

## Client Program Enrollment Instructions

GPRA Form      Intake \_\_\_\_      Follow-up \_\_\_\_



**Note:** Client must have an Opioid Use Disorder to enroll in any program (PMT).

### 1) Peer Recovery Support (P)

If client is enrolled in this program, use the **P watermark** form

### 2) Medication Assisted Treatment (M)

If client is enrolled in this program, use the **M watermark** form.

### 3) Telehealth Services (T)

If client is enrolled in this program, use the **T watermark** form.

**Note:** If a client of one program is then enrolled in another program you can use the original GPRA if it is less than 2 months old. Just fill out the watermark pages of new program and attach pages 2-21. If original GPRA is older than 2 months you must complete a new GPRA.

**If you have any questions, or need assistance, please contact Josh Mayo at [jmayo@itcmi.org](mailto:jmayo@itcmi.org)**

## Assigning ID numbers to new clients.

**Important:** Follow these instructions for modifying an existing client ID number or assigning a new client ID number. Note: All **NEW** clients will need a **NEW GPRA intake** completed.

**Keeping a current client ID number:** If a client is already enrolled in services such as Peer Recovery Support (P) and has a Client ID like **BM4001\_P**, they will keep their current client ID number.

**Modifying an existing client ID number:** If a client already has a P and is then also enrolled in Medication Assisted Treatment, you will add an M behind the P which signifies that the client is both a Peer Recovery Support client as well as a Medication Assisted Treatment client. The same goes for Telehealth (T) clients.

Example: **Client's ID number is BM4001\_P** and they are only receiving Peer Recovery Support. The same client is then enrolled in Medication Assisted Treatment, their **Client ID number becomes BM4001\_PM** If the client then also becomes a Telehealth client, their **Client ID would become BM4001\_PMT**

**Assigning a new Client ID number:** If a client is new, they will receive a new 4 digit number that identifies both the Tribe that is providing services to them, and the type of program.

### Every Client ID will contain three things:

1. The prefix of the Tribe where services are provided - such as Bay Mills is BM, Sault Tribe is ST, etc.
2. A number - either existing Client ID number or a new 4-digit number
3. Letter(s) signifying the type of program - P, M, and/or T

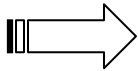
**Attention:** Tribes are now responsible for assigning numbers to clients. It is extremely important that a staff member at your agency keeps a **log of names that match numbers** in a secure location as we no longer have the voucher system and cannot match client numbers with names.

Client ID \_\_\_\_\_

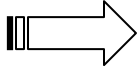
**CSAT GPRA Client/Participant Outcome  
Measures for Discretionary Programs  
(Revised 4/29/2020)**

Name of Primary Counselor/Interviewer: \_\_\_\_\_ Tribal Access Site **BM**

Name of person completing GPRA



**Each question requires an answer.**



**Please double check your work.**

**THIS FORM CAN NOT BE COUNTED BY SPARS UNLESS IT IS COMPLETE**

**ONCE A CLIENT ID # IS ASSIGNED, IT WILL NEVER CHANGE. THIS REMAINS WITH THE CLIENT  
NO MATTER HOW MANY INTAKES OR FOLLOW-UPS ARE COMPLETED.**

**In order to enroll a client in the MAT, Peer-Recovery or Telehealth programs, the client must have an opioid use  
disorder diagnosis (Primary, Secondary or Tertiary)**

**FAX TO INTER-TRIBAL COUNCIL OF MICHIGAN  
Fax- 906-632-7744 or email [jmayo@itcmi.org](mailto:jmayo@itcmi.org)**

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information, if all items are asked of a client/participant; to the extent that providers already obtain much of this information as part of their ongoing client/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 7-1044, 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 0930-0208.

