"/> DON'T KNOW	<input type="checkbox"/> DON'T KNOW

B. DRUG AND ALCOHOL USE

Reported **BY CLIENT**

	Number of Days	RF	DK
1. During the past 30 days, how many days have you used the following:			
a. Any alcohol <i>[IF ZERO, SKIP TO ITEM B1c.] *</i>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>
b1. Alcohol to intoxication (5+ drinks in one sitting)	<input type="text"/>	<input type="radio"/>	<input type="radio"/>
b2. Alcohol to intoxication (4 or fewer drinks in one sitting and felt high)	<input type="text"/>	<input type="radio"/>	<input type="radio"/>
c. Illegal drugs <i>[IF B1a OR B1c = 0, REFUSED (RF), DON'T KNOW (DK), THEN SKIP TO ITEM B2.]</i>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>
d. Both alcohol and drugs (on the same day)	<input type="text"/>	<input type="radio"/>	<input type="radio"/>

* B1a should equal B1b1 + B1b2

Route of Administration Types:

1. Oral 2. Nasal 3. Smoking 4. Non-intravenous (IV) injection 5. IV

*Note the usual route. For more than one route, choose the most severe. The routes are listed from least severe (1) to more severe (5).

2. During the past 30 days, how many days have you used any of the following (include Route of Administration): [IF THE VALUE IN ANY ITEM B2a–B2i > 0, THEN THE VALUE IN B1c MUST BE > 0.]

	# Days	RF	DK	Route	RF	DK
a. Cocaine/Crack	____	<input type="checkbox"/>	<input type="checkbox"/>	____	<input type="checkbox"/>	<input type="checkbox"/>
b. Marijuana/Hashish	____	<input type="checkbox"/>	<input type="checkbox"/>	____	<input type="checkbox"/>	<input type="checkbox"/>
c. Opiates:						
1. Heroin (Smack, H, Junk, Skag)	____	<input type="checkbox"/>	<input type="checkbox"/>	____	<input type="checkbox"/>	<input type="checkbox"/>
2. Morphine	____	<input type="checkbox"/>	<input type="checkbox"/>	____	<input type="checkbox"/>	<input type="checkbox"/>
3. Dilaudid	____	<input type="checkbox"/>	<input type="checkbox"/>	____	<input type="checkbox"/>	<input type="checkbox"/>
4. Demerol	____	<input type="checkbox"/>	<input type="checkbox"/>	____	<input type="checkbox"/>	<input type="checkbox"/>
5. Percocet	____	<input type="checkbox"/>	<input type="checkbox"/>	____	<input type="checkbox"/>	<input type="checkbox"/>
6. Darvon	____	<input type="checkbox"/>	<input type="checkbox"/>	____	<input type="checkbox"/>	<input type="checkbox"/>
7. Codeine	____	<input type="checkbox"/>	<input type="checkbox"/>	____	<input type="checkbox"/>	<input type="checkbox"/>
8. Tylenol 2, 3, 4	____	<input type="checkbox"/>	<input type="checkbox"/>	____	<input type="checkbox"/>	<input type="checkbox"/>
9. OxyContin/Oxycodone	____	<input type="checkbox"/>	<input type="checkbox"/>	____	<input type="checkbox"/>	<input type="checkbox"/>
d. Non-prescription methadone	____	<input type="checkbox"/>	<input type="checkbox"/>	____	<input type="checkbox"/>	<input type="checkbox"/>
e. Hallucinogens/psychedelics, PCP (Angel Dust, Ozone, Wack, Rocket Fuel), MDMA (Ecstasy, XTC, X, Adam), LSD (Acid, Boomers, Yellow Sunshine), Mushrooms , or Mescaline						
	____	<input type="checkbox"/>	<input type="checkbox"/>	____	<input type="checkbox"/>	<input type="checkbox"/>
f. Methamphetamine or other amphetamines (Meth, Uppers, Speed, Ice, Chalk, Crystal, Glass, Fire, Crank)						
g. Tranquilizers:						
1. Benzodiazepines: Diazepam (Valium); Alprazolam (Xanax); Triazolam (Halcion); and Estazolam Prosom and Rohypnol, also known as roofies, roche, and cope)						
	____	<input type="checkbox"/>	<input checked="" type="checkbox"/>	____	<input type="checkbox"/>	<input type="checkbox"/>
2. Barbiturates: Mephobarbital (Mebacut) and pentobarbital sodium (Nembutal)						
	____	<input type="checkbox"/>	<input type="checkbox"/>	____	<input type="checkbox"/>	<input type="checkbox"/>
3. Non-prescription GHB (known as Grievous Bodily Harm, Liquid Ecstasy, and Georgia Home Boy)						
	____	<input type="checkbox"/>	<input type="checkbox"/>	____	<input type="checkbox"/>	<input type="checkbox"/>
4. Ketamine (known as Special K or Vitamin K)						
	____	<input type="checkbox"/>	<input type="checkbox"/>	____	<input type="checkbox"/>	<input type="checkbox"/>
5. Other tranquilizers, downers, sedatives, or hypnotics						
	____	<input type="checkbox"/>	<input type="checkbox"/>	____	<input type="checkbox"/>	<input type="checkbox"/>
h. Inhalants (poppers, snappers, rush, whippets)						
	____	<input type="checkbox"/>	<input type="checkbox"/>	____	<input type="checkbox"/>	<input type="checkbox"/>
i. Other illegal drugs (Specify)						
	____	<input type="checkbox"/>	<input type="checkbox"/>	____	<input type="checkbox"/>	<input type="checkbox"/>

