

# Virginia Emergency Covid-19 Grant

## Treatment GPRA (Government Performance and Results Act) Survey

# Intake Survey

This survey was compiled by the OMNI Institute based on the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) Government Performance and Results Act (GPRA) Client Outcome Measures for Discretionary Programs.

It is designed for use by the agencies who are providing treatment services funded by the Virginia Emergency Covid-19 Grant.

For more information or questions, please contact the OMNI VA Covid Grant support team at [VACovidGrantSupport@omni.org](mailto:VACovidGrantSupport@omni.org)



# Intake Survey Contents

CONSENT TO PARTICIPATE IN THE EVALUATION .....3

ADMINISTRATIVE SECTIONS FOR AGENCY STAFF TO COMPLETE:

A. RECORD MANAGEMENT .....7  
A. BEHAVIORAL HEALTH DIAGNOSES .....8  
A. PLANNED SERVICES .....12

INTERVIEW SECTIONS TO BE COMPLETED WITH CLIENT:

A. DEMOGRAPHICS.....13  
A. MILITARY FAMILY & DEPLOYMENT .....14  
B. DRUG AND ALCOHOL USE .....16  
C. FAMILY AND LIVING CONDITIONS .....17  
D. EDUCATION, EMPLOYMENT, AND INCOME .....19  
E. CRIME & CRIMINAL JUSTICE STATUS .....21  
F. MENTAL & PHYSICAL HEALTH AND TREATMENT/RECOVERY .....21  
F. VIOLENCE AND TRAUMA .....24  
G. SOCIAL CONNECTEDNESS.....25  
H. PROGRAM-SPECIFIC QUESTIONS .....26

# CONSENT TO PARTICIPATE IN THE EVALUATION

*[PLEASE PROVIDE THIS PAGE TO THE CLIENT TO KEEP.]*

## **Key Information**

1. This evaluation is about the substance use treatment and/or mental health services you will receive as part of Virginia's Emergency COVID-19 Grant. We are interested in understanding how the services you receive impact mental health, substance use, and related behaviors.
2. Participation in the evaluation is completely voluntary.
3. The evaluation will include three surveys (intake, discharge, and follow-up six months after intake), with each survey taking up to 40 minutes.
4. You may be asked questions about sensitive topics such as drug and alcohol use, mental health, and if over 18, sexual activity. These questions may be distressing to you as you think about your experiences. You may skip any question you do not want to answer.
5. There are no direct benefits to you from your taking part in this evaluation. However, findings from the evaluation may benefit the substance use treatment or mental health fields.
6. This evaluation and the services you are receiving are funded by the Emergency COVID-19 Grant, which is a project funded by the federal government's Substance Abuse and Mental Health Services Administration.
7. If you complete the survey offered to you at intake, at six months after intake, and at discharge to services, you will be eligible to receive a \$30 gift card at each survey.

## **Why am I being invited to participate in this evaluation?**

You are being offered substance use and/or mental health services as part of the Virginia Emergency COVID-19 grant, a project funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). You are being asked to participate in an evaluation of the services you receive to understand how well it works for people. **This evaluation is voluntary.** If you decide not to take part, you can still receive services. The evaluation is meant to find out how services impact mental health, substance use, and related behaviors.

## **How many people will take part in the evaluation?**

The evaluation will include approximately 1000 people who enter substance use treatment and/or mental health services through the grant from August 2020 through May 2022.

## **What information will be collected for the evaluation?**

If you agree to be in this evaluation, you will be asked to share information about your age, gender and race/ethnicity. You will also be asked about such things as your living situation, physical or mental health, use of alcohol or drugs, treatment received, criminal justice involvement, your education, if you work, and income. Information about any treatment services you receive from this program will also be collected.

## **What happens to the information collected for the evaluation?**

This information will be collected by the facility where you are completing the survey and shared with OMNI Institute, a research and evaluation firm in Denver, CO which Virginia has hired to manage this evaluation. Your name will not be shared with OMNI Institute, only an ID number that is used in your medical records. **The information you share will only be used for this evaluation and will be kept confidential.** The information you provide will be combined with

information from others in the program so that **results from the evaluation cannot be linked to you individually.**

Federal and state laws require that staff at each of the partner agencies protect the privacy of your records. Evaluation reports won't use any names or other information that would identify you personally. The evaluation team takes very careful steps to keep your information strictly confidential and minimizes the risk of loss of privacy.

There are exceptions to confidentiality. If you say something that makes us suspect that abuse or neglect has occurred to a child or an elderly person, we have to report that to Child Protective Services or Adult Protective Services. Also, if you tell us that you want to hurt yourself or someone else, we have to report that so you can get help.

### **How long will I be in the evaluation?**

You will be asked to complete an intake survey, a follow-up survey approximately 5-8 months from now, and a survey whenever you discharge from services. Each survey may take up to 40 minutes to complete. You will be considered to be in the evaluation until you have completed all three surveys, or until the grant ends on May 31, 2022.

### **What risks are there if I participate in this evaluation?**

This evaluation does not involve medical tests or procedures. Because of this, the risk for physical injury is low. You may be asked questions about sensitive topics such as drug and alcohol use, mental health, and if over 18, sexual activity. These questions may be distressing to you as you think about your experiences. **You may skip any question you do not want to answer**, and you will still receive the incentives if you skip questions. You may also decide to stop your participation in the evaluation at any time.

