

OMB No. 0930-0400
Expires: 01/31/2028

Substance Abuse and Mental Health Services Administration (SAMHSA) Unified Performance Reporting Tool (SUPRT) - A

Administrative Report

June 2025

Public reporting burden for this collection of information is estimated to average 20 minutes per response. Send comments regarding this burden estimate, or any other aspect of this collection of information, to the Substance Abuse and Mental Health Services Administration (SAMHSA) Reports Clearance Officer, Room 15E57B, 5600 Fishers Lane, 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 Office of Management and Budget (OMB) control number. The control number for this project is 0930-0400.

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A. RECORD MANAGEMENT

Client ID

Site ID

Grant ID

A1. [AT BASELINE] What is the client's month and year of birth (MM/YYYY)?

/

A2. What is the date of the assessment (MM/DD/YYYY)?

/ /
MONTH DAY YEAR

A3. Which assessment type?

- Baseline
- Reassessment (for clients in care at 3 or 6 months)
- Annual (for clients in care for more than 12 months)
- Record closeout

A4. [AT BASELINE ASSESSMENT ONLY] When did the client first receive services under this grant (MM/YYYY)?

/

A5. [AT REASSESSMENT OR ANNUAL OR CLOSEOUT] When did the client most recently receive services under this grant (MM/YYYY)?

/

A6. [AT RECORD CLOSEOUT] Why are you closing out this client's record?

- Completed the program
- No contact
- Withdrew from/Refused treatment
- Referred out
- Transferred to a different grant program
- Incarceration
- Moved
- Death
- Other

A6a. [IF QUESTION A6 IS DEATH] What is the cause of death?

- Suicide
- Overdose
- Other behavioral health cause
- Other cause
- Not documented in record

B. BEHAVIORAL HEALTH HISTORY

B1. What insurance does the client or guarantor have?

SELECT ALL THAT APPLY

- Medicare
- Medicaid
- Private Insurance or Employer Provided
- TRICARE, CHAMPUS, CHAMPVA or other veteran or military health care
- Indian Health Service Tribal Health Care
- An assistance program [for example, a medication assistance program]
- Any other type of health insurance or health coverage plan
- None
- Not documented in records or not documented in records using this standard

B2. In the past 30 days, was the client admitted to a hospital?

- Yes – Behavioral health reasons, for example mental health or substance use disorder
- Yes – other health reasons, for example injury or illness
- No
- Not documented in records or not documented in records using this standard

B3. In the past 30 days, did the client visit an emergency department?

- Yes – Behavioral health reasons, for example mental health or substance use disorder
- Yes – other health reasons, for example injury or illness
- No
- Not documented in records or not documented in records using this standard

B4. In the past 30 days, did the client experience a behavioral health crisis or request crisis response, for example from 988 or 911?

- Yes
- No
- Not documented in records or not documented in records using this standard

B4a. [IF QUESTION B4 IS YES] What is the primary crisis issue?

- Suicide risk
- Other risk of harm to self or others (e.g. NSSI, homicidal thoughts)
- Mental health
- Substance use other than overdose
- Overdose
- Other
- Not documented in records or not documented in records using this standard

- B5. In the past 30 days, did the client spend one or more nights at a residential behavioral health treatment facility, for example crisis stabilization or residential substance use disorder treatment facility, including for withdrawal management?**
- Yes
 - No
 - Not documented in records or not documented in records using this standard
- B6. [CLIENTS 11 YEARS OR OLDER ONLY] In the past 90 days, was the client arrested, taken into custody, or detained?**
- Yes
 - No
 - Not applicable
 - Not documented in records or not documented in records using this standard
- B7. [CLIENTS 11 YEARS OR OLDER ONLY] In the past 90 days, did the client spend one or more nights in jail or a correctional facility?**
- Yes
 - No
 - Not applicable
 - Not documented in records or not documented in records using this standard
- B8. [CLIENTS 11 YEARS OR OLDER ONLY] In the past 90 days, has the client been on probation, parole, or intensive pretrial supervision for one or more days?**
- Yes
 - No
 - Not applicable
 - Not documented in records or not documented in records using this standard

C. BEHAVIORAL HEALTH SCREENINGS

Please indicate the client’s screening results, as documented in an individual clinical or client record (whether paper or electronic).

C1. Within the past 30 days, was the client screened or assessed by your program for risk of suicidality?

- Yes – Screening result was negative (no or low risk)
- Yes – Screening result was positive (at risk)
- No, not screened or assessed
- Not documented in records or not documented in records using this standard

C2. Within the past 30 days, was the client screened or assessed by your program for substance use?

- Yes – Screening result was negative (no or low risk for substance use disorder (SUD))
- Yes – Screening result was positive (at risk for SUD)
- No, not screened or assessed
- Not documented in records or not documented in records using this standard

C3. [IF QUESTION C2 IS “YES”] During the screening and assessment process, what was the reported use for the following substances?

Substance	Recent use (within the past 30 days)	Past use (greater than 30 days)	Never used	Not documented
a. Alcohol.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Opioids	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Cannabis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Sedative, hypnotic, or anxiolytics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Cocaine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Methamphetamine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Other stimulants	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Hallucinogens or psychedelics.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Inhalants.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Other psychoactive substances	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Tobacco or nicotine.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

C4. Within the past 30 days, was the client screened or assessed by your program for the following disorders? (Please select one per disorder)

Disorder	Screened / assessed	Not screened	Not applicable	Not documented in records
a. Depression, depressive disorders.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Anxiety disorders.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Bipolar disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Psychosis, psychotic disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Trauma disorders, including PTSD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. [IF CLIENT < 18 YEARS] Developmental, neurologic disorders.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. [IF CLIENT < 18 YEARS] Behavioral and emotional.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

D. BEHAVIORAL HEALTH DIAGNOSIS

Please indicate the client’s current behavioral health diagnoses using the most current version of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes, as made by a clinician and documented in a clinical record.

D1. Substance use disorder diagnosis (record up to 3)

- Enter ICD-10-CM code F10-F19- or indicate no diagnosis | _ _ | _ _ | _ _ |
- Enter ICD-10-CM code F10-F19- or indicate no diagnosis | _ _ | _ _ | _ _ |
- Enter ICD-10-CM code F10-F19- or indicate no diagnosis | _ _ | _ _ | _ _ |
- No diagnosis

D2. Mental health diagnosis (record up to 3)

- Enter ICD-10-CM code F20-F99- or indicate no diagnosis | _ _ | _ _ | _ _ |
- Enter ICD-10-CM code F20-F99- or indicate no diagnosis | _ _ | _ _ | _ _ |
- Enter ICD-10-CM code F20-F99- or indicate no diagnosis | _ _ | _ _ | _ _ |
- No diagnosis

D3. Other factors influencing health status (record up to 3)

- Enter ICD-10-CM code Z55-Z65 or Z69-Z76- or indicate no diagnosis | _ _ | _ _ | _ _ |
- Enter ICD-10-CM code Z55-Z65 or Z69-Z76- or indicate no diagnosis | _ _ | _ _ | _ _ |
- Enter ICD-10-CM code Z55-Z65 or Z69-Z76- or indicate no diagnosis | _ _ | _ _ | _ _ |
- No diagnosis

OTHER HEALTH STATUS QUESTIONS

Please indicate additional health status information as applicable and as documented in a clinical record.