3. In the past 30 days, have you injected drugs? [IF ANY ROUTE OF ADMINISTRATION IN B2a–B2i = 4 or 5, THEN B3 MUST = YES.]
☐ Yes ☐ No ☐ Refused ☐ Don't know

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO SECTION C.]

4. In the past 30 days, how often did you use a syringe/needle, cooker, cotton, or water that someone else used?

- | | | |
|--|--|-------------------------------------|
| <input type="checkbox"/> Always | <input type="checkbox"/> Less than half the time | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> More than half the time | <input type="checkbox"/> Never | |
| <input type="checkbox"/> Half the time | <input type="checkbox"/> Refused | |

C. FAMILY AND LIVING CONDITIONS

Reported BY CLIENT

1. In the past 30 days, where have you been living most of the time? [DO NOT READ RESPONSE OPTIONS TO CLIENT.]

- ☐ Shelter (safe havens, transitional living center, low-demand facilities, reception centers, other temporary day or evening facility)
- ☐ Street/outdoors (sidewalk, doorway, park, public or abandoned building)
- ☐ Institution (hospital, nursing home, jail/prison)
- ☐ Housed: **[IF HOUSED, CHECK APPROPRIATE SUBCATEGORY:]**
- Own/rent apartment, room or house
 - Someone else's apartment, room or house
 - Dormitory/college residence
 - Halfway house
 - Residential treatment
 - Other housed (please specify) _____
- Don't know
- Refused

2. How satisfied are you with the conditions of your living space?

- | | | |
|--|--|---|
| <input type="checkbox"/> Very dissatisfied | <input type="checkbox"/> Neither satisfied nor | <input type="checkbox"/> Very satisfied |
| <input type="checkbox"/> Dissatisfied | dissatisfied | <input type="checkbox"/> Refused |
| | <input type="checkbox"/> Satisfied | <input type="checkbox"/> Don't know |

3. During the past 30 days, how stressful have things been for you because of your use of alcohol or other drugs? **[IF B1a OR B1c > 0, THEN C3 CANNOT = "NOT APPLICABLE." If B1a OR B1c = 0, THEN C3 MUST = "NOT APPLICABLE"]**

- | | | |
|---------------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Not at all | <input type="checkbox"/> Extremely | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Somewhat | <input type="checkbox"/> Not applicable | |
| <input type="checkbox"/> Considerably | <input type="checkbox"/> Refused | |

4. During the past 30 days, has your use of alcohol or other drugs caused you to reduce or give up important activities? **[IF B1a OR B1c > 0, THEN C4 CANNOT = "NOT APPLICABLE." If B1a OR B1c = 0, THEN C4 MUST = "NOT APPLICABLE"]**

- | | | |
|-------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Not at all | <input type="checkbox"/> Considerably | <input type="checkbox"/> Not applicable |
| <input type="checkbox"/> Somewhat | <input type="checkbox"/> Extremely | <input type="checkbox"/> Refused |
| <input type="checkbox"/> Don't know | | |