### **What benefits are there if I participate in this evaluation?**

If you complete the intake, the 6-month follow-up survey, and the discharge survey, you will receive a \$30 gift card at each survey. In addition, the data you provide may benefit the substance use and mental health treatment communities and future patients, as findings have the potential to lead to a better understanding of treatment outcomes and factors associated with success.

### **What other options are there?**

This evaluation is voluntary. If you don't want to take part in the evaluation, you can still get the treatment services provided by this grant.

### **How will my legal rights be impacted by participating in this evaluation?**

You will not lose any of your legal rights by agreeing to participate in this evaluation.

### **Can I stop participation in the evaluation?**

**You can leave the evaluation at any time.** To leave the evaluation, contact Julia Simhai at OMNI Institute, [jsimhai@omni.org](mailto:jsimhai@omni.org) or (303) 839-9422 ext. 137. The evaluation team will remove your information from the evaluation records and will not use it in any reports prepared after they hear from you. They will not contact you for the follow-up or discharge survey. If you withdraw from the evaluation before the 6-month follow-up survey, you will not be eligible for the gift card, but you will not lose any benefits or services from any medical provider.

### **Who can I contact with questions, concerns, or complaints?**

If you have questions, concerns, or complaints about this study, please contact: Julia Simhai at OMNI Institute at [jsimhai@omni.org](mailto:jsimhai@omni.org) or (303) 839-9422 ext. 137.

**[OBTAIN SIGNATURE FROM CLIENT AND SAVE THIS FORM IN CSB RECORDS SEPARATE FROM THE INTAKE SURVEY DATA.]**

**Patient Consent and Legal Rights**

I have read the information above or it has been read to me. The evaluation has been explained to me, and all my questions have been answered to my satisfaction. By signing this consent form, I agree to each of the items listed below:

- I agree to be in this evaluation and the treatment facility may use the personal information I give in the interview for evaluation purposes.
- This treatment facility may contact me when I discharge from services and approximately six months from now to ask for additional survey interviews. I can decide at that time whether to be interviewed.
- This treatment facility may collect information about treatment services I receive through this program.
- I give my permission for this treatment facility to try to find me through the names and contact information I provide, as well as by contacting case managers or service providers that have worked with me as a part of this grant to ask for updated contact information for me.

I am voluntarily signing this form. I have been given a copy of this consent form. I am not giving up any of my legal rights by signing this form. There is no penalty if I decide not to take part or leave the evaluation.

**PRINT NAME OF PARTICIPANT OR PARENT/GUARDIAN (if participant is under age 18):**

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**Signature of Participant or Parent/Guardian**

**Date**

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**Signature of Person Conducting Intake into Evaluation**

**Date**

*[Page left blank to allow consent form to be removed from packet.]*

# A. RECORD MANAGEMENT

[REPORTED BY PROGRAM STAFF AT INTAKE ONLY. DO NOT INCLUDE IN CLIENT INTERVIEW.]

**Client ID** \_\_\_\_\_  
[IF CSB, CLIENT ID SAME AS CCS3 ID]

**Interview Date**    |\_|\_|/|\_|\_|/|\_|\_|\_|\_|  
                            Month       Day           Year

**Agency Name** \_\_\_\_\_

**Minor Status**

Is this client a minor (under age 18)?

- Yes
- No [IF NO, SKIP TO A. BEHAVIORAL HEALTH DIAGNOSES]

Is this client under age 12?

- Yes [IF YES, SKIP TO END SURVEY]
- No [IF NO, SKIP TO A. BEHAVIORAL HEALTH DIAGNOSES]

# A. BEHAVIORAL HEALTH DIAGNOSES

[REPORTED BY PROGRAM STAFF AT INTAKE ONLY. DO NOT INCLUDE IN CLIENT INTERVIEW.]

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. **At least one diagnosis must be selected. Select up to three.** 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? (select up to 3 total)	For each diagnosis selected, indicate whether diagnosis is primary, secondary, or tertiary		
		Primary	Secondary	Tertiary
<b><u>Alcohol-related disorders</u></b>				
F10.10 – Alcohol use disorder, uncomplicated, mild	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F10.11 – Alcohol use disorder, mild, in remission	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F10.20 – Alcohol use disorder, uncomplicated, moderate/severe	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F10.21 – Alcohol use disorder, moderate/severe, in remission	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F10.9 – Alcohol use, unspecified	<input type="checkbox"/>	<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="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F11.11 – Opioid use disorder, mild, in remission	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F11.20 – Opioid use disorder, uncomplicated, moderate/severe	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F11.21 – Opioid use disorder, moderate/severe, in remission	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F11.9 – Opioid use, unspecified	<input type="checkbox"/>	<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="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F12.11 – Cannabis use disorder, mild, in remission	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F12.20 – Cannabis use disorder, uncomplicated, moderate/severe	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F12.21 – Cannabis use disorder, moderate/severe, in remission	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F12.9 – Cannabis use, unspecified	<input type="checkbox"/>	<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="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F13.11 – Sedative, hypnotic, or anxiolytic use disorder, mild, in remission	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F13.20 – Sedative, hypnotic, or anxiolytic use disorder, uncomplicated, moderate/severe	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F13.21 – Sedative, hypnotic, or anxiolytic use disorder, moderate/severe, in remission	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F13.9 – Sedative, hypnotic, or anxiolytic use, unspecified	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*(List continues on next page)*



