OMB No. 0930-0285
Expiration Date 5/31/2015

Transformation Accountability (TRAC)
Center for Mental Health Services

NOMs Client-Level Measures for Discretionary Programs Providing Direct Services

SERVICES TOOL
for
Minority AIDs Initiative – TCE, Adult Programs

ADMINISTRATIVE REASSESSMENT

CMHS
Center for Mental Health Services
SAMHSA

February 2014
Version 7

Public reporting burden for this collection of information is estimated to average 30 minutes per response if all items are asked of a consumer/participant; to the extent that providers already obtain much of this information as part of their ongoing consumer/participant intake or follow-up, less time will be required. Send comments regarding this burden estimate or any other aspect of this collection of information to SAMHSA Reports Clearance Officer, Room 7-1045, 1 Choke Cherry Road, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The control number for this project is 0930-0285.

RECORD MANAGEMENT

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

Consumer ID |____|____|____|____|____|____|____|____|____|____|____|

Grant ID (Grant/Contract/Cooperative Agreement) |____|____|____|____|____|____|____|____|____|____|

Site ID |____|____|____|____|____|____|____|____|____|____|

1. Indicate Assessment Type:

○ Reassessment
Which 6-month reassessment?

|____|____|
[ENTER 06 FOR A 6-MONTH, 12 FOR A 12-MONTH, 18 FOR AN 18-MONTH ASSESSMENT, ETC.]

2. Was the interview conducted?

○ No

Why not? Choose only one.

- ○ Not able to obtain consent from proxy
- ○ Consumer was impaired or unable to provide consent
- ○ Consumer refused this interview only
- ○ Consumer was not reached for interview
- ○ Consumer refused all interviews

[FOR REASSESSMENTS:
IF AN INTERVIEW WAS NOT CONDUCTED, GO TO SECTION I.]

I. REASSESSMENT STATUS

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

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

- ○ Yes
- ○ No

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

- ○ Yes
- ○ No

[GO TO SECTION K.]

K. SERVICES RECEIVED

OMB No. 0930-0208
Expiration Date 05/31/2015

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

[IF THE INFORMATION BELOW IS UNKNOWN, RECORD "UNK" IN THE SPACE PROVIDED. IF THE SERVICE IS NOT AVAILABLE PLEASE ENTER "SNA" IN THE SPACE PROVIDED.]

1. On what date did the consumer last receive services? |____|____| / |____|____|____|____|
MONTH YEAR

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**
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.]***

Treatment Services	**Sessions**
1. Screening	|__|__|__|
2. Referral to Treatment	|__|__|__|
3. Assessment	|__|__|__|
4. Treatment/Recovery Planning	|__|__|__|
5. Individual Counseling	|__|__|__|
6. Group Counseling	|__|__|__|
7. Family/Marriage Counseling	|__|__|__|
8. Co-Occurring Treatment/ Recovery Services	|__|__|__|
9. Pharmacological Interventions	|__|__|__|
10. HIV/AIDS Counseling	|__|__|__|
11. 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)_____	|__|__|__|

Medical Services	**Sessions**
1. Medical Care	|__|__|__|
2. Alcohol/Drug Testing	|__|__|__|
3. HIV/AIDS Medical Support & Testing	|__|__|__|
4. Other Medical Services (Specify) _____	|__|__|__|

After Care Services	**Sessions**
1. Continuing Care	|__|__|__|
2. Relapse Prevention	|__|__|__|
3. Recovery Coaching	|__|__|__|
4. Self-Help and Support Groups	|__|__|__|
5. Spiritual Support	|__|__|__|
6. Other After Care Services (Specify)_____	|__|__|__|

K. SERVICES RECEIVED (Continued)

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)_____	|__|__|__|