

FOLLOW-UP INTERVIEW NOMs

Consumer ID | | | | | | | | | | | | | | | |

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

Site ID | | | | | | | | | | | | | | | |

1. Assessment

- Baseline Assessment
- 6-Month Reassessment
- 12-Month Reassessment
- 18-Month Reassessment
- 24-Month Reassessment
- 30-Month Reassessment
- 36-Month Reassessment
- 42-Month Reassessment
- 48-Month Reassessment
- 54-Month Reassessment
- 60-Month Reassessment
- 66-Month Reassessment
- Clinical Discharge

2. Interview Conducted?

- Yes **[GO TO 3]**
- No

3. When was the interview conducted or attempted?

[REASSESSMENTS AND CLINICAL DISCHARGE: IF ANSWERED "CONSUMER CANNOT BE REACHED FOR INTERVIEW" IN 2a, GO TO INSTRUCTIONS BELOW 5]

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

5. Was the respondent the child or the caregiver?

- Child [PREFER CHILD AGE 11 AND OLDER]
- Caregiver

B. Functioning

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

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

2. In order to provide the best possible mental health and related services, we need to know what you think about how well your child was able to deal with everyday life during the past 30 days. Please indicate your disagreement/agreement with each of the following statements.

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER (CAREGIVER).]

STATEMENT	RESPONSE OPTIONS						
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	REFUSED	NOT APPLICABLE
a. My child is handling daily life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. My child gets along with family members.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. My child gets along with friends and other people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. My child is doing well in school and/or work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. My child is able to cope when things go wrong.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
f. I am satisfied with our family life right now.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

B. MILITARY FAMILY AND DEPLOYMENT

[QUESTION 5 IS NOT APPLICABLE TO CHILD PROGRAMS.]

6. Is anyone in your child's family or someone close to your child currently serving on active duty in or retired/separated from the Armed Forces, the Reserves, or the National Guard?

- Yes, only one person
- Yes, more than one person
- No **[GO TO SECTION C]**
- REFUSED **[GO TO SECTION C]**
- DON'T KNOW **[GO TO SECTION C]**

For the first person:

6.a.1 What is the relationship of that person (Service Member) to your child?

- MOTHER/FATHER
- BROTHER/SISTER
- SPOUSE/PARTNER
- CHILD
- OTHER, SPECIFY _____
- REFUSED
- DON'T KNOW

6.b.1 Has the Service Member experienced any of the following? Please answer for each of the following. You may say yes to more than one.

	YES	NO	REFUSED	DON'T KNOW
Deployed in support of Combat Operations (e.g. Iraq or Afghanistan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was physically injured during Combat Operations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developed combat stress symptoms/difficulties adjusting following deployment, including PTSD, depression, or suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Died or was killed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

[IF THE RESPONSE TO 6 WAS "YES, ONLY ONE PERSON", GO TO SECTION C. OTHERWISE, CONTINUE.]

For the second person:

6.a.2 What is the relationship of that person (Service Member) to your child?

- MOTHER/FATHER
- BROTHER/SISTER
- SPOUSE/PARTNER
- CHILD
- OTHER, SPECIFY _____
- REFUSED
- DON'T KNOW

6.b.2 Has the Service Member experienced any of the following? Please answer for each of the following. You may say yes to more than one.

	YES	NO	REFUSED	DON'T KNOW
Deployed in support of Combat Operations (e.g. Iraq or Afghanistan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was physically injured during Combat Operations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developed combat stress symptoms/difficulties adjusting following deployment, including PTSD, depression, or suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Died or was killed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

[IF THE CONSUMER HAS INFORMATION FOR ANOTHER SERVICE MEMBER, CONTINUE. OTHERWISE, GO TO SECTION C.]

For the third person:

6.a.3 What is the relationship of that person (Service Member) to your child?