**Insurance Information:**

**Medicaid Eligible:** YES NO

**Enrolled in Medicaid:** YES NO

**Other Insurance:** YES NO

**Insurance Company Name:** \_\_\_\_\_

**A. RECORD MANAGEMENT****Client/Participant ID** BM | | | | | | |**Interview Type** (circle only one type) –

Intake [GO TO INTERVIEW DATE]

 1<sup>st</sup> Intake6 month follow-up → → → Did you conduct a follow-up interview?  Yes  No  
[IF NO, GO DIRECTLY TO SECTION I]Discharge → Did you conduct a discharge interview?  Yes  No [IF NO, GO  
DIRECTLY TO SECTION J] – Only discharge a client if you are sure they will not return for service**Interview Date** | | | | / | | | | / | | | |  
Month / Day / Year**[FOLLOW-UP AND DISCHARGE INTERVIEWS: SKIP TO SECTION B]****NOTE: In Sections A through G, whenever the answers to the questions are given in CAPITAL letters, do NOT read the options to the client: wait for the client to respond and fill in the corresponding option. We are looking for the client's perception, not that of the interviewer.****Client's Tribe - Check only one**

- |   |   |
|---|---|
| <input type="checkbox"/> <i>Bay Mills Indian Community</i>                      | <input type="checkbox"/> <i>Nottawaseppi Huron Band of Potawatomi</i>       |
| <input type="checkbox"/> <i>Grand Traverse Band of Ottawa and Chippewa</i>      | <input type="checkbox"/> <i>Pokagon Band of Potawatomi</i>                  |
| <input type="checkbox"/> <i>Hannahville Indian Community</i>                    | <input type="checkbox"/> <i>Saginaw Chippewa Indian Tribe</i>               |
| <input type="checkbox"/> <i>Keweenaw Bay Indian Community</i>                   | <input type="checkbox"/> <i>Sault Ste Marie Tribe of Chippewa Indian</i>    |
| <input type="checkbox"/> <i>Lac Vieux Desert Band of Lake Superior Chippewa</i> | <input type="checkbox"/> <i>Non-Enrolled Descendent</i>                     |
| <input type="checkbox"/> <i>Little River Band</i>                               | <input type="checkbox"/> <i>Non-Native Family Member of a Tribal Member</i> |
| <input type="checkbox"/> <i>Little Traverse Bay Band of Odawa Indians</i>       | <input type="checkbox"/> <i>Non- Michigan tribe.</i>                        |
| <input type="checkbox"/> <i>Match-E-Be-Nash-She-Wish Potawatomi Gun Lake</i>    | <i>What Tribe?</i>  |

## A. 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.

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
<b><u>SUBSTANCE USE DISORDER DIAGNOSES</u></b>				
<b><u>Alcohol-related disorders</u></b>				
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"/>
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"/>
<b><u>Opioid-related disorders</u></b>				
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"/>
<b><u>Cannabis-related disorders</u></b>				
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"/>
<b><u>Sedative-, hypnotic-, or anxiolytic-related disorders</u></b>				
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"/>

## A. BEHAVIORAL HEALTH DIAGNOSES (CONTINUED)

Behavioral Health Diagnoses	Diagnosed?	For each diagnosis selected, please indicate whether diagnosis is primary, secondary, or tertiary, if known		
	Select up to 3	Primary	Secondary	Tertiary
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"/>
<b><u>Cocaine-related disorders</u></b>				
F14.10 – Cocaine use disorder, uncomplicated, mild	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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"/>
<b><u>Other stimulant-related disorders</u></b>				
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"/>
<b><u>Hallucinogen-related disorders</u></b>				
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"/>
<b><u>Inhalant-related disorders</u></b>				
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"/>

## A. BEHAVIORAL HEALTH DIAGNOSES (CONTINUED)

Behavioral Health Diagnoses	Diagnosed?	For each diagnosis selected, please indicate whether diagnosis is primary, secondary, or tertiary, if known		
	Select up to 3	Primary	Secondary	Tertiary
<b><u>Other psychoactive substance-related disorders</u></b>				
F19.10 – Other psychoactive substance use disorder, uncomplicated, mild	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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"/>
<b><u>Nicotine dependence</u></b>				
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"/>
<b><u>MENTAL HEALTH DIAGNOSES</u></b>				
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"/>
F60.3 – Borderline personality disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## A. BEHAVIORAL HEALTH DIAGNOSES (CONTINUED)