D4. Is the client currently pregnant?

- Yes
- No
- Not applicable
- Not documented in records or not documented in records using this standard

D5. [CLINICAL HIGH RISK PSYCHOSIS CLIENTS ONLY] [AT REASSESSMENT OR ANNUAL] Has the client experienced an episode of psychosis since their last assessment?

- Yes
- No
- Not documented in records or not documented in records using this standard

D6. [SUBSTANCE USE DISORDER TREATMENT CLIENTS ONLY] In the previous 30 days, did the client experience an overdose or take too much of a substance that resulted in needing supervision or medical attention?

- Yes
- No
- Not applicable
- Not documented in records or not documented in records using this standard

D6a. [IF QUESTION D6 IS YES] After taking too much of a substance or overdosing, what intervention(s) did the client receive?

SELECT ALL THAT APPLY

- Naloxone (Narcan) or other opioid overdose reversal medication
- Care in an emergency department
- Care from a primary care provider
- Admission to a hospital
- Supervision by someone else
- Other
- Not applicable
- Not documented in records or not documented in records using this standard

D7. [MAI PROGRAM CLIENTS ONLY] Has the client ever tested positive for HIV?

- Yes, HIV-positive
- No, HIV-negative
- Not documented in records or not documented in records using this standard

D7a. [IF QUESTION D7 IS YES, HIV-INFECTED] Is the client currently on ART?

- Yes, currently taking ART
- No, not currently taking ART
- Not documented in records or not documented in records using this standard

D7b. [IF QUESTION D7 IS NO, HIV-NEGATIVE] Is the client currently taking HIV PrEP?

- Yes, currently on PrEP
- No, not currently on PrEP
- Not documented in records or not documented in records using this standard

D8. Has the client ever tested positive for Hepatitis C?

- Yes, active or previous Hepatitis C infection
- No, never had Hepatitis C
- Not documented in records or not documented in records using this standard

D8a. [IF QUESTION D8 IS YES, ACTIVE OR PREVIOUS HEPATITIS C INFECTION] Is the client currently taking viral Hepatitis C treatment?

- Yes, currently taking viral Hepatitis C treatment
- No, took treatment and cured
- No, Hepatitis C infection naturally cleared without need for treatment
- No, not currently taking treatment
- Not documented in records or not documented in records using this standard

E. SERVICES RECEIVED

Services Received is collected by grantee staff at Reassessment, Annual Assessments and Closeout.

Identify all the services your grant project provided to the client since their previous assessment.

BEHAVIORAL HEALTH SERVICES

E1. Since the previous administrative assessment, did the project provide or refer the client for one or more behavioral health services?

- Yes
- No
- Not documented in records

E1a-p. If yes, please indicate which:

	Yes – provided	Referred for service	No – not provided or referred	Not documented in records / unknown
a. Case or care management or coordination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Person- or family-centered treatment planning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Substance use psychoeducation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Mental health psychoeducation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Mental health therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Co-occurring therapy (substance use & mental health)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Group counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Individual counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Family counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Psychiatric rehabilitation services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Prescription medication for mental health disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Medication for substance use disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. Intensive day treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
n. Withdrawal management (whether in hospital, residential, or ambulatory)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
o. After care planning and referrals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
p. Co-occurring disorders (including developmental or neurologic)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**E2a-j. [IF E1a_l = MEDICATION FOR SUBSTANCE USE DISORDER IS YES – PROVIDED]
Indicate medication received**

	Yes – received	No – not received	Not documented in records / unknown
a. Naltrexone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Extended-release Naltrexone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Disulfiram	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Acamprosate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Methadone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Buprenorphine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Nicotine cessation therapy (e.g. Nicotine patch, gum, lozenge) ..	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Bupropion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Varenicline	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

CRISIS SERVICES

E3. Since the previous administrative assessment, did the project provide or refer the client for one or more crisis services?

- Yes
- No
- Not documented in records

E3a-d. If yes, please indicate which:

	Yes – provided	Referred for service	No – not provided or referred	Not documented in records / unknown
a. Crisis response planning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Crisis response	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Crisis stabilization	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Crisis follow-up	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

RECOVERY AND SUPPORT SERVICES

E4. Since the previous administrative assessment, did the project provide or refer the client for one or more recovery support services?

- Yes
- No
- Not documented in records

E4a-l. If yes, please indicate which:

	Yes – provided	Referred for service	No – not provided or referred	Not documented in records / unknown
a. Employment support.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Family support services, including family peer support.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Childcare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Transportation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Education support.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Housing support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Recovery housing.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Spiritual, ceremonial, and/or traditional activities.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Mutual support groups.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Peer support specialist services, coaching or mentoring.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Respite care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Therapeutic foster care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

INTEGRATED SERVICES

E5. Since the previous administrative assessment, did the project provide or refer the client for one or more integrated services?

- Yes
- No
- Not documented in records

E5a-i. If yes, please indicate which:

	Yes – provided	Referred for service	No – not provided or referred	Not documented in records / unknown
a. Primary health care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Maternal health care or OB/GYN	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. HIV testing.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Viral hepatitis testing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. HIV treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. HIV pre-exposure prophylaxis (PrEP).....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Viral hepatitis treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Other STI testing or treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Dental care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

F. DEMOGRAPHICS

Demographics is collected by grantee staff at Baseline only if the Client or Caregiver declined consent for the SUPRT-C.

If the individual declined the Client or Caregiver SUPT-C form at baseline, please provide demographic information below. These data can be pulled from other internal sources, however it should still come directly from clients, with the exact categories or response options as indicated below, and not be assumed.

F1. What is the client's race or ethnicity? Select all that apply and enter additional details in the spaces below.

- White – Provide details below.
 - German
 - Irish
 - English
 - Italian
 - Polish
 - French
 - Enter, for example, Scottish, Norwegian, Dutch, etc. _____
- Hispanic or Latino – Provide details below.
 - Mexican or Mexican American
 - Puerto Rican
 - Cuban
 - Salvadoran
 - Dominican
 - Colombian
 - Enter, for example, Guatemalan, Spaniard, Ecuadorian, etc. _____
- Black or African American – Provide details below.
 - African American
 - Jamaican
 - Haitian
 - Nigerian
 - Ethiopian
 - Somali
 - Enter, for example, Ghanaian, South African, Barbadian, etc. _____

- Asian – Provide details below.
 - Chinese
 - Filipino
 - Asian Indian
 - Vietnamese
 - Korean
 - Japanese
 - Enter, for example, Pakistani, Cambodian, Hmong, etc. _____
- American Indian or Alaska Native – Provide details below.
 - Specify, for example, Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Tlingit, etc. _____
- Middle Eastern or North African – Provide details below.
 - Lebanese
 - Iranian
 - Egyptian
 - Syrian
 - Moroccan
 - Israeli
 - Enter, for example, Algerian, Iraqi, Kurdish, etc. _____
- Native Hawaiian or Pacific Islander – Provide details below.
 - Native Hawaiian
 - Samoan
 - Chamorro
 - Tongan
 - Fijian
 - Marshallese
 - Enter, for example, Palauan, Tahitian, Chuukese, etc. _____
- Race/ethnicity not captured in grantee records using detailed OMB categories.
- Client/caregiver declined to provide race/ethnicity.