5. During the past 30 days, has your use of alcohol or other drugs caused you to have emotional problems? **[IF B1a OR B1c > 0, THEN C5 CANNOT = "NOT APPLICABLE." If B1a OR B1c = 0, THEN C5 MUST = "NOT APPLICABLE"]**

- ☐ Not at all ☐ Extremely ☐ Don't know
☐ Somewhat ☐ Not applicable
☐ Considerably ☐ Refused

6. **[IF NOT MALE] Are you currently pregnant?**

- ☐ Yes ☐ No ☐ Refused ☐ Don't know

7. **Do you have children?**

- ☐ Yes ☐ No ☐ Refused ☐ Don't know

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO SECTION D.]

a. **How many children do you have? [IF C7 = YES, THEN THE VALUE IN C7a MUST BE > 0.]**

- ☐ Refused ☐ Don't know

b. **Are any of your children living with someone else due to a child protection court order?**

- ☐ Yes ☐ No ☐ Refused ☐ Don't know

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO ITEM C7d.]

c. **[IF YES] How many of your children are living with someone else due to a child protection court order? [THE VALUE IN C7c CANNOT EXCEED THE VALUE IN C7a.]**

- ☐ Refused ☐ Don't know

d. **For how many of your children have you lost parental rights? [THE CLIENT'S PARENTAL RIGHTS WERE TERMINATED.] [THE VALUE IN ITEM C7d CANNOT EXCEED THE VALUE IN C7a.]**

- ☐ Refused ☐ Don't know

D. EDUCATION, EMPLOYMENT, AND INCOME

Reported BY CLIENT

1. **Are you currently enrolled in school or a job training program? [IF ENROLLED] Is that full time or part time? [IF CLIENT IS INCARCERATED, CODE D1 AS "NOT ENROLLED."]**

- ☐ Not enrolled ☐ Other (specify) _____ ☐ Don't know
☐ Enrolled, part time ☐ Enrolled, full time ☐ Refused

2. What is the highest level of education you have finished, whether or not you received a degree?

- | | |
|---|--|
| <input type="checkbox"/> Never attended | <input type="checkbox"/> 11 th grade |
| <input type="checkbox"/> 1 st grade | <input type="checkbox"/> 12 th grade |
| <input type="checkbox"/> 2 nd grade | <input type="checkbox"/> College or university/1 st year completed |
| <input type="checkbox"/> 3 rd grade | <input type="checkbox"/> College or university/2 nd year completed |
| <input type="checkbox"/> 4 th grade | <input type="checkbox"/> College or university/3 rd year completed |
| <input type="checkbox"/> 5 th grade | <input type="checkbox"/> Bachelor's degree (BA, BS) or higher |
| <input type="checkbox"/> 6 th grade | <input type="checkbox"/> Vocational/technical program after high school but not Voc/Tech diploma |
| <input type="checkbox"/> 7 th grade | <input type="checkbox"/> Voc/Tech diploma after high school |
| <input type="checkbox"/> 8 th grade | <input type="checkbox"/> Refused |
| <input type="checkbox"/> 9 th grade | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> 10 th grade | |

3. Are you currently employed?

[CLARIFY BY FOCUSING ON STATUS DURING MOST OF THE PREVIOUS WEEK, DETERMINING WHETHER CLIENT WORKED AT ALL OR HAD A REGULAR JOB BUT WAS OFF WORK. IF CLIENT IS "ENROLLED, FULL TIME" IN D1 AND INDICATES "EMPLOYED, FULL TIME" IN D3, ASK FOR CLARIFICATION. IF CLIENT IS INCARCERATED AND HAS NO WORK OUTSIDE OF JAIL, CODE D3 AS "UNEMPLOYED, NOT LOOKING FOR WORK."]

- | | |
|---|---|
| <input type="checkbox"/> Employed, full time (35+ hours/week) | <input type="checkbox"/> Unemployed, retired |
| <input type="checkbox"/> Employed, part time | <input type="checkbox"/> Unemployed, not looking for work |
| <input type="checkbox"/> Unemployed, looking for work | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Unemployed, disabled | <input type="checkbox"/> Refused |
| <input type="checkbox"/> Unemployed, volunteer work | <input type="checkbox"/> Don't know |