- MOTHER/FATHER
- BROTHER/SISTER
- SPOUSE/PARTNER
- CHILD
- OTHER, SPECIFY _____
- REFUSED
- DON'T KNOW

6.b.3 Has the Service Member experienced any of the following? Please answer for each of the following. You may say yes to more than one.

	YES	NO	REFUSED	DON'T KNOW
Deployed in support of Combat Operations (e.g. Iraq or Afghanistan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was physically injured during Combat Operations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developed combat stress symptoms/difficulties adjusting following deployment, including PTSD, depression, or suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Died or was killed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

[IF THE CONSUMER HAS INFORMATION FOR ANOTHER SERVICE MEMBER, CONTINUE. OTHERWISE, GO TO SECTION C.]

For the fourth person:

6.a.4 What is the relationship of that person (Service Member) to your child?

- MOTHER/FATHER
- BROTHER/SISTER
- SPOUSE/PARTNER
- CHILD
- OTHER, SPECIFY _____
- REFUSED
- DON'T KNOW

6.b.4 Has the Service Member experienced any of the following? Please answer for each of the following. You may say yes to more than one.

	YES	NO	REFUSED	DON'T KNOW
Deployed in support of Combat Operations (e.g. Iraq or Afghanistan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was physically injured during Combat Operations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developed combat stress symptoms/difficulties adjusting following deployment, including PTSD, depression, or suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Died or was killed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

[IF THE CONSUMER HAS INFORMATION FOR ANOTHER SERVICE MEMBER, CONTINUE. OTHERWISE, GO TO SECTION C.]

For the fifth person:

6.a.5 What is the relationship of that person (Service Member) to your child?

- MOTHER/FATHER
- BROTHER/SISTER
- SPOUSE/PARTNER
- CHILD
- OTHER, SPECIFY _____
- REFUSED
- DON'T KNOW

6.b.5 Has the Service Member experienced any of the following? Please answer for each of the following. You may say yes to more than one.

	YES	NO	REFUSED	DON'T KNOW
Deployed in support of Combat Operations (e.g. Iraq or Afghanistan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was physically injured during combat Operations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developed combat stress symptoms/difficulties adjusting following deployment, including PTSD, depression, or suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Died or was killed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

[IF THE CONSUMER HAS INFORMATION FOR ANOTHER SERVICE MEMBER, CONTINUE. OTHERWISE, GO TO SECTION C.]

For the sixth person:

6.a.6 What is the relationship of that person (Service Member) to your child?

- MOTHER/FATHER
- BROTHER/SISTER
- SPOUSE/PARTNER
- CHILD
- OTHER, SPECIFY _____
- REFUSED
- DON'T KNOW

6.b.6 Has the Service Member experienced any of the following? Please answer for each of the following. You may say yes to more than one.

	YES	NO	REFUSED	DON'T KNOW
Deployed in support of Combat Operations (e.g. Iraq or Afghanistan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was physically injured during Combat Operations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developed combat stress symptoms/difficulties adjusting following deployment, including PTSD, depression, or suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Died or was killed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. STABILITY IN HOUSING

1. In the past 30 days how many ...	Number of Nights/ Times	REFUSED	DON'T KNOW
a. nights has your child been homeless?	_ _ _	<input type="checkbox"/>	<input type="checkbox"/>
b. nights has your child spent in a hospital for mental health care?	_ _ _	<input type="checkbox"/>	<input type="checkbox"/>
c. nights has your child spent in a facility for detox/inpatient or residential substance abuse	_ _ _	<input type="checkbox"/>	<input type="checkbox"/>
d. nights has your child spent in correctional facility including juvenile detention, jail, or prison?	_ _ _	<input type="checkbox"/>	<input type="checkbox"/>
[ADD UP THE TOTAL NUMBER OF NIGHTS SPENT HOMELESS, IN HOSPITAL FOR MENTAL HEALTH CARE, IN DETOX/INPATIENT OR RESIDENTIAL SUBSTANCE ABUSE TREATMENT, OR IN A CORRECTIONAL FACILITY. (ITEMS A-D, CANNOT EXCEED 30 NIGHTS)]	_ _ _		
e. times has your child gone to an emergency room for a psychiatric or emotional problem?	_ _ _	<input type="checkbox"/>	<input type="checkbox"/>

[IF 1A, 1B, 1C, OR 1D IS 16 OR MORE NIGHTS, GO TO SECTION D]

2. In the past 30 days, where has your child been living most of the time? [DO NOT READ RESPONSE OPTIONS TO CONSUMER (CAREGIVER). SELECT ONLY ONE.]