F2. What is the individual's sex?

- Female
- Male

OMB No. 0930-0400
Expires: 01/31/2028

**Substance Abuse and Mental Health Services
Administration (SAMHSA) Unified Performance
Reporting Tool (SUPRT) - C**

ADULT / CLIENT / ANNUAL FORM

Version: June 2025

OMB No. 0930-0400
Expires: 01/31/2028

CLIENT CONSENT

Are you answering for your child as a caregiver or family member? This form was designed for adults (persons 18 years or older) responding for themselves. If that's not you, please ask your provider for the form for Caregivers/family members or for youth (12-17 years old).

What is this form about?

The Substance Abuse Mental Health Services Administration (SAMHSA) funds part of your behavioral health services. SAMHSA collects this information to monitor and improve services in your community and across the nation. Your response to these questions will help SAMHSA and your provider.

How is my information used?

SAMHSA does not collect your name or information that can identify you. The Privacy Act of 1974, 5 U.S.C § 552a, also requires SAMHSA to protect the privacy of your information.

SAMHSA collects this information from all persons served. SAMHSA looks for trends or patterns in the data. SAMHSA combines information collected to see if services need to be improved.

Do I have to fill in this form?

No. You do not have to fill in this form. This will not result in any loss of services or benefits.

If you choose to participate, you may:

- skip questions you do not want to answer.
- stop filling in the form at any time.

How long does it take to fill in the form?

It should take you about 7 minutes.

How do I agree to participate?

By answering the following questions, you are agreeing to participate.

Public reporting burden for this collection of information is estimated to average 7 minutes per response. Send comments regarding this burden estimate, or any other aspect of this collection of information, to the Substance Abuse and Mental Health Services Administration (SAMHSA) Reports Clearance Officer, Room 15E57B, 5600 Fishers Lane, 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 Office of Management and Budget (OMB) control number. The control number for this project is 0930-0400.

A. CLIENT-REPORTED CORE OUTCOMES

A1. Please choose the option that best applies to you right now:

- I consider myself to be in recovery from substance use issues
- I consider myself to be in recovery from mental health issues
- I consider myself to be in recovery from substance use **and** mental health issues
- I do **not** consider myself to be in recovery for substance use or mental health issues
- I prefer not to answer

A2. As of right now, please select whether you strongly agree, agree, somewhat agree, somewhat disagree, disagree, or strongly disagree with each statement in the table below.

	Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree	Prefer not to answer
a. I am physically fine most days....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. My mental health is fine most days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. My substance use does not cause problems in my life.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. I have stable housing.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. I have a steady job or am involved in things like school, training, or volunteering.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. My life has purpose and meaning.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. I have enough money to meet my needs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. I am proud of the community I live in and feel a part of it.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. I am supported by the people around me.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. The future appears bright to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. I am in control of my life.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. I bounce back quickly after hard times.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

OMB No. 0930-0400
Expires: 01/31/2028

**Substance Abuse and Mental Health Services
Administration (SAMHSA) Unified Performance
Reporting Tool (SUPRT) - C**

ADULT / CLIENT / BASELINE FORM

Version: June 2025

OMB No. 0930-0400
Expires: 01/31/2028

CLIENT CONSENT

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SAMHSA collects this information from all persons served. SAMHSA looks for trends or patterns in the data. SAMHSA combines information collected to see if services need to be improved.

Do I have to fill in this form?

No. You do not have to fill in this form. This will not result in any loss of services or benefits.

If you choose to participate, you may:

- skip questions you do not want to answer.
- stop filling in the form at any time.

How long does it take to fill in the form?

It should take you about 15 minutes.

How do I agree to participate?

By answering the following questions, you are agreeing to participate.

Public reporting burden for this collection of information is estimated to average 15 minutes per response. Send comments regarding this burden estimate, or any other aspect of this collection of information, to the Substance Abuse and Mental Health Services Administration (SAMHSA) Reports Clearance Officer, Room 15E57B, 5600 Fishers Lane, 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 Office of Management and Budget (OMB) control number. The control number for this project is 0930-0400.

A. DEMOGRAPHICS

A1. What is your race or ethnicity? Select all that apply and enter additional details in the spaces below. Note, you may report more than one group.

- White – Provide details below.
 - German
 - Irish
 - English
 - Italian
 - Polish
 - French
 - Enter, for example, Scottish, Norwegian, Dutch, etc. _____
- Hispanic or Latino – Provide details below.
 - Mexican or Mexican American
 - Puerto Rican
 - Cuban
 - Salvadoran
 - Dominican
 - Colombian
 - Enter, for example, Guatemalan, Spaniard, Ecuadorian, etc. _____
- Black or African American – Provide details below.
 - African American
 - Jamaican
 - Haitian
 - Nigerian
 - Ethiopian
 - Somali
 - Enter, for example, Ghanaian, South African, Barbadian, etc. _____
- Asian – Provide details below.
 - Chinese
 - Filipino
 - Asian Indian
 - Vietnamese
 - Korean
 - Japanese
 - Enter, for example, Pakistani, Cambodian, Hmong, etc. _____
- American Indian or Alaska Native – Provide details below.
 - Specify, for example, Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Tlingit, etc. _____

- Middle Eastern or North African – Provide details below.
 - Lebanese
 - Iranian
 - Egyptian
 - Syrian
 - Moroccan
 - Israeli
 - Enter, for example, Algerian, Iraqi, Kurdish, etc. _____
- Native Hawaiian or Pacific Islander – Provide details below.
 - Native Hawaiian
 - Samoan
 - Chamorro
 - Tongan
 - Fijian
 - Marshallese
 - Enter, for example, Palauan, Tahitian, Chuukese etc. _____

A2. What is your sex?

- Female
- Male

A3. Do you speak a language other than English at home? (If no, please skip to question A4.)

- Yes
- No
- Prefer not to answer

A3a. For persons speaking a language other than English (answering yes to the question above): What is this language(s)?

CHECK ALL THAT APPLY

- American Sign Language (ASL)
- Arabic
- Chinese
- French
- Portuguese
- Spanish
- Other Language – specify: _____
- Prefer not to answer

A4. Have you ever served in the Armed Forces, the Reserves, the National Guard or other Uniformed Services?

- Yes, currently serving
- Yes, served in the past
- No
- Prefer not to answer

A5. Please respond to the following questions about your physical health.

	Yes	No	Prefer not to answer
a. Are you deaf or do you have serious difficulty hearing?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Are you blind or do you have serious difficulty seeing, even when wearing glasses?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Do you have serious difficulty walking or climbing stairs?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Do you have difficulty dressing or bathing?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

B. SOCIAL DRIVERS OF HEALTH

B1. How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

- Very hard
- Somewhat hard
- Not hard at all
- Prefer not to answer

B2. What is your living situation today?