4. Approximately, how much money did YOU receive (pre-tax individual income) in the past 30 days from ...

[IF D3 DOES NOT = "EMPLOYED" AND THE VALUE IN D4a IS GREATER THAN ZERO, PROBE. IF D3 = "UNEMPLOYED, LOOKING FOR WORK" AND THE VALUE IN D4b = 0, PROBE. IF D3 = "UNEMPLOYED, RETIRED" AND THE VALUE IN D4c = 0, PROBE. IF D3 = "UNEMPLOYED, DISABLED" AND THE VALUE IN D4d = 0, PROBE.] [Please fill in all line items a-g, even if = '0']

		RF	DK
a.	Wages	<input type="checkbox"/>	<input type="checkbox"/>
b.	Public assistance	<input type="checkbox"/>	<input type="checkbox"/>
c.	Retirement	<input type="checkbox"/>	<input type="checkbox"/>
d.	Disability	<input type="checkbox"/>	<input type="checkbox"/>
e.	Non-legal income	<input type="checkbox"/>	<input type="checkbox"/>
f.	Family and/or friends	<input type="checkbox"/>	<input type="checkbox"/>
g.	Other (Specify) _____	<input type="checkbox"/>	<input type="checkbox"/>

5. Have you enough money to meet your needs?

- | | | |
|-------------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Not at all | <input type="checkbox"/> Mostly | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> A little | <input type="checkbox"/> Completely | |
| <input type="checkbox"/> Moderately | <input type="checkbox"/> Refused | |

E. CRIME AND CRIMINAL JUSTICE STATUS

Reported BY CLIENT

1. In the past 30 days, how many times have you been arrested?

_____ times

☐ Refused

☐ Don't know

[IF NO ARRESTS, SKIP TO ITEM E3.]

2. In the past 30 days, how many times have you been arrested for drug-related offenses? [THE VALUE IN E2 CANNOT BE GREATER THAN THE VALUE IN E1.]

_____ times

☐ Refused

☐ Don't know

3. In the past 30 days, how many nights have you spent in jail/prison? [IF THE VALUE IN E3 IS GREATER THAN 15, THEN C1 MUST = INSTITUTION (JAIL/PRISON). IF C1 = INSTITUTION (JAIL/PRISON), THEN THE VALUE IN E3 MUST BE GREATER THAN OR EQUAL TO 15.]

_____ nights

☐ Refused

☐ Don't know

4. In the past 30 days, how many times have you committed a crime? [CHECK NUMBER OF DAYS USED ILLEGAL DRUGS IN ITEM B1c. ANSWER HERE IN E4 SHOULD BE EQUAL TO OR GREATER THAN NUMBER IN B1c BECAUSE USING ILLEGAL DRUGS IS A CRIME.]

|____| |____| |____| times

☐ Refused

☐ Don't know

5. Are you currently awaiting charges, trial, or sentencing?

☐ Yes

☐ No

☐ Refused

☐ Don't know

6. Are you currently on parole or probation?

☐ Yes

☐ No

☐ Refused

☐ Don't know

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY

Reported BY CLIENT

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

☐ Excellent

☐ Fair

☐ Don't know

☐ Very good

☐ Poor

☐ Good

☐ Refused

2. During the past 30 days, did you receive:

a. Inpatient treatment for:

[IF YES]

Altogether

	YES	for how many nights	NO	RF	DK
i. Physical complaint	<input type="checkbox"/>	_____ nights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. Mental or emotional difficulties	<input type="checkbox"/>	_____ nights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii. Alcohol or substance abuse	<input type="checkbox"/>	_____ nights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

b. Outpatient treatment for:

		[IF YES] Altogether			
	YES	for how many times	NO	RF	DK
i. Physical complaint	<input type="checkbox"/>	_____ times	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. Mental or emotional difficulties	<input type="checkbox"/>	_____ times	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii. Alcohol or substance abuse	<input type="checkbox"/>	_____ times	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

c. Emergency room treatment for:

		[IF YES] Altogether			
	YES	for how many times	NO	RF	DK
i. Physical complaint	<input type="checkbox"/>	_____ times	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. Mental or emotional difficulties	<input type="checkbox"/>	_____ times	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii. Alcohol or substance abuse	<input type="checkbox"/>	_____ times	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. During the past 30 days, did you engage in sexual activity?