Behavioral Health Diagnoses	Diagnosed?	For each diagnosis selected, please indicate whether diagnosis is primary, secondary, or tertiary, if known		
	Select up to 3	Primary	Secondary	Tertiary
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"/>

- Don't know  
 None of the above

## A. BEHAVIORAL HEALTH DIAGNOSES (CONTINUED)

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

- Yes
- No
- Don't know

#### a. 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

#### a. 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



## A. PLANNED SERVICES

*[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT INTAKE/BASELINE.]*

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	Yes	No
<b>[SELECT AT LEAST ONE MODALITY.]</b>		
1. Case Management	<input type="radio"/>	<input type="radio"/>
2. Day Treatment	<input type="radio"/>	<input type="radio"/>
3. Inpatient/Hospital (Other Than Detox)	<input type="radio"/>	<input type="radio"/>
4. Outpatient	<input type="radio"/>	<input type="radio"/>
5. Outreach	<input type="radio"/>	<input type="radio"/>
6. Intensive Outpatient	<input type="radio"/>	<input type="radio"/>
7. Methadone	<input type="radio"/>	<input type="radio"/>
8. Residential/Rehabilitation	<input type="radio"/>	<input type="radio"/>
9. Detoxification (Select Only One)		
A. Hospital Inpatient	<input type="radio"/>	<input type="radio"/>
B. Free-Standing Residential	<input type="radio"/>	<input type="radio"/>
C. Ambulatory Detoxification	<input type="radio"/>	<input type="radio"/>
10. After Care	<input type="radio"/>	<input type="radio"/>
11. Recovery Support	<input type="radio"/>	<input type="radio"/>
12. Other (Specify) _____	<input type="radio"/>	<input type="radio"/>

**[SELECT AT LEAST ONE SERVICE.]**

Treatment Services	Yes	No
<b>[SBIRT GRANTS: YOU MUST SELECT "YES" FOR AT LEAST ONE OF THE TREATMENT SERVICES NUMBERED 1-4.]</b>		
1. Screening	<input type="radio"/>	<input type="radio"/>
2. Brief Intervention	<input type="radio"/>	<input type="radio"/>
3. Brief Treatment	<input type="radio"/>	<input type="radio"/>
4. Referral to Treatment	<input type="radio"/>	<input type="radio"/>
5. Assessment	<input type="radio"/>	<input type="radio"/>
6. Treatment/Recovery Planning	<input type="radio"/>	<input type="radio"/>
7. Individual Counseling	<input type="radio"/>	<input type="radio"/>
8. Group Counseling	<input type="radio"/>	<input type="radio"/>
9. Family/Marriage Counseling	<input type="radio"/>	<input type="radio"/>
10. Co-Occurring Treatment/Recovery Services	<input type="radio"/>	<input type="radio"/>
11. Pharmacological Interventions	<input type="radio"/>	<input type="radio"/>
12. HIV/AIDS Counseling	<input type="radio"/>	<input type="radio"/>
13. Other Clinical Services (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 Transitional Drug-Free 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"/>

**A. DEMOGRAPHICS**

*[ASKED ONLY AT INTAKE/BASELINE.]*

**1. What is your gender?**

- MALE
- FEMALE
- TRANSGENDER
- OTHER (SPECIFY) \_\_\_\_\_
- REFUSED

**2. Are you Hispanic or Latino?**

- YES
- NO
- REFUSED

*[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.

<b>Ethnic Group</b>	<b>Yes</b>	<b>No</b>	<b>Refused</b>
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 is your race? Please answer yes or no for each of the following. You may say yes to more than one.**

<b>Race</b>	<b>Yes</b>	<b>No</b>	<b>Refused</b>
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 date of birth?\***

|\_\_| |\_\_| / |\_\_| |\_\_|    *[\*THE SYSTEM WILL ONLY SAVE MONTH AND YEAR.  
 TO MAINTAIN CONFIDENTIALITY, DAY IS NOT SAVED.]*  
 Month                  Day

|\_\_| |\_\_| |\_\_| |\_\_|  
 Year

- REFUSED

**A. MILITARY FAMILY AND DEPLOYMENT**

**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?**

- NO
- YES, IN THE ARMED FORCES
- YES, IN THE RESERVES
- YES, IN THE NATIONAL GUARD
- REFUSED
- DON'T KNOW

**[IF 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?**

- NO, SEPARATED OR RETIRED FROM THE ARMED FORCES, RESERVES, OR NATIONAL GUARD
- YES, IN THE ARMED FORCES
- YES, IN THE RESERVES
- YES, IN THE NATIONAL GUARD
- REFUSED
- 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