- CAREGIVER'S OWNED OR RENTED HOUSE, APARTMENT, TRAILER, OR ROOM
- INDEPENDENT OWNED OR RENTED HOUSE, APARTMENT, TRAILER OR ROOM
- SOMEONE ELSE'S HOUSE, APARTMENT, TRAILER, OR ROOM
- HOMELESS (SHELTER, STREET/OUTDOORS, PARK)
- GROUP HOME
- FOSTER CARE (SPECIALIZED THERAPEUTIC TREATMENT)
- TRANSITIONAL LIVING FACILITY
- HOSPITAL (MEDICAL)
- HOSPITAL (PSYCHIATRIC)
- DETOX/INPATIENT OR RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
- CORRECTIONAL FACILITY (JUVENILE DETENTION CENTER/JAIL/PRISON)
- OTHER HOUSED (SPECIFY) _____
- REFUSED
- DON'T KNOW

D. EDUCATION

1. **During the past 30 days of school, how many days was your child absent for any reason?**

- 0 DAYS
- 1 DAYS
- 2 DAYS
- 3 TO 5 DAYS
- 6 TO 10 DAYS
- MORE THAN 10 DAYS
- REFUSED
- DON'T KNOW
- NOT APPLICABLE

a. [IF ABSENT], **how many days were unexcused absences?**

- 0 DAYS
- 1 DAYS
- 2 DAYS
- 3 TO 5 DAYS
- 6 TO 10 DAYS
- MORE THAN 10 DAYS
- REFUSED
- DON'T KNOW
- NOT APPLICABLE

2. **What is the highest level of education your child has finished, whether or not he/she has received a degree?**

- NEVER ATTENDED
- PRESCHOOL
- KINDERGARTEN
- 1ST GRADE
- 2ND GRADE
- 3RD GRADE
- 4TH GRADE
- 5TH GRADE
- 6TH GRADE
- 7TH GRADE
- 8TH GRADE
- 9TH GRADE
- 10TH GRADE
- 11TH GRADE
- 12TH GRADE/HIGH SCHOOL DIPLOMA/EQUIVALENT (GED)
- VOC/TECH DIPLOMA
- SOME COLLEGE OR UNIVERSITY
- REFUSED
- DON'T KNOW

E. CRIME AND CRIMINAL JUSTICE STATUS

1. **In the past 30 days, how many times has your child been arrested?**

|__| |__| TIMES REFUSED DON'T KNOW

F. PERCEPTION OF CARE

1. In order to provide the best possible mental health and related services, we need to know what you think about the services your child received during the past 30 days, the people who provided it, and the results. Please indicate your disagreement/agreement with each of the following statements.

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER (CAREGIVER)]

STATEMENT	RESPONSE OPTIONS					
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	REFUSED
a. Staff here treated me with respect.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Staff respected my family's religious/spiritual beliefs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Staff spoke with me in a way that I understood.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Staff was sensitive to my cultural/ethnic background.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I helped choose my child's services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. I helped to choose my child's treatment goals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. I participated in my child's treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Overall, I am satisfied with the services my child received.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. The people helping my child stuck with us no matter what.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. I felt my child had someone to talk to when he/she was troubled.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. The services my child and/or family received were right for us.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. My family got the help we wanted for my child.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. My family got as much help as we needed for my child.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. [INDICATE WHO ADMINISTERED SECTION F - PERCEPTION OF CARE TO THE CONSUMER (CAREGIVER) FOR THIS INTERVIEW.]