- I have a steady place to live
- I have a place to live today but I am worried about losing it in the future
- I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
- Prefer not to answer

B3. Which of the following best describes your current living situation?

- House or apartment
- Your partner's place
- A friend or relative's and paying rent
- A friend or relative's and not paying rent
- Permanent housing program
- Transitional housing program
- Domestic violence shelter
- Emergency shelter
- Voucher hotel or motel
- Hotel or motel you pay for
- Residential drug or alcohol program
- Jail or prison
- Car or other vehicle
- Abandoned building
- Anywhere outside
- Somewhere else [where]: _____
- Prefer not to answer

B4. Are you currently employed?

- Employed, full time or part time (includes temporary, seasonal, hours change each week)
- Not employed, seeking employment
- Not employed, not seeking employment (includes if you are in school and not seeking a job, retired, not looking for work because of a disability, a homemaker, etc.)
- Other – specify: _____
- Prefer not to answer

B5. What is the highest level of education you have finished?

- Less than high school diploma
- High school degree or GED
- Some vocational, technical, college, or university credit(s)
- Associate's degree or technical/vocational certificate
- 4-year degree or higher
- Prefer not to answer

B6. In the last 3 months, have you attended school/college, homeschool, or vocational training regularly?

- Enrolled, attending regularly
- Enrolled, not attending regularly
- Not enrolled
- Prefer not to answer

B7. In the last 3 months, has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

CHECK ALL THAT APPLY

- Yes, it has kept me from medical appointments or from getting my medications
- Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
- No
- Prefer not to answer

C. CLIENT-REPORTED CORE OUTCOMES

C1. Please choose the option that best applies to you right now:

- I consider myself to be in recovery from substance use issues
- I consider myself to be in recovery from mental health issues
- I consider myself to be in recovery from substance use **and** mental health issues
- I do **not** consider myself to be in recovery for substance use or mental health issues
- I prefer not to answer

C2. As of right now, please select whether you strongly agree, agree, somewhat agree, somewhat disagree, disagree, or strongly disagree with each statement in the table below.

	Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree	Prefer not to answer
a. I am physically fine most days....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. My mental health is fine most days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. My substance use does not cause problems in my life.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. I have stable housing.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. I have a steady job or am involved in things like school, training, or volunteering.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. My life has purpose and meaning.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. I have enough money to meet my needs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. I am proud of the community I live in and feel a part of it.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. I am supported by the people around me.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. The future appears bright to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. I am in control of my life.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. I bounce back quickly after hard times.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

C3. On a scale of 0 to 100, if 0 represents no quality of life and 100 is perfect quality of life, how would you rate your quality of life?

|_|_|_|

C4. Which goals do you have for participating in this program?

CHECK ALL THAT APPLY

- Improve the symptoms that led me to services (for example distress, anxiety)
- Reduce my drug and/or alcohol use
- Gain access to medical services I need
- Enroll in or finish education (for example GED, degree, vocational training)
- Get or maintain a job
- Live in stable housing
- Be a better parent or caregiver
- Improve my friendships and relationships
- Comply with court order or avoid contact with the police and/or justice system
- Other goal - please describe: _____
- Prefer not to answer

Thank you for completing this baseline form.

Public reporting burden for this collection of information is estimated to average 15 minutes per response. Send comments regarding this burden estimate, or any other aspect of this collection of information, to the Substance Abuse and Mental Health Services Administration (SAMHSA) Reports Clearance Officer, Room 15E57B, 5600 Fishers Lane, 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 Office of Management and Budget (OMB) control number. The control number for this project is 0930-0400.

[OFFICE USE ONLY] RECORD MANAGEMENT – ADULT / CLIENT / BASELINE

CLIENT ID |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

SITE ID |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

GRANT ID |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

1. Was this assessment conducted with the client/caregiver?

- Yes – Client
- Yes – Caregiver/Proxy
- No

1a. [IF QUESTION 1 IS YES] When?

|_|_|_| / |_|_|_| / |_|_|_|_|_| MM / DD / YYYY

1b. [IF QUESTION 1 IS NO] Why not? Choose the primary reason.

- Client/Caregiver was unable to provide consent
- Client was not reached for assessment
- Client no longer in care

OMB No. 0930-0400
Expires: 01/31/2028

**Substance Abuse and Mental Health Services
Administration (SAMHSA) Unified Performance
Reporting Tool (SUPRT) - C**

ADULT / CLIENT / REASSESSMENT FORM

Version: June 2025

OMB No. 0930-0400

Expires: 01/31/2028

CLIENT CONSENT

Are you answering for your child as a caregiver or family member? This form was designed for adults (persons 18 years or older) responding for themselves. If that's not you, please ask your provider for the form for Caregivers/family members or for youth (12-17 years old).

What is this form about?

The Substance Abuse Mental Health Services Administration (SAMHSA) funds part of your behavioral health services. SAMHSA collects this information to monitor and improve services in your community and across the nation. Your response to these questions will help SAMHSA and your provider.

How is my information used?

SAMHSA does not collect your name or information that can identify you. The Privacy Act of 1974, 5 U.S.C § 552a, also requires SAMHSA to protect the privacy of your information.

SAMHSA collects this information from all persons served. SAMHSA looks for trends or patterns in the data. SAMHSA combines information collected to see if services need to be improved.

Do I have to fill in this form?

No. You do not have to fill in this form. This will not result in any loss of services or benefits.

If you choose to participate, you may:

- skip questions you do not want to answer.
- stop filling in the form at any time.

How long does it take to fill in the form?

It should take you about 10 minutes.

How do I agree to participate?

By answering the following questions, you are agreeing to participate.

Public reporting burden for this collection of information is estimated to average 10 minutes per response. Send comments regarding this burden estimate, or any other aspect of this collection of information, to the Substance Abuse and Mental Health Services Administration (SAMHSA) Reports Clearance Officer, Room 15E57B, 5600 Fishers Lane, 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 Office of Management and Budget (OMB) control number. The control number for this project is 0930-0400.

A. SOCIAL DRIVERS OF HEALTH

A1. How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

- Very hard
- Somewhat hard
- Not hard at all
- Prefer not to answer

A2. What is your living situation today?

- I have a steady place to live
- I have a place to live today but I am worried about losing it in the future
- I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
- Prefer not to answer

A3. Which of the following best describes your current living situation?

- House or apartment
- Your partner's place
- A friend or relative's and paying rent
- A friend or relative's and not paying rent
- Permanent housing program
- Transitional housing program
- Domestic violence shelter
- Emergency shelter
- Voucher hotel or motel
- Hotel or motel you pay for
- Residential drug or alcohol program
- Jail or prison
- Car or other vehicle
- Abandoned building
- Anywhere outside
- Somewhere else [where]: _____
- Prefer not to answer

A4. Are you currently employed?

- Employed, full time or part time (includes temporary, seasonal, hours change each week)
- Not employed, seeking employment
- Not employed, not seeking employment (includes in school not seeking, retired, due to disability, homemaker, etc.)
- Other – specify: _____
- Prefer not to answer

A5. What is the highest level of education you have finished?