**[SBIRT GRANTEES: FOR CLIENTS WHO SCREENED NEGATIVE, THE INTAKE INTERVIEW IS NOW COMPLETE.]**

**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, ONLY ONE
- YES, MORE THAN ONE
- REFUSED
- DON'T KNOW

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

**A. MILITARY FAMILY AND DEPLOYMENT (CONTINUED)**

**[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) \_\_\_\_\_

<b>Has the Service Member experienced any of the following? [CHECK ANSWER IN APPROPRIATE COLUMN FOR ALL THAT APPLY.]</b>	<b>_____ (Relationship) 1.</b>	<b>_____ (Relationship) 2.</b>	<b>_____ (Relationship) 3.</b>	<b>_____ (Relationship) 4.</b>	<b>_____ (Relationship) 5.</b>	<b>_____ (Relationship) 6.</b>
<b>6a. Deployed in support of combat operations (e.g., Iraq or Afghanistan)?</b>	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> REFUSED <input type="radio"/> DON'T KNOW	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> REFUSED <input type="radio"/> DON'T KNOW	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> REFUSED <input type="radio"/> DON'T KNOW	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> REFUSED <input type="radio"/> DON'T KNOW	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> REFUSED <input type="radio"/> DON'T KNOW	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> REFUSED <input type="radio"/> DON'T KNOW
<b>6b. Was physically injured during combat operations?</b>	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> REFUSED <input type="radio"/> DON'T KNOW	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> REFUSED <input type="radio"/> DON'T KNOW	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> REFUSED <input type="radio"/> DON'T KNOW	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> REFUSED <input type="radio"/> DON'T KNOW	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> REFUSED <input type="radio"/> DON'T KNOW	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> REFUSED <input type="radio"/> DON'T KNOW
<b>6c. Developed combat stress symptoms/difficulties adjusting following deployment, including post-traumatic stress disorder (PTSD), depression, or suicidal thoughts?</b>	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> REFUSED <input type="radio"/> DON'T KNOW	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> REFUSED <input type="radio"/> DON'T KNOW	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> REFUSED <input type="radio"/> DON'T KNOW	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> REFUSED <input type="radio"/> DON'T KNOW	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> REFUSED <input type="radio"/> DON'T KNOW	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> REFUSED <input type="radio"/> DON'T KNOW
<b>6d. Died or was killed?</b>	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> REFUSED <input type="radio"/> DON'T KNOW	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> REFUSED <input type="radio"/> DON'T KNOW	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> REFUSED <input type="radio"/> DON'T KNOW	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> REFUSED <input type="radio"/> DON'T KNOW	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> REFUSED <input type="radio"/> DON'T KNOW	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> REFUSED <input type="radio"/> DON'T KNOW

**B. DRUG AND ALCOHOL USE**

**1. During the past 30 days, how many days have you used the following:**

- |   | Number<br>of Days | REFUSED               | DON'T KNOW            |
|---|-------------------|-----------------------|-----------------------|
| a. Any alcohol <i>[IF ZERO, SKIP TO ITEM B1c.]</i>  | _ _ _             | <input type="radio"/> | <input type="radio"/> |
| b1. Alcohol to intoxication (5+ drinks in one sitting)  | _ _ _             | <input type="radio"/> | <input type="radio"/> |
| b2. Alcohol to intoxication (4 or fewer drinks in one sitting and felt high)                      | _ _ _             | <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="radio"/> | <input type="radio"/> |
| d. Both alcohol and drugs (on the same day)   | _ _ _             | <input type="radio"/> | <input type="radio"/> |