## A. BEHAVIORAL HEALTH DIAGNOSES (Continued)

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

*(List continues on next page)*

## A. BEHAVIORAL HEALTH DIAGNOSES (Continued)

Behavioral Health Diagnoses	Diagnosed? (select up to 3 total)	For each diagnosis selected, please indicate whether diagnosis is primary, secondary, or tertiary		
		Primary	Secondary	Tertiary
<b>Nicotine dependence</b>				
F17.20 – Tobacco use disorder, mild/moderate/severe	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F17.21 – Tobacco use disorder, mild/moderate/severe, in remission	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Mental health diagnoses</b>				
F20 – Schizophrenia	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F21 – Schizotypal disorder	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F22 – Delusional disorder	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F23 – Brief psychotic disorder	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F24 – Shared psychotic disorder	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F25 – Schizoaffective disorders	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F28 – Other psychotic disorder not due to a substance or known physiological condition	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F29 – Unspecified psychosis not due to a substance or known physiological condition	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F30 – Manic episode	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F31 – Bipolar disorder	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F32 – Major depressive disorder, single episode	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F33 – Major depressive disorder, recurrent	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F34 – Persistent mood [affective] disorders	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F39 – Unspecified mood [affective] disorder	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F40–F48 – Anxiety, dissociative, stress-related, somatoform, and other nonpsychotic mental disorders	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F50 – Eating disorders	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F51 – Sleep disorders not due to a substance or known physiological condition	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F60.2 – Antisocial personality disorder	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F60.3 – Borderline personality disorder	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F60.0, F60.1, F60.4–F69 – Other personality disorders	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F70–F79 – Intellectual disabilities	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F80–F89 – Pervasive and specific developmental disorders	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F90 – Attention-deficit hyperactivity disorders	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F91 – Conduct disorders	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F93 – Emotional disorders with onset specific to childhood	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F94 – Disorders of social functioning with onset specific to childhood or adolescence	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F95 – Tic disorder	<input type="checkbox"/>	<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="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F99 – Unspecified mental disorder	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

NONE OF THE ABOVE

DON'T KNOW

## A. BEHAVIORAL HEALTH DIAGNOSES (Continued)

[REPORTED BY PROGRAM STAFF AT INTAKE ONLY. DO NOT INCLUDE IN CLIENT INTERVIEW.]

**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?  
[CHECK ALL THAT APPLY]**

- 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?  
[CHECK ALL THAT APPLY]**

- 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

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

- Yes
- No **[IF NO, SKIP TO PLANNED SERVICES SECTION.]**

**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 AT INTAKE. DO NOT ASK CLIENTS]

<b>MODALITY [SELECT YES FOR AT LEAST ONE MODALITY]</b>	<b>Yes</b>	<b>No</b>
4. Case Management	<input type="radio"/>	<input type="radio"/>
5. Day Treatment	<input type="radio"/>	<input type="radio"/>
6. Inpatient/Hospital	<input type="radio"/>	<input type="radio"/>
7. Outpatient	<input type="radio"/>	<input type="radio"/>
8. Outreach	<input type="radio"/>	<input type="radio"/>
9. Intensive Outpatient	<input type="radio"/>	<input type="radio"/>
10. Methadone	<input type="radio"/>	<input type="radio"/>
11. Residential/Rehabilitation	<input type="radio"/>	<input type="radio"/>
12. Detox		
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"/>
13. After Care	<input type="radio"/>	<input type="radio"/>
14. Recovery Support	<input type="radio"/>	<input type="radio"/>
15. Other. Please specify: _____	<input type="radio"/>	<input type="radio"/>
<b>TREATMENT SERVICES [SELECT YES FOR AT LEAST ONE TREAT. SERVICE]</b>	<b>Yes</b>	<b>No</b>
16. Screening	<input type="radio"/>	<input type="radio"/>
17. Brief Intervention	<input type="radio"/>	<input type="radio"/>
18. Brief Treatment	<input type="radio"/>	<input type="radio"/>
19. Assessment	<input type="radio"/>	<input type="radio"/>
20. Referral to Treatment	<input type="radio"/>	<input type="radio"/>
21. Treatment/Recovery Planning	<input type="radio"/>	<input type="radio"/>
22. Individual Counseling	<input type="radio"/>	<input type="radio"/>
23. Group Counseling	<input type="radio"/>	<input type="radio"/>
24. Family/Marriage Counseling	<input type="radio"/>	<input type="radio"/>
25. Co-occurring Treatment/Recovery Services	<input type="radio"/>	<input type="radio"/>
26. Pharmacological Interventions	<input type="radio"/>	<input type="radio"/>
27. HIV/AIDS Counseling	<input type="radio"/>	<input type="radio"/>
28. Other Clinical Services. Please Specify: _____	<input type="radio"/>	<input type="radio"/>