- Less than high school diploma
- High school degree or GED
- Some vocational, technical, college, or university credit(s)
- Associate's degree or technical/vocational Certificate
- 4-year degree or higher
- Prefer not to answer

A6. In the last 3 months, have you attended school/college, homeschool, or vocational training regularly?

- Enrolled, attending regularly
- Enrolled, not attending regularly
- Not enrolled
- Prefer not to answer

A7. In the last 3 months, has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

CHECK ALL THAT APPLY

- Yes, it has kept me from medical appointments or from getting my medications.
- Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need.
- No
- Prefer not to answer

B. CLIENT-REPORTED CORE OUTCOMES

B1. Please choose the option that best applies to you right now:

- I consider myself to be in recovery from substance use issues
- I consider myself to be in recovery from mental health issues
- I consider myself to be in recovery from substance use **and** mental health issues
- I do **not** consider myself to be in recovery for substance use or mental health issues
- I prefer not to answer

B2. As of right now, please select whether you strongly agree, agree, somewhat agree, somewhat disagree, disagree, or strongly disagree with each statement in the table below.

	Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree	Prefer not to answer
a. I am physically fine most days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. My mental health is fine most days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. My substance use does not cause problems in my life.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. I have stable housing.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. I have a steady job or am involved in things like school, training, or volunteering.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. My life has purpose and meaning.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. I have enough money to meet my needs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. I am proud of the community I live in and feel a part of it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. I am supported by the people around me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. The future appears bright to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. I am in control of my life.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. I bounce back quickly after hard times.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

B3. On a scale of 0 to 100, if 0 represents no quality of life and 100 is perfect quality of life, how would you rate your quality of life?

|_|_|_|

B4. As a result of the services you received, which goals did you make progress on?

CHECK ALL THAT APPLY

- Improve the symptoms that led me to services (for example distress, anxiety)
- Reduce my drug and/or alcohol use
- Gain access to medical services I need
- Enroll in or finish education (for example GED, degree, vocational training)
- Get or maintain a job
- Live in stable housing
- Be a better parent or caregiver
- Improve my friendships and relationships
- Comply with court order or avoid contact with the police and/or justice system
- Other goal - Please describe: _____
- Prefer not to answer

Thank you for completing this reassessment form.

Public reporting burden for this collection of information is estimated to average 10 minutes per response. Send comments regarding this burden estimate, or any other aspect of this collection of information, to the Substance Abuse and Mental Health Services Administration (SAMHSA) Reports Clearance Officer, Room 15E57B, 5600 Fishers Lane, 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 Office of Management and Budget (OMB) control number. The control number for this project is 0930-0400.

[OFFICE USE ONLY] RECORD MANAGEMENT – ADULT / CLIENT / REASSESSMENT

CLIENT ID |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

SITE ID |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

GRANT ID |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

1. Was this assessment conducted with the client/caregiver?

- Yes – Client
- Yes – Caregiver/Proxy
- No

1a. [IF QUESTION 1 IS YES] When?

|_|_| / |_|_| / |_|_|_|_| MM / DD / YYYY

1b. [IF QUESTION 1 IS NO] Why not? Choose the primary reason.

- Client/Caregiver was unable to provide consent
- Client was not reached for assessment
- Client no longer in care

OMB No. 0930-0400
Expires: 01/31/2028

**Substance Abuse and Mental Health Services
Administration (SAMHSA) Unified Performance
Reporting Tool (SUPRT) - C**

CHILD (5 TO 17) / CAREGIVER / BASELINE FORM

Version: June 2025

OMB No. 0930-0400
Expires: 01/31/2028

CAREGIVER/FAMILY MEMBER CONSENT

Are you answering for your child as a caregiver or family member? This form was designed for caregivers or family members responding for their child. If that's not you, please ask your provider for the form for Youth (12 to 17) responding for themselves or for adults (18+ years old).

What is this form about?

The Substance Abuse Mental Health Services Administration (SAMHSA) funds part of your child's behavioral health services. SAMHSA collects this information to monitor and improve services in your community and across the nation. Your response to these questions will help SAMHSA and your child's provider.

How is my information used?

SAMHSA does not collect your child's name or information that can identify your child. The Privacy Act of 1974, 5 U.S.C § 552a, also requires SAMHSA to protect the privacy of your information.

SAMHSA collects this information from all persons served. SAMHSA looks for trends or patterns in the data. SAMHSA combines information collected to see if services need to be improved.

Do I have to fill in this form?

No. You do not have to fill in this form. This will not result in any loss of services or benefits.

If you choose to participate, you may:

- skip questions you do not want to answer.
- stop filling in the form at any time.

How long does it take to fill in the form?

It should take you about 10 minutes.

How do I agree to participate?

By answering the following questions, you are agreeing to participate.

Public reporting burden for this collection of information is estimated to average 10 minutes per response. Send comments regarding this burden estimate, or any other aspect of this collection of information, to the Substance Abuse and Mental Health Services Administration (SAMHSA) Reports Clearance Officer, Room 15E57B, 5600 Fishers Lane, 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 Office of Management and Budget (OMB) control number. The control number for this project is 0930-0400.

A. DEMOGRAPHICS

A1. What is your child’s race or ethnicity? Select all that apply and enter additional details in the spaces below. Note, you may report more than one group.

- White – Provide details below.
 - German
 - Irish
 - English
 - Italian
 - Polish
 - French
 - Enter, for example, Scottish, Norwegian, Dutch, etc. _____
- Hispanic or Latino – Provide details below.
 - Mexican or Mexican American
 - Puerto Rican
 - Cuban
 - Salvadoran
 - Dominican
 - Colombian
 - Enter, for example, Guatemalan, Spaniard, Ecuadorian, etc. _____
- Black or African American – Provide details below.
 - African American
 - Jamaican
 - Haitian
 - Nigerian
 - Ethiopian
 - Somali
 - Enter, for example, Ghanaian, South African, Barbadian, etc. _____
- Asian – Provide details below.
 - Chinese
 - Filipino
 - Asian Indian
 - Vietnamese
 - Korean
 - Japanese
 - Enter, for example, Pakistani, Cambodian, Hmong, etc. _____
- American Indian or Alaska Native – Provide details below.
 - Specify, for example, Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Tlingit, etc. _____

- Middle Eastern or North African – Provide details below.
 - Lebanese
 - Iranian
 - Egyptian
 - Syrian
 - Moroccan
 - Israeli
 - Enter, for example, Algerian, Iraqi, Kurdish, etc. _____
- Native Hawaiian or Pacific Islander – Provide details below.
 - Native Hawaiian
 - Samoan
 - Chamorro
 - Tongan
 - Fijian
 - Marshallese
 - Enter, for example, Palauan, Tahitian, Chuukese etc. _____

A2. What is your child's sex?

- Female
- Male

A3. Does your child speak a language other than English at home? (If no, please skip to question A4.)

- Yes
- No
- Prefer not to answer

A3a. For persons speaking a language other than English (answering yes to the question above): What is this language(s)?