- ADMINISTRATIVE STAFF
- CARE COORDINATOR
- CASE MANAGER
- CLINICIAN PROVIDING DIRECT SERVICES
- CLINICIAN NOT PROVIDING SERVICES
- CONSUMER PEER
- DATA COLLECTOR
- EVALUATOR
- FAMILY ADVOCATE
- RESEARCH ASSISTANT STAFF
- SELF-ADMINISTERED
- OTHER (SPECIFY) _____

G. SOCIAL CONNECTEDNESS

1. Please indicate your disagreement/agreement with each of the following statements. Please answer for relationships with persons other than your child’s mental health provider(s) over the past 30 days.

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER (CAREGIVER).]

STATEMENT	RESPONSE OPTIONS					
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	REFUSED
a. I know people who will listen and understand me when I need to talk.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I have people that I am comfortable talking with about my child’s problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. In a crisis, I would have the support I need from family or friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I have people with whom I can do enjoyable things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I. REASSESSMENT STATUS

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

1. Have you or other grant staff had contact with the consumer within 90 days of last encounter?
 - Yes
 - No

2. Is the consumer still receiving services from your project?
 - Yes
 - No

K. SERVICES RECEIVED

[SECTION K IS REPORTED BY GRANTEE STAFF AT REASSESSMENT AND DISCHARGE UNLESS STAFF PREVIOUSLY INDICATED "NO DATA" WOULD BE SUBMITTED.]

1. On what date did the consumer last receive services?

____|____| / |____|____|____|____|
MONTH YEAR

[IDENTIFY ALL OF THE SERVICES YOUR PROJECT PROVIDED TO THE CONSUMER SINCE HIS/HER LAST NOMS INTERVIEW; THIS INCLUDES CMHS-FUNDED AND NON-FUNDED SERVICES.]

Core Services	<u>Provided</u>	
	Yes	No
1. Screening	<input type="checkbox"/>	<input type="checkbox"/>
2. Assessment	<input type="checkbox"/>	<input type="checkbox"/>
3. Treatment Planning or Review	<input type="checkbox"/>	<input type="checkbox"/>
4. Psychopharmacological Services	<input type="checkbox"/>	<input type="checkbox"/>
5. Mental Health Services	<input type="checkbox"/>	<input type="checkbox"/>

[IF YES, PLEASE ESTIMATE HOW FREQUENTLY MENTAL HEALTH SERVICES WERE DELIVERED.]

Number of times ____ per Day Week Month Year

	Yes	No
6. Co-Occurring Services	<input type="checkbox"/>	<input type="checkbox"/>
7. Case Management	<input type="checkbox"/>	<input type="checkbox"/>
8. Trauma-specific Services	<input type="checkbox"/>	<input type="checkbox"/>

9. Was the consumer referred to another provider for any of the above core services?
Yes No

Support Services	<u>Provided</u>	
	Yes	No
1. Medical Care	<input type="checkbox"/>	<input type="checkbox"/>
2. Employment Services	<input type="checkbox"/>	<input type="checkbox"/>
3. Family Services	<input type="checkbox"/>	<input type="checkbox"/>
4. Child Care	<input type="checkbox"/>	<input type="checkbox"/>
5. Transportation	<input type="checkbox"/>	<input type="checkbox"/>
6. Education Services	<input type="checkbox"/>	<input type="checkbox"/>
7. Housing Support	<input type="checkbox"/>	<input type="checkbox"/>
8. Social Recreational Activities	<input type="checkbox"/>	<input type="checkbox"/>
9. Consumer Operated Services	<input type="checkbox"/>	<input type="checkbox"/>
10. HIV Testing	<input type="checkbox"/>	<input type="checkbox"/>

11. Was the consumer referred to another provider for any of the above support services?
Yes No