- ☐ Yes
 ☐ Not permitted to ask
 ☐ Refused
 ☐ No
 ☐ Don't know

[IF NO, NOT PERMITTED TO ASK, REFUSED, OR DON'T KNOW, SKIP TO F4]

[IF YES] Altogether, how many:

- | | Contacts | RF | DK |
|---|----------|--------------------------|--------------------------|
| a. Sexual contacts (vaginal, oral, or anal) did you have? | ____ | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Unprotected sexual contacts did you have? [THE VALUE IN F3b SHOULD NOT BE GREATER THAN THE VALUE IN F3a.] [IF ZERO, SKIP TO F4.] | ____ | | |
| c. Unprotected sexual contacts were with an individual who is or was [NONE OF THE VALUES IN F3c1–F3c3 CAN BE GREATER THAN THE VALUE IN F3b.] | | | |
| 1. HIV positive or has AIDS | ____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. An injection drug user | ____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. High on some substance | ____ | <input type="checkbox"/> | <input type="checkbox"/> |

4. Have you ever been tested for HIV?

- ☐ Yes
 ☐ Refused
 ☐ No **[SKIP TO F5.]**
☐ Don't know **[SKIP TO F5.]**

a. Do you know the results of your HIV testing?

- ☐ Yes
 ☐ No

5. How would you rate your quality of life?

- ☐ Very poor
 ☐ Good
 ☐ Don't know
 ☐ Poor
 ☐ Very good
 ☐ Neither poor nor good
 ☐ Refused

6. How satisfied are you with your health?

- | | | |
|--|--|---|
| <input type="checkbox"/> Very dissatisfied | <input type="checkbox"/> Neither satisfied nor | <input type="checkbox"/> Very satisfied |
| <input type="checkbox"/> Dissatisfied | dissatisfied | <input type="checkbox"/> Refused |
| | <input type="checkbox"/> Satisfied | <input type="checkbox"/> Don't know |

7. Do you have enough energy for everyday life?

- | | | |
|-------------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Not at all | <input type="checkbox"/> Mostly | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> A little | <input type="checkbox"/> Completely | |
| <input type="checkbox"/> Moderately | <input type="checkbox"/> Refused | |

8. How satisfied are you with your ability to perform your daily activities?

- | | | |
|--|--|---|
| <input type="checkbox"/> Very dissatisfied | <input type="checkbox"/> Neither satisfied nor | <input type="checkbox"/> Very satisfied |
| <input type="checkbox"/> Dissatisfied | dissatisfied | <input type="checkbox"/> Refused |
| | <input type="checkbox"/> Satisfied | <input type="checkbox"/> Don't know |

9. How satisfied are you with yourself?

- | | | |
|--|--|---|
| <input type="checkbox"/> Very dissatisfied | <input type="checkbox"/> Neither satisfied nor | <input type="checkbox"/> Very satisfied |
| <input type="checkbox"/> Dissatisfied | dissatisfied | <input type="checkbox"/> Refused |
| | <input type="checkbox"/> Satisfied | <input type="checkbox"/> Don't know |

10. In the past 30 days, not due to your use of alcohol or drugs, how many days have you:

- | | Days | RF | DK |
|---|------|--------------------------|--------------------------|
| a. Experienced serious depression | ____ | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Experienced serious anxiety or tension | ____ | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Experienced hallucinations | ____ | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Experienced trouble understanding, concentrating, or remembering | ____ | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Experienced trouble controlling violent behavior | ____ | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Attempted suicide | ____ | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Been prescribed medication for psychological/emotional problem | ____ | | |

[IF CLIENT REPORTS ZERO DAYS, RF, OR DK TO ALL ITEMS IN QUESTION F10, SKIP TO ITEM F12.]

11. How much have you been bothered by these psychological or emotional problems in the past 30 days?

- | | | |
|-------------------------------------|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Not at all | <input type="checkbox"/> Considerably | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Slightly | <input type="checkbox"/> Extremely | |
| <input type="checkbox"/> Moderately | <input type="checkbox"/> Refused | |

F. VIOLENCE AND TRAUMA

Reported **BY CLIENT**

12. 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 ☐ Refused ☐ Don't know

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO ITEM F13.]

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

12a. Have had nightmares about it or thought about it when you did not want to?

☐ Yes
☐ No
☐ Refused
☐ Don't know

12b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?

☐ Yes
☐ No
☐ Refused
☐ Don't know

12c. Were constantly on guard, watchful, or easily startled?