<b>CASE MANAGEMENT SERVICES</b>	<b>Yes</b>	<b>No</b>
29. Family Services (marriage education, parenting, child development services)	<input type="radio"/>	<input type="radio"/>
30. Child Care	<input type="radio"/>	<input type="radio"/>
31. Employment Services:		
a. Pre-employment	<input type="radio"/>	<input type="radio"/>
b. Employment coaching	<input type="radio"/>	<input type="radio"/>
32. Individual Services Coordination	<input type="radio"/>	<input type="radio"/>
33. Transportation	<input type="radio"/>	<input type="radio"/>
34. HIV/AIDS Services	<input type="radio"/>	<input type="radio"/>
35. Supportive Transitional Drug-free Housing Services	<input type="radio"/>	<input type="radio"/>
36. Other. Please specify: _____	<input type="radio"/>	<input type="radio"/>
<b>MEDICAL SERVICES</b>	<b>Yes</b>	<b>No</b>
37. Medical Care	<input type="radio"/>	<input type="radio"/>
38. Alcohol/Drug Testing	<input type="radio"/>	<input type="radio"/>
39. HIV/AIDS Medical Support & Testing	<input type="radio"/>	<input type="radio"/>
40. Other. Please specify: _____	<input type="radio"/>	<input type="radio"/>
<b>AFTER CARE SERVICES</b>	<b>Yes</b>	<b>No</b>
41. Continuing Care	<input type="radio"/>	<input type="radio"/>
42. Relapse Prevention	<input type="radio"/>	<input type="radio"/>
43. Recovery Coaching	<input type="radio"/>	<input type="radio"/>
44. Self-help & Support Services	<input type="radio"/>	<input type="radio"/>
45. Spiritual Support	<input type="radio"/>	<input type="radio"/>
46. Other. Please specify: _____	<input type="radio"/>	<input type="radio"/>
<b>EDUCATION SERVICES</b>	<b>Yes</b>	<b>No</b>
47. Substance Abuse Education	<input type="radio"/>	<input type="radio"/>
48. HIV/AIDS Education	<input type="radio"/>	<input type="radio"/>
49. Other. Please specify: _____	<input type="radio"/>	<input type="radio"/>
<b>PEER-TO-PEER RECOVERY SUPPORT SERVICES</b>	<b>Yes</b>	<b>No</b>
50. Peer Coaching or Mentoring	<input type="radio"/>	<input type="radio"/>
51. Housing Support	<input type="radio"/>	<input type="radio"/>
52. Alcohol- and Drug-Free Social Activities	<input type="radio"/>	<input type="radio"/>
53. Information and Referral	<input type="radio"/>	<input type="radio"/>
54. Other. Please specify: _____	<input type="radio"/>	<input type="radio"/>

# A. DEMOGRAPHICS

## [CLIENT INTERVIEW PORTION BEGINS HERE.]

Let's start with some demographic questions about you. Remember that your answers to this survey are confidential and will not affect the treatment services you receive. You may choose to skip any questions you do not want to answer.

### 55. What gender do you identify with? [GENDER IDENTITY]

- MALE
- FEMALE
- TRANSGENDER
- DO NOT IDENTIFY AS MALE, FEMALE, OR TRANSGENDER
- OTHER, please specify: \_\_\_\_\_
- REFUSED
- DON'T KNOW

### 56. Are you Hispanic or Latino?

- YES
- NO **[SKIP TO 58.]**
- REFUSED **[SKIP TO 58.]**
- DON'T KNOW **[SKIP TO 58.]**

### 57. [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.

Ethnic Group	Yes	No	REFUSED
Central American	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cuban	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dominican	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mexican	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Puerto Rican	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
South American	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other, specify: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

### 58. What is your race? Please answer yes or no for each of the following. You may say yes to more than one.

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

### 59. What is your date of birth?

\_\_\_\_\_|\_\_\_\_\_| / \_\_\_\_|\_\_\_\_\_| / \_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|       REFUSED  
Month      Day      Year

## A. MILITARY FAMILY & DEPLOYMENT

I'd like to ask you some questions about your and your family's military history. Your answers to these questions are confidential and you may choose to skip any questions you do not want to answer.

**[IF CLIENT IS A MINOR, SKIP TO QUESTION 62.]**

**60. [IF CLIENT IS NOT A MINOR] 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 **[SKIP TO QUESTION 62.]**
- YES, IN THE ARMED FORCES
- YES, IN THE RESERVES
- YES, IN THE NATIONAL GUARD
- REFUSED **[SKIP TO QUESTION 62.]**
- DON'T KNOW **[SKIP TO QUESTION 62.]**

**[IF NO, REFUSED, OR DON'T KNOW, SKIP TO QUESTION 62.]**

**61a. 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 ARMED FORCES, RESERVES, OR NATIONAL GUARD
- YES, IN THE ARMED FORCES
- YES, IN THE RESERVES
- YES, IN THE NATIONAL GUARD
- REFUSED
- DON'T KNOW

**61b. 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

**62. 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 **[SKIP TO SECTION B.]**
- YES, ONLY ONE
- YES, MORE THAN ONE
- REFUSED **[SKIP TO SECTION B.]**
- DON'T KNOW **[SKIP TO SECTION B.]**

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

## A. MILITARY FAMILY & DEPLOYMENT (Continued)

**[IF YES TO 62, ANSWER FOR UP TO 6 PEOPLE]**

<b>63a. What is the relationship of that person (Service Member) to you?</b> <b>[SELECT RELATIONSHIP IN COLUMN HEADING AT RIGHT]</b>	<b>Relationship 1:</b> <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Brother <input type="radio"/> Sister <input type="radio"/> Spouse <input type="radio"/> Partner <input type="radio"/> Child <input type="radio"/> Other (specify): _____	<b>Relationship 2:</b> <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Brother <input type="radio"/> Sister <input type="radio"/> Spouse <input type="radio"/> Partner <input type="radio"/> Child <input type="radio"/> Other (specify): _____	<b>Relationship 3:</b> <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Brother <input type="radio"/> Sister <input type="radio"/> Spouse <input type="radio"/> Partner <input type="radio"/> Child <input type="radio"/> Other (specify): _____	<b>Relationship 4:</b> <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Brother <input type="radio"/> Sister <input type="radio"/> Spouse <input type="radio"/> Partner <input type="radio"/> Child <input type="radio"/> Other (specify): _____	<b>Relationship 5:</b> <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Brother <input type="radio"/> Sister <input type="radio"/> Spouse <input type="radio"/> Partner <input type="radio"/> Child <input type="radio"/> Other (specify): _____	<b>Relationship 6:</b> <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Brother <input type="radio"/> Sister <input type="radio"/> Spouse <input type="radio"/> Partner <input type="radio"/> Child <input type="radio"/> Other (specify): _____
---	---	---	---	---	---	---