CHECK ALL THAT APPLY

- American Sign Language (ASL)
- Arabic
- Chinese
- French
- Portuguese
- Spanish
- Other Language – specify: _____
- Prefer not to answer

A4. Please respond to the following questions about your child's physical health.

	Yes	No	Prefer not to answer
a. Is your child deaf or does your child have serious difficulty hearing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Is your child blind or does your child have serious difficulty seeing, even when wearing glasses?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Because of a physical, mental, or emotional condition, does your child have serious difficulty concentrating, remembering, or making decisions?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Does your child have serious difficulty walking or climbing stairs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Does your child have difficulty dressing or bathing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Because of a physical, mental, or emotional condition, does your child have difficulty doing errands alone such as visiting a doctor's office or shopping?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

B. SOCIAL-DRIVERS OF HEALTH

- B1. How hard is it for you to pay for the very basics like food, housing, medical care, and heating for your child?**
- Very hard
 - Somewhat hard
 - Not hard at all
 - I am not the person responsible for paying for the basics for my child
 - Prefer not to answer
- B2. What is your child's living situation today?**
- My child has a steady place to live
 - My child has a place to live today but I am worried they may lose it in the future
 - My child does not have a steady place to live (My child is temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
 - Prefer not to answer
- B3. Which of the following best describes your child's current living situation?**
- Your house or apartment
 - Your partner's place
 - A friend or relative's and paying rent
 - A friend or relative's and not paying rent
 - Permanent housing program
 - Transitional housing program
 - Domestic violence shelter
 - Emergency shelter
 - Voucher hotel or motel
 - Hotel or motel you pay for
 - Residential drug or alcohol program
 - Jail or prison
 - Car or other vehicle
 - Abandoned building
 - Anywhere outside
 - Somewhere else [where]: _____
 - Prefer not to answer
- B4. What is the highest level of education your child has finished?**
- Preschool – Kindergarten
 - Grade 1 – Grade 5
 - Grade 6 – Grade 8
 - Grade 9 - 12
 - High school degree or GED
 - Prefer not to answer

OMB No. 0930-0400
Expires: 01/31/2028

**Substance Abuse and Mental Health Services
Administration (SAMHSA) Unified Performance
Reporting Tool (SUPRT) - C**

CHILD (5 TO 17) / CAREGIVER / REASSESSMENT FORM

Version: June 2025

OMB No. 0930-0400
Expires: 01/31/2028

CAREGIVER/FAMILY MEMBER CONSENT

Are you answering for your child as a caregiver or family member? This form was designed for caregivers or family members responding for their child. If that's not you, please ask your provider for the form for Youth (12 to 17) responding for themselves or for adults (18+ years old).

What is this form about?

The Substance Abuse Mental Health Services Administration (SAMHSA) funds part of your child's behavioral health services. SAMHSA collects this information to monitor and improve services in your community and across the nation. Your response to these questions will help SAMHSA and your child's provider.

How is my information used?

SAMHSA does not collect your child's name or information that can identify your child. The Privacy Act of 1974, 5 U.S.C § 552a, also requires SAMHSA to protect the privacy of your information.

SAMHSA collects this information from all persons served. SAMHSA looks for trends or patterns in the data. SAMHSA combines information collected to see if services need to be improved.

Do I have to fill in this form?

No. You do not have to fill in this form. This will not result in any loss of services or benefits.

If you choose to participate, you may:

- skip questions you do not want to answer.
- stop filling in the form at any time.

How long does it take to fill in the form?

It should take you about 5 minutes.

How do I agree to participate?

By answering the following questions, you are agreeing to participate.

Public reporting burden for this collection of information is estimated to average 5 minutes per response. Send comments regarding this burden estimate, or any other aspect of this collection of information, to the Substance Abuse and Mental Health Services Administration (SAMHSA) Reports Clearance Officer, Room 15E57B, 5600 Fishers Lane, 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 Office of Management and Budget (OMB) control number. The control number for this project is 0930-0400.

A. SOCIAL DRIVERS OF HEALTH

A1. How hard is it for you to pay for the very basics like food, housing, medical care, and heating for your child?

- Very hard
- Somewhat hard
- Not hard at all
- I am not the person responsible for paying for the basics for my child
- Prefer not to answer

A2. What is your child's living situation today?

- My child has a steady place to live
- My child has a place to live today but I am worried they may lose it in the future
- My child does not have a steady place to live (My child is temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
- Prefer not to answer

A3. Which of the following best describes your child's current living situation?

- Your house or apartment
- Your partner's place
- A friend or relative's and paying rent
- A friend or relative's and not paying rent
- Permanent housing program
- Transitional housing program
- Domestic violence shelter
- Emergency shelter
- Voucher hotel or motel
- Hotel or motel you pay for
- Residential drug or alcohol program
- Jail or prison
- Car or other vehicle
- Abandoned building
- Anywhere outside
- Somewhere else [where]: _____
- Prefer not to answer

OMB No. 0930-0400
Expires: 01/31/2028

**Substance Abuse and Mental Health Services
Administration (SAMHSA) Unified Performance
Reporting Tool (SUPRT) - C**

YOUNG CHILD (0 TO 4) / CAREGIVER / BASELINE FORM

Version: June 2025

OMB No. 0930-0400
Expires: 01/31/2028

CAREGIVER/FAMILY MEMBER CONSENT

Are you answering for your child (aged 0 to 4) as a caregiver or family member? This form was designed for caregivers or family members responding for their young child. If that's not you, please ask your provider for the form for a Child (5 to 17) or Youth (12 to 17) responding for themselves.

What is this form about?

The Substance Abuse Mental Health Services Administration (SAMHSA) funds part of your child's behavioral health services. SAMHSA collects this information to monitor and improve services in your community and across the nation. Your response to these questions will help SAMHSA and your child's provider.

How is my information used?

SAMHSA does not collect your child's name or information that can identify your child. The Privacy Act of 1974, 5 U.S.C § 552a, also requires SAMHSA to protect the privacy of your information.

SAMHSA collects this information from all persons served. SAMHSA looks for trends or patterns in the data. SAMHSA combines information collected to see if services need to be improved.

Do I have to fill in this form?

No. You do not have to fill in this form. This will not result in any loss of services or benefits.

If you choose to participate, you may:

- skip questions you do not want to answer.
- stop filling in the form at any time.

How long does it take to fill in the form?

It should take you about 6 minutes.

How do I agree to participate?

By answering the following questions, you are agreeing to participate.

Public reporting burden for this collection of information is estimated to average 6 minutes per response. Send comments regarding this burden estimate, or any other aspect of this collection of information, to the Substance Abuse and Mental Health Services Administration (SAMHSA) Reports Clearance Officer, Room 15E57B, 5600 Fishers Lane, 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 Office of Management and Budget (OMB) control number. The control number for this project is 0930-0400.

A. DEMOGRAPHICS

A1. What is your child's race or ethnicity? Select all that apply and enter additional details in the spaces below. Note, you may report more than one group.