☐ Yes
☐ No
☐ Refused
☐ Don't know

12d. Felt numb and detached from others, activities, or your surroundings?

☐ Yes
☐ No
☐ Refused
☐ Don't know

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

☐ Never ☐ More than a few times ☐ Don't know
☐ A few times ☐ Refused

G. SOCIAL CONNECTEDNESS

Reported BY CLIENT

1. In the past 30 days, did you attend any voluntary self-help groups for recovery that were not affiliated with a religious or faith-based organization? In other words, did you participate in a nonprofessional, peer-operated organization that is devoted to helping individuals who have addiction-related problems, such as Alcoholics Anonymous, Narcotics Anonymous, Oxford House, Secular Organization for Sobriety, or Women for Sobriety, etc.?

- ☐ Yes [IF YES] SPECIFY HOW MANY TIMES |____| ☐ Refused ☐ Don't know
☐ No
☐ Refused
☐ Don't know

2. In the past 30 days, did you attend any religious/faith-affiliated recovery self-help groups?

- ☐ Yes [IF YES] SPECIFY HOW MANY TIMES |____| ☐ Refused ☐ Don't know
☐ No
☐ Refused
☐ Don't know

3. In the past 30 days, did you attend meetings of organizations that support recovery other than the organizations described above?

- ☐ Yes [IF YES] SPECIFY HOW MANY TIMES |____| ☐ Refused ☐ Don't know
☐ No
☐ Refused
☐ Don't know

4. In the past 30 days, did you have interaction with family and/or friends that are supportive of your recovery?

- ☐ Yes ☐ No ☐ Refused ☐ Don't know

5. To whom do you turn when you are having trouble? [SELECT ONLY ONE.]

- | | | |
|--|-------------------------------------|--------------------------------|
| <input type="checkbox"/> No one | <input type="checkbox"/> Friends | <input type="checkbox"/> Other |
| <input type="checkbox"/> Clergy member | <input type="checkbox"/> Refused | (specify) _____ |
| <input type="checkbox"/> Family member | <input type="checkbox"/> Don't know | |

6. How satisfied are you with your personal relationships?

- | | | |
|--|--|---|
| <input type="checkbox"/> Very dissatisfied | <input type="checkbox"/> Neither satisfied nor | <input type="checkbox"/> Very satisfied |
| <input type="checkbox"/> Dissatisfied | dissatisfied | <input type="checkbox"/> Refused |
| | <input type="checkbox"/> Satisfied | <input type="checkbox"/> Don't know |

I. FOLLOW UP STATUS

Reported **BY PROGRAM STAFF ONLY** at follow up

1. What is the follow-up status of the client? [THIS IS A REQUIRED FIELD: NA, REFUSED, DON'T KNOW, AND MISSING WILL NOT BE ACCEPTED.]

- ☐ 01 = Deceased at time of due date
- ☐ 11 = Completed interview within specified window
- ☐ 12 = Completed interview outside specified window
- ☐ 21 = Located, but refused, unspecified
- ☐ 22 = Located, but unable to gain institutional access
- ☐ 23 = Located, but otherwise unable to gain access
- ☐ 24 = Located, but withdrawn from project
- ☐ 31 = Unable to locate, moved
- ☐ 32 = Unable to locate, other (Specify) _____

2. Is the client still receiving services from your program?

- ☐ Yes ☐ No

[IF THIS IS A FOLLOW-UP INTERVIEW, STOP NOW; THE INTERVIEW IS COMPLETE.]

J. DISCHARGE STATUS

Reported **BY PROGRAM STAFF ONLY** at discharge

1. On what date was the client discharged?

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

2. What is the client's discharge status?

☐ 01 = Completion/Graduate

☐ 02 = Termination

If the client was terminated, what was the reason for termination? [SELECT ONE RESPONSE.]

☐ 01 = Left on own against staff advice with satisfactory progress

☐ 02 = Left on own against staff advice without satisfactory progress

☐ 03 = Involuntarily discharged due to nonparticipation

☐ 04 = Involuntarily discharged due to violation of rules

☐ 05 = Referred to another program or other services with satisfactory progress

☐ 06 = Referred to another program or other services with unsatisfactory progress

☐ 07 = Incarcerated due to offense committed while in treatment/recovery with satisfactory progress

☐ 08 = Incarcerated due to offense committed while in treatment/recovery with unsatisfactory progress

☐ 09 = Incarcerated due to old warrant or charged from before entering treatment/recovery with satisfactory progress

☐ 10 = Incarcerated due to old warrant or charged from before entering treatment/recovery with unsatisfactory progress

☐ 11 = Transferred to another facility for health reasons

☐ 12 = Death

☐ 13 = Other (Specify) _____

3. Did the program test this client for HIV?

☐ Yes **[SKIP TO SECTION K.]**

☐ No

4. [IF NO] Did the program refer this client for testing?