**Has the service member experienced any of the following?**  
**[CHECK ANSWER IN APPROPRIATE COLUMN FOR ALL THAT APPLY]**

<b>63b. 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
---	--	--	--	--	--	--

**If response to 63b is "No", "Refused", or "Don't know", skip to Section B.**

<b>63c. 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>63d. Developed combat stress symptoms/ difficulties adjusting following deployment, including 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>63e. 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

I'd like to ask you some questions about your history of alcohol and other drug use. Your answers to these questions are confidential and you may choose to skip any questions you do not want to answer.

For the following substances: During the past 30 days, how many days have you used the following substances?	Past 30-Day Use		
	# of days in past 30	REFUSED	DONT KNOW
1. Alcohol		<input type="radio"/>	<input type="radio"/>
a. Alcohol to intoxication (5+ drinks in one sitting)		<input type="radio"/>	<input type="radio"/>
b. Alcohol to intoxication (4 or less in one sitting)		<input type="radio"/>	<input type="radio"/>
2. Illegal drugs		<input type="radio"/>	<input type="radio"/>
3. Both alcohol and illegal 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).

For the following substances: <ul style="list-style-type: none"> <li>• During the past 30 days, how many days have you used the following substances?</li> <li>• What is your usual route of substance administration?</li> </ul> <i>[FOR # DAYS USED IN PAST 30, IF THE VALUE IN ANY ITEM B4 – B24&gt;0, THEN THE VALUE IN B2 MUST BE&gt;0]</i>	Past 30-Day Use			Route in Past 30 Days			
	# of days in past 30	REFUSED	DONT KNOW	Route*	NOT APPLICABLE	REFUSED	DONT KNOW
4. Cocaine/Crack		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Marijuana/cannabis		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Heroin		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Morphine		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Dilaudid		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Demerol		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Percocet		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Darvon		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Codeine		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Tylenol 2, 3, 4		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. OxyContin/Oxycodone		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Non-prescription Methadone		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Hallucinogens/psychedelics		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Methamphetamine or other amphetamines		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. Benzodiazepines		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. Barbiturates		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. Non-prescription GHB		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. Ketamine		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. Other tranquilizers, downers, sedatives, or hypnotics		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. Inhalants		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. Other illegal drugs		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



## B. DRUG AND ALCOHOL USE (Continued)

25. *[IF ANY OF B4-B24 ROUTE = 4 OR 5]* 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

I'd like to ask you some questions about your family and where you have been living lately. Your answers to these questions are confidential and you may choose to skip any questions you do not want to answer.

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

*[DO NOT READ RESPONSE OPTIONS TO CLIENT, SELECT ONLY ONE]*

*[15 OR MORE DAYS IS CONSIDERED MOST OF THE TIME.]*

- 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: OWN/RENT APARTMENT, ROOM, OR HOUSE
- HOUSED: SOMEONE ELSE'S APARTMENT, ROOM, OR HOUSE
- HOUSED: DORMITORY/COLLEGE RESIDENCE
- HOUSED: HALFWAY HOUSE
- HOUSED: RESIDENTIAL TREATMENT
- HOUSED: 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 B1 OR B2 > 0, THEN C3 CANNOT = NA]*

- Not at all
- Somewhat
- Considerably
- Extremely
- NOT APPLICABLE *[USE ONLY IF B1 AND B2 = 0]*
- REFUSED
- DON'T KNOW

## C. FAMILY AND LIVING CONDITIONS (Continued)

4. During the past 30 days, has your use of alcohol or other drugs caused you to reduce or give up important activities? *[IF B1 OR B2 > 0, THEN C4 CANNOT = NA]*

- Not at all
- Somewhat
- Considerably
- Extremely
- NOT APPLICABLE *[USE ONLY IF B1 AND B2 = 0]*
- REFUSED
- DON'T KNOW

5. During the past 30 days, has your use of alcohol or other drugs caused you to have emotional problems? *[IF B1 OR B2 > 0, THEN C5 CANNOT = NA]*

- Not at all
- Somewhat
- Considerably
- Extremely
- NOT APPLICABLE *[USE ONLY IF B1 AND B2 = 0]*
- REFUSED
- DON'T KNOW

6. **[ASK ONLY IF FEMALE]** Are you currently pregnant?

