

Treatment Data System

**a division of the Office of Substance Abuse Data Systems
OSADS**

A-1 & D-1 INSTRUCTION MANUAL

Office of Substance Abuse & Mental Health Services (SAMHS)
41 Anthony Avenue
#11 State House Station
Augusta, ME 04333-0011

February 2013

**Treatment Data System
USER MANUAL**

Prepared by the Staff of Substance Abuse & Mental Health Services

Stacey M. Chandler, Statistician I, Data & Research Team

TABLE OF CONTENTS

Overview.....	1
Introduction.....	2
TDS - The Treatment Data System.....	3
Correct Form to Use.....	3
Timing And Consequences of Late Data.....	5
When Do You Enter The Completed Forms?.....	6
Where Do You Call If You Have Questions or Need More Forms?	6
Part 1 - TDS A-1 Admission Form.....	7
Part 2 - TDS D-1 Discharge Form.....	33
Appendix A- Attorney General's Opinion.....	52
Appendix B - Service Definitions	53
Appendix C - Referred Agency Codes.....	58
Appendix D - Federal ID Codes (Parts I, II & III have been removed).....	61
Appendix E - Global Assessment of Functioning (GAF) Scale	63

Web Address for SAMHS
<http://www.maineosa.org>

OVERVIEW

This document provides the details of the Treatment Data System (TDS).

TDS is a comprehensive management information system that lends itself to client outcome evaluation. Preliminary studies completed by Maine substance abuse service providers in the mid-1980's showed that approximately 50% of the clients who have received services will reenter the substance abuse treatment system. TDS allows the State to assess client outcomes, trends, costs, etc., related to high and low use populations. The system also allows us to assess health, economic, etc., outcomes for the clients who will not reenter the treatment system. In addition, TDS is capable of addressing needs and service outcomes as they relate to smaller and special needs populations, e.g., the elderly.

Follow up - When funding is available:

To determine if the client benefited from these State-funded services, the State will contract with an outside agency to conduct client follow-up interviews six months post treatment. Participation in the follow-up is voluntary. Participation, or the lack of participation, in the follow-up interview process, will not have any effect upon the client's treatment or the State's willingness to pay for the treatment.

INTRODUCTION

The Treatment Data System (TDS) was mandated by the State Legislature in P.L. 1983 c. 464. TDS is a vital management tool, used by the Office of Substance Abuse & Mental Health Services to provide:

- X Documentation that clients were served and that services were delivered by community providers supported by state and federal substance abuse funds, in compliance with the legislatively approved budget and statutory mandates.
- X Data on performance that is being jointly used by state and local agencies to manage services and funding.

TDS will also be used to meet the federal requirements of the Treatment Episode Data Set (TEDS). TEDS was established by the former National Institute on Alcohol Abuse and Alcoholism (NIAAA) now the United States Department of Health and Human Services Substance Abuse & Mental Health Services Administration (SAMHSA) and the National Institute on Drug Abuse (NIDA) to meet requirements specified in the Anti-Drug Abuse Act of 1988.

It is due to the federal requirements of the TEDS that any agency receiving state funds (including Federal Block Grant) must report all substance abuse clients, regardless of the source of funding for individual clients.

Since the inception of the system, requirements on which clients should be reported have been extended to include: all clients served by a licensed substance agency, any clients involved in the Driver Education and Evaluation Program (DEEP), any client for who MaineCare (Medicaid) reimbursement will be sought for their substance abuse treatment, and all clients in treatment at methadone programs.

A TDS registry is maintained for all agencies and programs that receive state funds to perform client services under contract with the State Departments (Department of Corrections and Department of Health and Human Services).

Client information reported to the SAMHS through TDS is confidential and protected by law (HIPPA and CFR 42 Part II) and operating computer safeguards. No person or agency other than authorized personnel can gain access to client information in TDS.

A word about the Manual . . . The purpose of the TDS User Manual is to provide current reporting instructions and common TDS item definitions for state and local TDS users. TDS is a complex data system requiring users to maintain a high level of understanding of its procedures. The manual is most readily used as a reference book, although it is recommended that anyone completing TDS forms first read the manual from cover to cover one time and attend TDS training. This manual is designed to accommodate the needs of multi-service providers as well as providers of a single-service setting.

All changes in reporting instructions that modify this manual will be communicated to the TDS contact person via email; please ensure that your agency's TDS contact person has contacted the TDS office to be put on the list of TDS contacts.

TDS - The Treatment Data System

The purpose of TDS is to provide specific admission and discharge data about an individual client stored by TDS under the client code. This data is then available for aggregation within TDS to produce output reports.

TDS Forms:

Four different forms are used in TDS—depending on which service setting the client is using.

- A-1 Admission Form
- D-1 Discharge Form
- ORT-1 Opioid Replacement Therapy Update Form
- A-D Shelter / Detoxification Form

This manual covers the A-1 and D-1 Forms.