- White – Provide details below.
 - German
 - Irish
 - English
 - Italian
 - Polish
 - French
 - Enter, for example, Scottish, Norwegian, Dutch, etc. _____
- Hispanic or Latino – Provide details below.
 - Mexican or Mexican American
 - Puerto Rican
 - Cuban
 - Salvadoran
 - Dominican
 - Colombian
 - Enter, for example, Guatemalan, Spaniard, Ecuadorian, etc. _____
- Black or African American – Provide details below.
 - African American
 - Jamaican
 - Haitian
 - Nigerian
 - Ethiopian
 - Somali
 - Enter, for example, Ghanaian, South African, Barbadian, etc. _____
- Asian – Provide details below.
 - Chinese
 - Filipino
 - Asian Indian
 - Vietnamese
 - Korean
 - Japanese
 - Enter, for example, Pakistani, Cambodian, Hmong, etc. _____
- American Indian or Alaska Native
 - Specify, for example, Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Tlingit, etc. _____

- Middle Eastern or North African – Provide details below.
 - Lebanese
 - Iranian
 - Egyptian
 - Syrian
 - Moroccan
 - Israeli
 - Enter, for example, Algerian, Iraqi, Kurdish, etc. _____
- Native Hawaiian or Pacific Islander – Provide details below.
 - Native Hawaiian
 - Samoan
 - Chamorro
 - Tongan
 - Fijian
 - Marshallese
 - Enter, for example, Palauan, Tahitian, Chuukese etc. _____

A2. What is your child’s sex?

- Female
- Male

A3. Please respond to the following questions about your child’s physical health.

	Yes	No	Prefer not to answer
a. Is your child deaf or does your child have serious difficulty hearing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Is your child blind or does your child have serious difficulty seeing, even when wearing glasses?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

B. SOCIAL DRIVERS OF HEALTH

B1. How hard is it for you to pay for the very basics like food, housing, medical care, and heating for your child?

- Very hard
- Somewhat hard
- Not hard at all
- I am not the person responsible for paying for the basics for my child
- Prefer not to answer

B2. What is your child's living situation today?

- My child has a steady place to live
- My child has a place to live today but I am worried they may lose it in the future
- My child does not have a steady place to live (My child is temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
- Prefer not to answer

B3. Which of the following best describes your child's current living situation?

- Your house or apartment
- Your partner's place
- A friend or relative's and paying rent
- A friend or relative's and not paying rent
- Permanent housing program
- Transitional housing program
- Domestic violence shelter
- Emergency shelter
- Voucher hotel or motel
- Hotel or motel you pay for
- Residential drug or alcohol program
- Jail or prison
- Car or other vehicle
- Abandoned building
- Anywhere outside
- Somewhere else [where]: _____
- Prefer not to answer

OMB No. 0930-0400
Expires: 01/31/2028

**Substance Abuse and Mental Health Services
Administration (SAMHSA) Unified Performance
Reporting Tool (SUPRT) - C**

**YOUNG CHILD (0 TO 4) / CAREGIVER / REASSESSMENT
FORM**

Version: June 2025

OMB No. 0930-0400
Expires: 01/31/2028

CAREGIVER/FAMILY MEMBER CONSENT

Are you answering for your child as a caregiver or family member? This form was designed for caregivers or family members responding for their young child. If that's not you, please ask your provider for the form for Child (5 to 17) or Youth (12 to 17) responding for themselves.

What is this form about?

The Substance Abuse Mental Health Services Administration (SAMHSA) funds part of your child's behavioral health services. SAMHSA collects this information to monitor and improve services in your community and across the nation. Your response to these questions will help SAMHSA and your child's provider.

How is my information used?

SAMHSA does not collect your child's name or information that can identify your child. The Privacy Act of 1974, 5 U.S.C § 552a, also requires SAMHSA to protect the privacy of your information.

SAMHSA collects this information from all persons served. SAMHSA looks for trends or patterns in the data. SAMHSA combines information collected to see if services need to be improved.

Do I have to fill in this form?

No. You do not have to fill in this form. This will not result in any loss of services or benefits.

If you choose to participate, you may:

- skip questions you do not want to answer.
- stop filling in the form at any time.

How long does it take to fill in the form?

It should take you about 3 minutes.

How do I agree to participate?

By answering the following questions, you are agreeing to participate.

Public reporting burden for this collection of information is estimated to average 3 minutes per response. Send comments regarding this burden estimate, or any other aspect of this collection of information, to the Substance Abuse and Mental Health Services Administration (SAMHSA) Reports Clearance Officer, Room 15E57B, 5600 Fishers Lane, 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 Office of Management and Budget (OMB) control number. The control number for this project is 0930-0400.

A. SOCIAL DRIVERS OF HEALTH

A1. How hard is it for you to pay for the very basics like food, housing, medical care, and heating for your child?

- Very hard
- Somewhat hard
- Not hard at all
- I am not the person responsible for paying for the basics for my child
- Prefer not to answer

A2. What is your child's living situation today?

- My child has a steady place to live
- My child has a place to live today but I am worried they may lose it in the future
- My child does not have a steady place to live (My child is temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
- Prefer not to answer

A3. Which of the following best describes your child's current living situation?

- Your house or apartment
- Your partner's place
- A friend or relative's and paying rent
- A friend or relative's and not paying rent
- Permanent housing program
- Transitional housing program
- Domestic violence shelter
- Emergency shelter
- Voucher hotel or motel
- Hotel or motel you pay for
- Residential drug or alcohol program
- Jail or prison
- Car or other vehicle
- Abandoned building
- Anywhere outside
- Somewhere else [where]: _____
- Prefer not to answer

OMB No. 0930-0400
Expires: 01/31/2028

**Substance Abuse and Mental Health Services
Administration (SAMHSA) Unified Performance
Reporting Tool (SUPRT) - C**

YOUTH (12 TO 17) / CLIENT / BASELINE FORM

Version: June 2025

OMB No. 0930-0400
Expires: 01/31/2028

CLIENT CONSENT

Are you answering for your child as a caregiver or family member? This form was designed for Youth (persons 12 to 17 years old) responding for themselves. If that's not you, please ask your provider for the form for Caregivers/family members or for adults (18+ years old).

What is this form about?

The Substance Abuse Mental Health Services Administration (SAMHSA) funds part of your behavioral health services. SAMHSA collects this information to monitor and improve services in your community and across the nation. Your response to these questions will help SAMHSA and your provider.

How is my information used?

SAMHSA does not collect your name or information that can identify you. The Privacy Act of 1974, 5 U.S.C § 552a, also requires SAMHSA to protect the privacy of your information.

SAMHSA collects this information from all persons served. SAMHSA looks for trends or patterns in the data. SAMHSA combines information collected to see if services need to be improved.

Do I have to fill in this form?

No. You do not have to fill in this form. This will not result in any loss of services or benefits.

If you choose to participate, you may:

- skip questions you do not want to answer.
- stop filling in the form at any time.

How long does it take to fill in the form?

It should take you about 10 minutes.

How do I agree to participate?

By answering the following questions, you are agreeing to participate.

Public reporting burden for this collection of information is estimated to average 10 minutes per response. Send comments regarding this burden estimate, or any other aspect of this collection of information, to the Substance Abuse and Mental Health Services Administration (SAMHSA) Reports Clearance Officer, Room 15E57B, 5600 Fishers Lane, 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 Office of Management and Budget (OMB) control number. The control number for this project is 0930-0400.

