CLIENT LEVEL OUTCOME TOOL

For Use at Discharge from Services

VOUCHER ID:	HER ID: PROVIDER:			HARGE				
INTERVIEW CONDUCT If no, why not? Choose only of Client was impaired or und provide consent If no interview, SKIP to the section	ne response. Ible to	nt refused to		-	Clie	nt was not re	eached for	an interview
	HE	ALTH &	WELL	NESS				
			Po	or	Fair (Good G	Very Good E	xcellent
How would you rate you right now?	r overall physica	<u>I</u> health						
How would you rate you right now?	r overall <u>mental</u> I	health						
Thinking about your men which includes stress, de problems with emotions days during the past 30 mental health not good	epression, and , how many days was your	# days	how n physic doing	hany day cal or me your usu	ys did yo ental - ke	proximate ur health - ep you fro ties, such o eation?	- pm	# days
In the past 30 days, have	e you done one of	the follow	ving:				Yes	No
Spent time in a hospita	l for mental healt	h care?						
Spent time in a facility	for detox or treat	ment for a	substand	ce use di	isorder?			
Gone to an emergency	room for a ment	al health	or emotic	nal prob	olem?			
Please indicate your disc agreement with each of statements.	•	Strongly Disagree	Disagree	Undecide	ed Agree	Strongly Agree	No Respons	se N/A
I am able to take care o	f my needs.							
I am able to handle thin go wrong.	gs when they							
I am able to do things th do.	at I want to							
	A TO	BILITY			<u> </u>			
				osine				
In the past 30 days, I hav	e had a safe plac	e to live.					Yes	No
In the past 30 days, I hav	e been satisfied	with the c	onditions	of my li	ving spa	ce.	Ves Ves	No

Child Care Provider Behavioral Health Voucher Program

SOCIAL CONNECTEDNESS

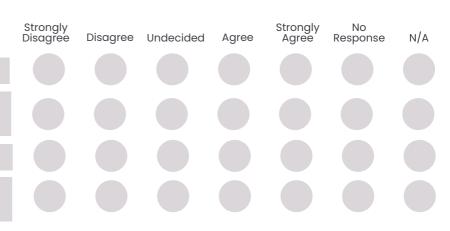
Please indicate your disagreement / agreement with each of the following statements.

I am happy with the friendships I have.

I have people with whom I can do enjoyable things.

I feel I belong in my community.

In a crisis, I would have the support I need from family or friends.



PERCEPTION OF ACCESS TO SERVICES

Please indicate your disagreement / agreement with each of the following statements.	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	No Response	N/A
Services were available at times that were convenient to me.							
I was able to get the help I felt I needed.							

PERCEPTIONS OF OUTCOMES

Please indicate your disagreement / agreement with each of the following statements.	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	No Response	N/A
I am able to deal more effectively with daily problems.							
I feel more in control of my life.							
I am better able to deal with crisis.							
I am getting along better with those around me.							
I feel I am doing better at work.							
My symptoms are not bothering me as much as they were.							
Please describe what services you feel you need going forward.							

DISCHARGE DATA FROM PROVIDER

All discharge records should have this section completed, with or without the ability to interview the client. This information is to be completed by the provider.

Date of Last Service Provided (MM-DD-YYYY)

For the following questions please identify all the services provided to the client during their participation in the voucher program. This includes voucher-funded and non-voucher funded services.

CORE SERVICES	Provided	Referred to another agency	Services known to be provided by another agency	Unknown	Service Not Available
Screening	Yes / No	Yes / No	Yes / No		
Assessment	Yes / No	Yes / No	Yes / No		
Treatment Planning or Review	Yes / No	Yes / No	Yes / No		
Psychopharma- cological Services	Yes / No	Yes / No	Yes / No		
Mental Health Services	Yes / No	Yes / No	Yes / No		
Co-occurring Services	Yes / No	Yes / No	Yes / No		
Case Management	Yes / No	Yes / No	Yes / No		
Trauma-Specific Services	Yes / No	Yes / No	Yes / No		

DISCHARGE DATA FROM PROVIDER

All discharge records should have this section completed, with or without the ability to interview the client. This information is to be completed by the provider.

SUPPORT SERVICES	Provided	Referred to another agency	Services known to be provided by another agency	Unknown	Service Not Available
Medical Care	Yes / No	Yes / No	Yes / No		
Employment Services	Yes / No	Yes / No	Yes / No		
Family Services	Yes / No	Yes / No	Yes / No		
Child Care Assistance	Yes / No	Yes / No	Yes / No		
Transportation Assistance	Yes / No	Yes / No	Yes / No		
Education Services	Yes / No	Yes / No	Yes / No		
Housing Support	Yes / No	Yes / No	Yes / No		
Social Recreational Activities	Yes / No	Yes / No	Yes / No		
Consumer- Operated Services (e.g., support groups)	Yes / No	Yes / No	Yes / No		

Will the client be receiving additional services after all voucher-covered services have been completed?

Yes No

Describe what funding source the client will be moving to after all covered Voucher services have been completed (e.g., private pay, sliding scale).