**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 MOST SEVERE (5).

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

- |  | Number<br>of Days | RF                    | DK                    | Route* | RF                    | DK                    |
|--|-------------------|-----------------------|-----------------------|--------|-----------------------|-----------------------|
| a. Cocaine/Crack   | _ _ _             | <input type="radio"/> | <input type="radio"/> | _ _    | <input type="radio"/> | <input type="radio"/> |
| b. Marijuana/Hashish (Pot, Joints, Blunts, Chronic, Weed, Mary Jane)   | _ _ _             | <input type="radio"/> | <input type="radio"/> | _ _    | <input type="radio"/> | <input type="radio"/> |
| c. Opiates:  |                   |                       |                       |        |                       |                       |
| 1. Heroin (Smack, H, Junk, Skag)   | _ _ _             | <input type="radio"/> | <input type="radio"/> | _ _    | <input type="radio"/> | <input type="radio"/> |
| 2. Morphine  | _ _ _             | <input type="radio"/> | <input type="radio"/> | _ _    | <input type="radio"/> | <input type="radio"/> |
| 3. Dilaudid  | _ _ _             | <input type="radio"/> | <input type="radio"/> | _ _    | <input type="radio"/> | <input type="radio"/> |
| 4. Demerol   | _ _ _             | <input type="radio"/> | <input type="radio"/> | _ _    | <input type="radio"/> | <input type="radio"/> |
| 5. Percocet  | _ _ _             | <input type="radio"/> | <input type="radio"/> | _ _    | <input type="radio"/> | <input type="radio"/> |
| 6. Darvon  | _ _ _             | <input type="radio"/> | <input type="radio"/> | _ _    | <input type="radio"/> | <input type="radio"/> |
| 7. Codeine   | _ _ _             | <input type="radio"/> | <input type="radio"/> | _ _    | <input type="radio"/> | <input type="radio"/> |
| 8. Tylenol 2, 3, 4   | _ _ _             | <input type="radio"/> | <input type="radio"/> | _ _    | <input type="radio"/> | <input type="radio"/> |
| 9. OxyContin/Oxycodone   | _ _ _             | <input type="radio"/> | <input type="radio"/> | _ _    | <input type="radio"/> | <input type="radio"/> |
| d. Non-prescription methadone  | _ _ _             | <input type="radio"/> | <input type="radio"/> | _ _    | <input type="radio"/> | <input type="radio"/> |
| 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="radio"/> | <input type="radio"/> | _ _    | <input type="radio"/> | <input type="radio"/> |
| f. Methamphetamine or other amphetamines (Meth, Uppers, Speed, Ice, Chalk, Crystal, Glass, Fire, Crank)  | _ _ _             | <input type="radio"/> | <input type="radio"/> | _ _    | <input type="radio"/> | <input type="radio"/> |

**B. DRUG AND ALCOHOL USE (CONTINUED)**

**Route of Administration Types:**

1. Oral 2. Nasal 3. Smoking 4. Non-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 MOST SEVERE (5).

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

	Number of Days	RF	DK	Route*	RF	DK
g. 1. Benzodiazepines: Diazepam (Valium); Alprazolam (Xanax); Triazolam (Halcion); and Estazolam (Prosom and Rohypnol, also known as roofies, roche, and cope)	_ _ _	<input type="radio"/>	<input type="radio"/>	_ _	<input type="radio"/>	<input type="radio"/>
2. Barbiturates: Mephobarbital (Mebacut) and pentobarbital sodium (Nembutal)	_ _ _	<input type="radio"/>	<input type="radio"/>	_ _	<input type="radio"/>	<input type="radio"/>
3. Non-prescription GHB (known as Grievous Bodily Harm, Liquid Ecstasy, and Georgia Home Boy)	_ _ _	<input type="radio"/>	<input type="radio"/>	_ _	<input type="radio"/>	<input type="radio"/>
4. Ketamine (known as Special K or Vitamin K)	_ _ _	<input type="radio"/>	<input type="radio"/>	_ _	<input type="radio"/>	<input type="radio"/>
5. Other tranquilizers, downers, sedatives, or hypnotics	_ _ _	<input type="radio"/>	<input type="radio"/>	_ _	<input type="radio"/>	<input type="radio"/>
h. Inhalants (poppers, snappers, rush, whippets)	_ _ _	<input type="radio"/>	<input type="radio"/>	_ _	<input type="radio"/>	<input type="radio"/>
i. Other illegal drugs (Specify) _____	_ _ _	<input type="radio"/>	<input type="radio"/>	_ _	<input type="radio"/>	<input type="radio"/>