- YES
- NO
- REFUSED
- DON'T KNOW

7. Do you have children?

- YES
- NO *[SKIP TO SECTION D.]*
- REFUSED *[SKIP TO SECTION D.]*
- DON'T KNOW *[SKIP TO SECTION D.]*

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

7a. *[IF YES]* How many children do you have? *[IF C7=YES, THEN VALUE IN C7a MUST BE ≥ 1]*

CHILDREN       REFUSED       DON'T KNOW

7b. *[IF YES]* 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 7d.]*

7c. *[IF YES]* How many of your children are living with someone else due to a child protection court order? *[THE VALUE IN C7c MUST BE ≤ VALUE IN C7a]*

CHILDREN       REFUSED       DON'T KNOW

## C. FAMILY AND LIVING CONDITIONS (Continued)

7d. For how many children have you lost parental rights? [THE VALUE IN C7d MUST BE  $\leq$  VALUE IN C7a]

|\_| CHILDREN

REFUSED

DON'T KNOW

## D. EDUCATION, EMPLOYMENT, AND INCOME

Now I have some questions about your education, your employment status, and your income. Your answers are confidential and you may choose to skip any questions you do not want to answer.

1. Are you currently enrolled in school or a job training program? [IF ENROLLED] Is that full time or part time? [IF INCARCERATED, SELECT '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
- 1<sup>ST</sup> GRADE
- 2<sup>ND</sup> GRADE
- 3<sup>RD</sup> GRADE
- 4<sup>TH</sup> GRADE
- 5<sup>TH</sup> GRADE
- 6<sup>TH</sup> GRADE
- 7<sup>TH</sup> GRADE
- 8<sup>TH</sup> GRADE
- 9<sup>TH</sup> GRADE
- 10<sup>TH</sup> GRADE
- 11<sup>TH</sup> GRADE
- 12<sup>TH</sup> GRADE/HIGH SCHOOL DIPLOMA/GED
- COLLEGE OR UNIVERSITY/1<sup>ST</sup> YEAR COMPLETED
- COLLEGE OR UNIVERSITY/2<sup>ND</sup> YEAR COMPLETED/ASSOCIATE DEGREE (AA, AS)
- COLLEGE OR UNIVERSITY/3<sup>RD</sup> YEAR COMPLETED
- BACHELOR'S DEGREE (BA, BS) OR HIGHER
- VOCATIONAL/TECHNICAL PROGRAM AFTER HS BUT NO VOC/TEC DIPLOMA
- VOCATIONAL/TECHNICAL DIPLOMA AFTER HIGH SCHOOL
- REFUSED
- DON'T KNOW

## D. EDUCATION, EMPLOYMENT, AND INCOME (Continued)

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 D1 = "ENROLLED, FULL TIME" and client indicates "EMPLOYED, FULL TIME" here, ask for clarification. If client is incarcerated and has no work outside of jail, select "UNEMPLOYED, NOT LOOKING FOR WORK"]

- EMPLOYED, FULL TIME (35+ HOURS/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

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

	AMOUNT	REFUSED	DON'T KNOW
4. Wages	\$ _ _ _ _ _ _ ,  _ _ _ _ _ _	<input type="radio"/>	<input type="radio"/>
5. Public assistance	\$ _ _ _ _ _ _ ,  _ _ _ _ _ _	<input type="radio"/>	<input type="radio"/>
6. Retirement (pension, benefits, or social security)	\$ _ _ _ _ _ _ ,  _ _ _ _ _ _	<input type="radio"/>	<input type="radio"/>
7. Disability	\$ _ _ _ _ _ _ ,  _ _ _ _ _ _	<input type="radio"/>	<input type="radio"/>
8. Non-legal income	\$ _ _ _ _ _ _ ,  _ _ _ _ _ _	<input type="radio"/>	<input type="radio"/>
9. Family and/or friends	\$ _ _ _ _ _ _ ,  _ _ _ _ _ _	<input type="radio"/>	<input type="radio"/>
10. Other. Specify: _____	\$ _ _ _ _ _ _ ,  _ _ _ _ _ _	<input type="radio"/>	<input type="radio"/>

[IF D3 DOES NOT = "EMPLOYED" AND D4 > 0, PROBE. IF D3 = "UNEMPLOYED, RETIRED" AND D6 = 0, PROBE. IF D3 = "UNEMPLOYED, DISABLED" AND D7 = 0, PROBE.]

11. Have you enough money to meet your needs?

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

## E. CRIME & CRIMINAL JUSTICE STATUS

Now I have some questions about whether you've been arrested recently, committed any crimes, or spent time in jail or prison. I want to remind you that your answers to these questions are confidential and you may choose to skip any questions you do not want to answer.

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

|\_|\_| TIMES       REFUSED       DON'T KNOW

**[IF NO ARRESTS, SKIP TO 3]**

2. **[IF ARRESTED]** In the past 30 days, how many times have you been arrested for drug-related offenses? **[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 C1 (WHERE LIVING FOR PAST MONTH) = "INSTITUTION (JAIL/PRISON)", THEN THIS ANSWER MUST BE ≥ 15.]**

|\_|\_| NIGHTS       REFUSED       DON'T KNOW

4. In the past 30 days, how many times have you committed 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 & PHYSICAL HEALTH AND TREATMENT/RECOVERY

Now I have some questions about your physical, mental and treatment history. I want to remind you that your answers to these questions are confidential and you may choose to skip any questions you want.

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

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

## F. MENTAL & PHYSICAL HEALTH AND TREATMENT/ RECOVERY (Continued)

DURING THE PAST 30 DAYS, DID YOU RECEIVE:	YES	NO	RF	DK
<b><u>Inpatient treatment for:</u></b>	<b># OF NIGHTS</b>			
2. Physical complaint	_ _ _	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Mental or emotional difficulties	_ _ _	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Alcohol or substance abuse	_ _ _	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b><u>Outpatient treatment for:</u></b>	<b># OF TIMES</b>			
5. Physical complaint	_ _ _	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Mental or emotional difficulties	_ _ _	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Alcohol or substance abuse	_ _ _	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b><u>Emergency room treatment for:</u></b>	<b># OF TIMES</b>			
8. Physical complaint	_ _ _	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Mental or emotional difficulties	_ _ _	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Alcohol or substance abuse	_ _ _	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**[IF CLIENT IS A MINOR, SKIP TO QUESTION 12.]**

Now I have some questions about your sexual health history. I want to remind you that your answers to these questions are confidential and you may choose to skip any questions you do not want to answer.