A. DEMOGRAPHICS

A1. What is your race or ethnicity? Select all that apply and enter additional details in the spaces below. Note, you may report more than one group.

- White – Provide details below.
 - German
 - Irish
 - English
 - Italian
 - Polish
 - French
 - Enter, for example, Scottish, Norwegian, Dutch, etc. _____
- Hispanic or Latino – Provide details below.
 - Mexican or Mexican American
 - Puerto Rican
 - Cuban
 - Salvadoran
 - Dominican
 - Colombian
 - Enter, for example, Guatemalan, Spaniard, Ecuadorian, etc. _____
- Black or African American – Provide details below.
 - African American
 - Jamaican
 - Haitian
 - Nigerian
 - Ethiopian
 - Somali
 - Enter, for example, Ghanaian, South African, Barbadian, etc. _____
- Asian – Provide details below.
 - Chinese
 - Filipino
 - Asian Indian
 - Vietnamese
 - Korean
 - Japanese
 - Enter, for example, Pakistani, Cambodian, Hmong, etc. _____
- American Indian or Alaska Native – Provide details below.
 - Specify, for example, Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Tlingit, etc. _____

- Middle Eastern or North African – Provide details below.
 - Lebanese
 - Iranian
 - Egyptian
 - Syrian
 - Moroccan
 - Israeli
 - Enter, for example, Algerian, Iraqi, Kurdish, etc. _____
- Native Hawaiian or Pacific Islander – Provide details below.
 - Native Hawaiian
 - Samoan
 - Chamorro
 - Tongan
 - Fijian
 - Marshallese
 - Enter, for example, Palauan, Tahitian, Chuukese etc. _____

A2. What is your sex?

- Female
- Male

A3. Do you speak a language other than English at home? (If no, please skip to question A4.)

- Yes
- No
- Prefer not to answer

A3a. For persons speaking a language other than English (answering yes to the question above): What is this language(s)?

CHECK ALL THAT APPLY

- American Sign Language (ASL)
- Arabic
- Chinese
- French
- Portuguese
- Spanish
- Other Language – specify: _____
- Prefer not to answer

A4. Please respond to the following questions about your physical health.

	Yes	No	Prefer not to answer
a. Are you deaf or do you have serious difficulty hearing?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Are you blind or do you have serious difficulty seeing, even when wearing glasses?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Do you have serious difficulty walking or climbing stairs?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Do you have difficulty dressing or bathing?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

B. SOCIAL DRIVERS OF HEALTH

B1. What is your living situation today?

- I have a steady place to live
- I have a place to live today but I am worried about losing it in the future
- I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
- Prefer not to answer

B2. Which of the following best describes your current living situation?

- My parent/guardian's house or apartment
- Your partner's place
- A friend or relative's and paying rent
- A friend or relative's and not paying rent
- Permanent housing program
- Transitional housing program
- Domestic violence shelter
- Emergency shelter
- Voucher hotel or motel
- Hotel or motel you pay for
- Residential drug or alcohol program
- Jail or prison
- Car or other vehicle
- Abandoned building
- Anywhere outside
- Somewhere else [where]: _____
- Prefer not to answer

B3. What is the highest level of education you have finished?

- Preschool – Kindergarten
- Grade 1 – Grade 5
- Grade 6 – Grade 8
- Grade 9 – 12
- High school degree or GED
- Prefer not to answer

B4. In the last 3 months, have you attended school/college, homeschool, or vocational training regularly?

- Enrolled, attending regularly
- Enrolled, not attending regularly
- Not enrolled
- Prefer not to answer

Thank you for completing this baseline form.

Public reporting burden for this collection of information is estimated to average 10 minutes per response. Send comments regarding this burden estimate, or any other aspect of this collection of information, to the Substance Abuse and Mental Health Services Administration (SAMHSA) Reports Clearance Officer, Room 15E57B, 5600 Fishers Lane, 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 Office of Management and Budget (OMB) control number. The control number for this project is 0930-0400.

[OFFICE USE ONLY] RECORD MANAGEMENT – YOUTH / CLIENT / BASELINE

CLIENT ID |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

SITE ID |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

GRANT ID |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

1. Was this assessment conducted with the client/caregiver?

- Yes – Client
- Yes – Caregiver/Proxy
- No

1a. [IF QUESTION 1 IS YES] When?

|_|_|_| / |_|_|_| / |_|_|_|_|_| MM / DD / YYYY

1b. [IF QUESTION 1 IS NO] Why not? Choose the primary reason.

- Client/Caregiver was unable to provide consent
- Client was not reached for assessment
- Client no longer in care

OMB No. 0930-0400
Expires: 01/31/2028

**Substance Abuse and Mental Health Services
Administration (SAMHSA) Unified Performance
Reporting Tool (SUPRT) - C**

YOUTH (12 TO 17) / CLIENT / REASSESSMENT FORM

Version: June 2025

OMB No. 0930-0400
Expires: 01/31/2028

CLIENT CONSENT

Are you answering for your child as a caregiver or family member? This form was designed for Youth (persons 12 to 17 years old) responding for themselves. If that's not you, please ask your provider for the form for Caregivers/family members or for adults (18+ years old).

What is this form about?

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How is my information used?

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Do I have to fill in this form?

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If you choose to participate, you may:

- skip questions you do not want to answer.
- stop filling in the form at any time.

How long does it take to fill in the form?

It should take you about 5 minutes.

How do I agree to participate?

By answering the following questions, you are agreeing to participate.

Public reporting burden for this collection of information is estimated to average 5 minutes per response. Send comments regarding this burden estimate, or any other aspect of this collection of information, to the Substance Abuse and Mental Health Services Administration (SAMHSA) Reports Clearance Officer, Room 15E57B, 5600 Fishers Lane, 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 Office of Management and Budget (OMB) control number. The control number for this project is 0930-0400.

A. SOCIAL DRIVERS OF HEALTH

A1. What is your living situation today?

- I have a steady place to live
- I have a place to live today but I am worried about losing it in the future
- I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
- Prefer not to answer

A2. Which of the following best describes your current living situation?

- My parent/guardian's house or apartment
- Your partner's place
- A friend or relative's and paying rent
- A friend or relative's and not paying rent
- Permanent housing program
- Transitional housing program
- Domestic violence shelter
- Emergency shelter
- Voucher hotel or motel
- Hotel or motel you pay for
- Residential drug or alcohol program
- Jail or prison
- Car or other vehicle
- Abandoned building
- Anywhere outside
- Somewhere else [where]: _____
- Prefer not to answer

A3. What is the highest level of education you have finished?

- Preschool – Kindergarten
- Grade 1 – Grade 5
- Grade 6 – Grade 8
- Grade 9 - 12
- High school degree or GED
- Prefer not to answer

A4. In the last 3 months, have you attended school/college, homeschool, or vocational training regularly?

- Enrolled, attending regularly
- Enrolled, not attending regularly
- Not enrolled
- Prefer not to answer