**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?**

- Always
- More than half the time
- Half the time
- Less than half the time
- Never
- REFUSED
- DON'T KNOW

## C. FAMILY AND LIVING CONDITIONS

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 [TLC], 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 (SPECIFY) \_\_\_\_\_
  - REFUSED
  - DON'T KNOW
2. **How satisfied are you with the conditions of your living space?**
- Very dissatisfied
  - Dissatisfied
  - Neither satisfied nor dissatisfied
  - Satisfied
  - Very satisfied
  - REFUSED
  - 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."]**
- Not at all
  - Somewhat
  - Considerably
  - Extremely
  - NOT APPLICABLE [USE ONLY IF B1a AND B1c = 0.]
  - REFUSED
  - DON'T KNOW
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."]**
- Not at all
  - Somewhat
  - Considerably
  - Extremely
  - NOT APPLICABLE [USE ONLY IF B1a AND B1c = 0.]
  - REFUSED
  - DON'T KNOW

**C. FAMILY AND LIVING CONDITIONS (CONTINUED)**

**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."]**

- Not at all
- Somewhat
- Considerably
- Extremely
- NOT APPLICABLE [USE ONLY IF B1a AND B1c = 0.]
- REFUSED
- DON'T KNOW

**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

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
- 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?**

- NEVER ATTENDED
- 1ST GRADE
- 2ND GRADE
- 3RD GRADE
- 4TH GRADE
- 5TH GRADE
- 6TH GRADE
- 7TH GRADE
- 8TH GRADE
- 9TH GRADE
- 10TH GRADE
- 11TH GRADE
- 12TH GRADE/HIGH SCHOOL DIPLOMA/EQUIVALENT
- COLLEGE OR UNIVERSITY/1ST YEAR COMPLETED
- COLLEGE OR UNIVERSITY/2ND YEAR COMPLETED/ASSOCIATES DEGREE (AA, AS)
- COLLEGE OR UNIVERSITY/3RD YEAR COMPLETED
- BACHELOR'S DEGREE (BA, BS) OR HIGHER
- VOCATIONAL/TECHNICAL (VOC/TECH) PROGRAM AFTER HIGH SCHOOL BUT NO VOC/TECH DIPLOMA
- VOC/TECH DIPLOMA AFTER HIGH SCHOOL
- REFUSED
- DON'T KNOW

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."]**

- 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

**D. EDUCATION, EMPLOYMENT, AND INCOME (CONTINUED)**

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.]

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

5. Have you enough money to meet your needs?

- Not at all
- A little
- Moderately
- Mostly
- Completely
- REFUSED
- DON'T KNOW

**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 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**

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

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

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

a. Inpatient treatment for:

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

b. Outpatient treatment for:

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

c. Emergency room treatment for:

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

**F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (CONTINUED)**

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

- Yes
- No *[SKIP TO F4.]*
- NOT PERMITTED TO ASK *[SKIP TO F4.]*
- REFUSED *[SKIP TO F4.]*
- DON'T KNOW *[SKIP TO F4.]*

*[IF YES] Altogether, how many:*

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

**4. Have you ever been tested for HIV?**

- Yes *[GO TO F4a.]*
- No *[SKIP TO F5.]*
- REFUSED *[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
- Poor
- Neither poor nor good
- Good
- Very good
- REFUSED
- DON'T KNOW

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**F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (CONTINUED)****6. How satisfied are you with your health?**

- Very dissatisfied
- Dissatisfied
- Neither satisfied nor dissatisfied
- Satisfied
- Very satisfied
- REFUSED
- DON'T KNOW

**7. Do you have enough energy for everyday life?**

- Not at all
- A little
- Moderately
- Mostly
- Completely
- REFUSED
- DON'T KNOW