☐ Yes

☐ No

K. SERVICES RECEIVEDReported **BY PROGRAM STAFF ONLY** at discharge

Identify the number of **DAYS** of services provided to the client during the client's course of treatment/recovery. **[ENTER ZERO IF NO SERVICES PROVIDED. YOU SHOULD HAVE AT LEAST ONE DAY FOR MODALITY.]**

	Modality	Days			Days
1.	Case Management	_ _ _ _	9.	Detoxification (Select Only One):	
2.	Day Treatment	_ _ _ _	A.	Hospital Inpatient	_ _ _ _
3.	Inpatient/Hospital (Other Than Detox)	_ _ _ _	B.	Free-Standing Residential	_ _ _ _
		_ _ _ _			_ _ _ _
4.	Outpatient	_ _ _ _	C.	Ambulatory Detoxification	_ _ _ _
5.	Outreach	_ _ _ _			_ _ _ _
6.	Intensive Outpatient	_ _ _ _	10.	After Care	_ _ _ _
7.	Methadone	_ _ _ _	11.	Recovery Support	_ _ _ _
8.	Residential/Rehabilitation	_ _ _ _	12.	Other (Specify)	_ _ _ _
		_ _ _ _			_ _ _ _

Identify the number of **SESSIONS** provided to the client during the client's course of treatment/recovery. **[ENTER ZERO IF NO SERVICES PROVIDED.]**

Treatment Services	Sessions			Sessions
1. Screening	_ _ _ _	A.	Pre-Employment	_ _ _ _
2. Brief Intervention	_ _ _ _	B.	Employment Coaching	_ _ _ _
3. Brief Treatment	_ _ _ _	4.	Individual Services Coordination	_ _ _ _
4. Referral to Treatment	_ _ _ _			_ _ _ _
5. Assessment	_ _ _ _	5.	Transportation	_ _ _ _
6. Treatment/Recovery Planning	_ _ _ _	6.	HIV/AIDS Service	_ _ _ _
	_ _ _ _	7.	Supportive Transitional Drug-Free Housing Services	_ _ _ _
7. Individual Counseling	_ _ _ _	8.	Other Case Management Services (Specify)	_ _ _ _
8. Group Counseling	_ _ _ _			_ _ _ _
9. Family/Marriage Counseling	_ _ _ _			_ _ _ _
	_ _ _ _			_ _ _ _
10. Co-Occurring Treatment/Recovery Services	_ _ _ _			_ _ _ _
11. Pharmacological Interventions	_ _ _ _			_ _ _ _
	_ _ _ _			_ _ _ _
12. HIV/AIDS Counseling	_ _ _ _			_ _ _ _
13. Other Clinical Services (Specify)	_ _ _ _			_ _ _ _
	_ _ _ _			_ _ _ _

Case Management Services	Sessions
1. Family Services (Including Marriage Education, Parenting, Child Development Services)	_ _ _ _
2. Child Care	_ _ _ _
3. Employment Service	_ _ _ _

After Care Services	Sessions
1. Continuing Care	_ _ _ _
2. Relapse Prevention	_ _ _ _
3. Recovery Coaching	_ _ _ _
4. Self-Help and Support Groups	_ _ _ _
5. Spiritual Support	_ _ _ _

Sessions

6. Other After Care Services
(Specify) |__|__|__|

Education Services **Sessions**

1. Substance Abuse Education |__|__|__|

2. HIV/AIDS Education |__|__|__|

3. Other Education Services
(Specify) |__|__|__|

Peer-to-Peer Recovery Support Services

Sessions

1. Peer Coaching or Mentoring |__|__|__|

2. Housing Support |__|__|__|

3. Alcohol- and Drug-Free Social Activities |__|__|__|

4. Information and Referral |__|__|__|

5. Other Peer-to-Peer Recovery Support
Services (Specify) |__|__|__|