**11. [IF CLIENT IS NOT A MINOR] During the past 30 days, did you engage in sexual activity?**

- YES
- NO **[SKIP TO 12]**
- NOT PERMITTED TO ASK **[SKIP TO 12]**
- REFUSED **[SKIP TO 12]**
- DON'T KNOW **[SKIP TO 12]**

[IF 11 = YES] During the past 30 days, how many:	# OF CONTACTS	RF	DK
11a. Sexual contacts (vaginal, oral, or anal) did you have?	_ _ _	<input type="radio"/>	<input type="radio"/>
11b. Unprotected sexual contacts did you have? [IF '0', SKIP TO 12; 11b CANNOT BE > 11a]	_ _ _	<input type="radio"/>	<input type="radio"/>
11c. [IF 11b > 0] Unprotected sexual contacts did you have with an individual who is or was HIV positive or has AIDS?	_ _ _	<input type="radio"/>	<input type="radio"/>
11d. [IF 11b > 0] Unprotected sexual contacts did you have with an individual who is or was an injection drug user?	_ _ _	<input type="radio"/>	<input type="radio"/>
11e. [IF 11b > 0] Unprotected sexual contacts did you have with an individual who is or was high on some substance?	_ _ _	<input type="radio"/>	<input type="radio"/>

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

- YES
- NO **[SKIP TO 13]**
- REFUSED **[SKIP TO 13]**
- DON'T KNOW **[SKIP TO 13]**

## **F. MENTAL & PHYSICAL HEALTH AND TREATMENT/ RECOVERY (Continued)**

**12a. [IF YES] Do you know the results of your HIV testing?**

- YES
- NO
- REFUSED

**13. How would you rate the quality of your life?**

- Very poor
- Poor
- Neither poor nor good
- Good
- Very good
- REFUSED
- DON'T KNOW

**14. How satisfied are you with your health?**

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

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

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

**16. 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

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

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

## F. MENTAL & PHYSICAL HEALTH AND TREATMENT/ RECOVERY (Continued)

In the past 30 days, <u>NOT</u> due to your use of alcohol or drugs, how many days have you:	# OF DAYS	RF	DK
18. Experienced serious depression	_ _ _	<input type="radio"/>	<input type="radio"/>
19. Experienced serious anxiety or tension	_ _ _	<input type="radio"/>	<input type="radio"/>
20. Experienced hallucinations	_ _ _	<input type="radio"/>	<input type="radio"/>
21. Experienced trouble understanding, concentrating, or remembering	_ _ _	<input type="radio"/>	<input type="radio"/>
22. Experienced trouble controlling violent behavior	_ _ _	<input type="radio"/>	<input type="radio"/>
23. Attempted suicide	_ _ _	<input type="radio"/>	<input type="radio"/>
24. Been prescribed medications for psychological/emotional problems	_ _ _	<input type="radio"/>	<input type="radio"/>

**[IF CLIENT REPORTS ZERO DAYS, REFUSED, OR DON'T KNOW TO ALL ITEMS 18-24, SKIP TO VIOLENCE AND TRAUMA SECTION, # 26]**

**25. [IF ANY DAYS REPORTED IN 18-24.] 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

The next series of questions are about violence and trauma and they can be sensitive. I want to remind you that your answers to these questions are confidential and you may choose to skip any questions you do not want to answer.

**26. 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 the family; natural disaster; terrorism; neglect; or traumatic grief)?**

- YES
- NO **[SKIP TO 27]**
- REFUSED **[SKIP TO 27]**
- DON'T KNOW **[SKIP TO 27]**

**[IF NO, REFUSED, OR DON'T KNOW, SKIP TO 27]**

<b>[IF YES] Did any of these experiences feel so frightening, horrible, or upsetting that, in the past and/or present, you:</b>	YES	NO	RF	DK
26a. Have had nightmares about it or thought about it when you did not want to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26c. Were constantly on guard, watchful, or easily startled?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26d. Felt numb and detached from others, activities, or your surroundings?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



## F. VIOLENCE AND TRAUMA (Continued)

27. 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:    |\_\_|\_\_| 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:    |\_\_|\_\_| 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:    |\_\_|\_\_| TIMES     REFUSED     DON'T KNOW
- NO
- REFUSED
- DON'T KNOW

4. In the past 30 days, did you have interactions 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
- OTHER (specify) \_\_\_\_\_
- REFUSED
- DON'T KNOW

## G. SOCIAL CONNECTEDNESS (Continued)

### 6. How satisfied are you with your personal relationships?

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

## H. PROGRAM-SPECIFIC QUESTIONS

This final section asks questions about how you have been impacted by COVID-19. The first three questions are required to be asked, while the remaining questions (questions 4 and 5) are recommended as part of the grant, but are not mandatory for completion.