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

- Very dissatisfied
- Dissatisfied
- Neither satisfied nor dissatisfied
- Satisfied
- Very satisfied
- REFUSED
- DON'T KNOW

**9. How satisfied are you with yourself?**

- Very dissatisfied
- Dissatisfied
- Neither satisfied nor dissatisfied
- Satisfied
- Very satisfied
- REFUSED
- DON'T KNOW

**F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (CONTINUED)**

**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="radio"/>	<input type="radio"/>
b. Experienced serious anxiety or tension	_ _ _	<input type="radio"/>	<input type="radio"/>
c. Experienced hallucinations	_ _ _	<input type="radio"/>	<input type="radio"/>
d. Experienced trouble understanding, concentrating, or remembering	_ _ _	<input type="radio"/>	<input type="radio"/>
e. Experienced trouble controlling violent behavior	_ _ _	<input type="radio"/>	<input type="radio"/>
f. Attempted suicide	_ _ _	<input type="radio"/>	<input type="radio"/>
g. Been prescribed medication for psychological/emotional problem	_ _ _	<input type="radio"/>	<input type="radio"/>

**[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?**

- Not at all
- Slightly
- Moderately
- Considerably
- Extremely
- REFUSED
- DON'T KNOW

**F. VIOLENCE AND TRAUMA**

**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

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**F. VIOLENCE AND TRAUMA (CONTINUED)**

**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
- A few times
- More than a few times
- REFUSED
- DON'T KNOW

## G. SOCIAL CONNECTEDNESS

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.]
- NO ONE
- CLERGY MEMBER
- FAMILY MEMBER
- FRIENDS
- REFUSED
- DON'T KNOW
- OTHER (SPECIFY) \_\_\_\_\_
6. How satisfied are you with your personal relationships?
- Very dissatisfied
- Dissatisfied
- Neither satisfied nor dissatisfied
- Satisfied
- Very satisfied
- REFUSED
- DON'T KNOW



**I. FOLLOW-UP STATUS**

*[REPORTED BY PROGRAM STAFF ABOUT CLIENT 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 ABOUT CLIENT 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) \_\_\_\_\_

**K. SERVICES RECEIVED**

**[REPORTED BY PROGRAM STAFF ABOUT CLIENT 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.]**

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

<b>Treatment Services</b>	<b>Sessions</b>
<b>[SBIRT GRANTS: YOU MUST HAVE AT LEAST ONE SESSION FOR ONE OF THE TREATMENT SERVICES NUMBERED 1-4.]</b>	
1. Screening	_ _ _
2. Brief Intervention	_ _ _
3. Brief Treatment	_ _ _
4. Referral to Treatment	_ _ _
5. Assessment	_ _ _
6. Treatment/Recovery Planning	_ _ _
7. Individual Counseling	_ _ _
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	
A. Pre-Employment	_ _ _
B. Employment Coaching	_ _ _
4. Individual Services Coordination	_ _ _
5. Transportation	_ _ _
6. HIV/AIDS Service	_ _ _
7. Supportive Transitional Drug-Free Housing Services	_ _ _
8. Other Case Management Services (Specify) _____	_ _ _

<b>Medical Services</b>	<b>Sessions</b>
1. Medical Care	_ _ _
2. Alcohol/Drug Testing	_ _ _
3. HIV/AIDS Medical Support and Testing	_ _ _
4. Other Medical Services (Specify) _____	_ _ _

<b>After Care Services</b>	<b>Sessions</b>
1. Continuing Care	_ _ _
2. Relapse Prevention	_ _ _
3. Recovery Coaching	_ _ _
4. Self-Help and Support Groups	_ _ _
5. Spiritual Support	_ _ _
6. Other After Care Services (Specify) _____	_ _ _

<b>Education Services</b>	<b>Sessions</b>
1. Substance Abuse Education	_ _ _
2. HIV/AIDS Education	_ _ _
3. Other Education Services (Specify) _____	_ _ _

<b>Peer-to-Peer Recovery Support Services</b>	<b>Sessions</b>
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) _____	_ _ _