### 1. Are you a healthcare provider?

- YES *[IF YES, ASK 1A]*
- NO *[IF NO, SKIP TO 2]*
- REFUSED *[IF REFUSED, SKIP TO 2]*

#### 1a. *[IF 1=YES]* Are you providing healthcare for COVID-19 positive patients?

- YES
- NO
- REFUSED

### 2. Have you been personally diagnosed with coronavirus? *[IF NO, REFUSED, OR DON'T KNOW, SKIP TO 3]*

- Yes, the diagnosis was confirmed by a test
- Yes, the diagnosis was confirmed by a medical provider but without a test
- No, but I experienced symptoms consistent with a COVID-19 diagnosis
- No, and I have not experienced symptoms consistent with a COVID-19 diagnosis *[SKIP TO 3]*
- REFUSED *[SKIP TO 3]*
- DON'T KNOW *[SKIP TO 3]*

#### 2a. *[IF 2=YES or "No, but I experienced symptoms consistent with a COVID-19 diagnosis"]* Please rate the severity of the symptoms of coronavirus that you experienced.

- Mild: Symptoms effectively managed at home
- Moderate: Symptoms severe and required brief hospitalization diagnosis
- Severe: Symptoms severe and required ventilation
- REFUSED
- DON'T KNOW

**3. How many of your family members or close friends have been diagnosed with coronavirus? \_\_\_\_\_ [IF >0, THEN 3a]**

**3a. [IF 3=0, SKIP TO 4] Rate the symptoms of the family member or close friend who was most sick:**

- None
- Mild: Symptoms effectively managed at home
- Moderate: Symptoms severe and required brief hospitalization diagnosis
- Severe: Symptoms severe and required ventilation
- REFUSED
- DON'T KNOW

**3b. Has a family member or friend died due to COVID-19?**

- Yes
- No
- REFUSED
- DON'T KNOW

**4. We also wanted to check in on how you are feeling emotionally. We noticed that some people impacted by COVID-19 are having a hard time. Please indicate if you have experienced any of the following symptoms during the coronavirus pandemic. Are you feeling: [CHECK ONE BOX PER ROW]**

	Not at all	Rarely	Sometimes	Often	All the time or nearly all the time
Helpless or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sad	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Angry	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Irritable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxious	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Afraid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Changes in appetite (increased or decreased)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Body aches and/or pains	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty sleeping (falling asleep and/or staying asleep)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**4a. How much of a problem have these symptoms been in your everyday life?**

- Not a problem at all
- A little bit of a problem
- Somewhat of a problem
- Very much of a problem
- REFUSED
- DON'T KNOW

**5. Please indicate how the Coronavirus pandemic has changed your life in each of the following ways.**

**5a. Routines (ex. Changes in routines related to work, education, social life, religious activities, hobbies, etc.):**

- No change
- Mild: Change in only one area (e.g. work, education, social life, hobbies, religious activities).
- Moderate: Change in two areas (e.g. work, education, social life, hobbies, religious activities).
- Severe: Change in three or more areas (e.g. work, education, social life, hobbies, religious activities).

**5b. Family Income/Employment:**

- No change
- Mild: Small change; able to meet all needs and pay bills.
- Moderate: Having to make cuts but able to meet basic needs and pay bills.
- Severe: Unable to meet basic needs and/or pay bills.

**5c. Food Access:**

- No change
- Mild: Enough food but difficulty getting to stores and/or finding needed items.
- Moderate: Occasionally without enough food and/or good quality (e.g., healthy) foods.
- Severe: Frequently without enough food and/or good quality (e.g., healthy) foods.

**5d. Medical health care access:**

- No change
- Mild: Appointments moved to telehealth.
- Moderate: Delays or cancellations in appointments and/or delays in getting prescriptions; changes have minimal impact on health.
- Severe: Unable to access needed care resulting in severe risk and/or significant impact.

**5e. Mental health treatment access:**

- No change, Do not need treatment at this time
- No change, Currently have access.
- Mild: Appointments moved to telehealth.
- Moderate: Delays or cancellations in appointments and/or delays in getting prescriptions; changes have minimal impact on health.
- Severe: Unable to access needed care resulting in severe risk and/or significant impact.

**5f. Access to extended family and non-family social supports:**

- No change.
- Mild: Continued visits with social distancing and/or regular phone calls and/or televideo or social media contacts.
- Moderate: Loss of in person and remote contact with a few people, but not all supports.
- Severe: Loss of in person and remote contact with all support

**5g. Experiences of stress related to coronavirus pandemic:**

- None.
- Mild: Occasional worries and/or minor stress-related symptoms (e.g., feel a little anxious, sad, and/or angry; mild/rare trouble sleeping).
- Moderate: Frequent worries and/or moderate stress-related symptoms (e.g., feel moderately anxious, sad, and/or angry; moderate/occasional trouble sleeping).
- Severe: Persistent worries and/or severe stress-related symptoms (e.g., feel extremely anxious, sad, and/or angry; severe/frequent trouble sleeping).

**5h. Stress and discord in the family:**

- None.
- Mild: Family members occasionally short-tempered with one another; no physical violence.
- Moderate: Family members frequently short-tempered with one another; and/or children in the home getting in physical fights with one another.
- Severe: Family members frequently short-tempered with one another and adults in the home throwing things at one another, and/or knocking over furniture, and/or hitting and/or harming one another.

***[END OF SURVEY.]***

***Please enter this survey into the online entry form within four days after completing this interview. This form can be found on the Resources page of the portal: [viriniacovidgrantsupport.org/resources](http://viriniacovidgrantsupport.org/resources).***