DEFINITION: "SERVICE SETTING" means a distinct type of service or group of services for persons with substance abuse problems, provided in the community under a contract with the two State Departments (Department of Corrections and the Department of Health and Human Services).

The forms are identified by titles appearing in the top left corners.

Correct Form to Use:

- X The A-1 Admission Form (blue) is for all initial admissions and readmissions of all clients except shelter and detoxification.
- X The D-1 Discharge Form (yellow) is for all discharges except shelter and detoxification.
- X The ORT-1 Form (green) is for Methadone Maintenance Clients and are done once a year to monitor client progress.
- X The A-D Shelter and Detoxification Form (pink) is for shelter and detoxification clients. A variation of the form is used for Driver Education and Evaluation Programs (DEEP) clients in the Prime for Life and Moving Ahead Programs.

NOTE: Instructions for the A-D & ORT forms are in a separate manual. To obtain that manual please call the TDS office at 287-6337.

Who Should Be Filling Out the TDS Forms?

It is recommended that the counselor having the face-to-face contact with the client should fill out the TDS forms either during the first session or soon after. However, portions of the form could be completed by an intake person *if necessary*. Those portions of the form should only relate to generic demographic items such as living arrangements, marital status, etc. All items relating to a client's use of substances MUST be completed by a certified counselor.

Which Clients are Admitted to TDS?

If your agency is a Licensed Substance Abuse Agency, all your agency's substance abuse clients must be entered into TDS. If your agency receives any state or federal funds, you must complete the TDS forms on all your agency's substance abuse clients (substance abusers and affected others/co-dependents) if they meet the following criteria:

- X Has a substance abuse related problem;
- X Has completed the screening and intake process;
- X Has been formally admitted for service;
- X Has his or her own client record; and
- X Is receiving service.

NOTE: Any agency/provider that is DEEP certified, Medicaid reimbursable, and/or methadone certified **must** complete a TDS form on all clients receiving those services.

As a rule, a client may not be admitted to more than one substance abuse service setting at a time, whether within the same provider or by two separate providers. For example, an OSA-funded agency has a contract for detoxification and residential rehabilitation services. A client seeking treatment at the agency is in need of both detoxification and residential rehabilitation services. First, the client is admitted to the detoxification service setting and discharged. Upon completion of the detoxification program, the client is then admitted to the residential rehabilitation program.

Note: When entering a client into TDS, if a message appears saying "Duplicate Record Cannot Submit", contact the TDS office; this means the client may have already been entered into the system by your agency or the client has another admission for the same date.

Which Clients Should be Discharged from TDS?

Clients should be discharged from TDS for the usual reasons, such as completing a program or a client left without program agreement. Clients should be discharged within 30 days of the last date of contact. A case should never remain open longer than 90 days without the client receiving a face-to-face counseling session unless a specific

reason (other than non-appearance for scheduled sessions) is noted in the client record.

TDS Reporting Requirements

All licensed substance abuse treatment providers must report electronically to TDS via the TDS website. The Office of Substance Abuse & Mental Health Services will provide the URL (address), user ID, and password.

Special dispensation can be given for a limited time period at the discretion of the Office of Substance Abuse & Mental Health Services. To request dispensation, please contact Stacey Chandler at 287-6337.

Timing and Consequences of Late Data

Submission of TDS data is a contractual/certification/licensing requirement. Contract payments will be delayed if providers fail to submit data in a timely manner. Also, certification is dependent on timely submittal and could result in revocation of the certification.

Programs that consistently submit late data are required to prepare a written corrective action plan to rectify the situation.

Not reporting in a timely manner may also have a negative impact on agency's performance reporting and may not accurately reflect the work they have accomplished.

Not reporting in a timely manner or at all will be reported to MaineCare.

Agency Reported Contact Person

Each agency must have a reported contact person. If the contact person leaves the agency, the TDS office must be notified immediately of the departure of the contact person and the name, address, telephone number and email address of the new contact person.

System to Identify Client using the TDS Client Id

Each agency and/or provider must maintain a system for readily identifying clients by their TDS client ID's (which is made up with the Date of Birth (D.O.B.) and the last four Social Security Numbers (SSN's)). For examples, please call the TDS office.

When Do You Enter the Completed Forms?

IF YOUR AGENCY HAS NO ADMISSIONS OR DISCHARGES FOR A GIVEN MONTH, SEND A LETTER OR EMAIL NOTIFYING THE TDS OFFICE TO THAT EFFECT.

**COMPLETED FORMS MUST BE ELECTRONICALLY ENTERED INTO THE SYSTEM
NO LATER THAN THE 15TH OF THE MONTH FOLLOWING THE TREATMENT
ADMISSION OR DISCHARGE OF THE CLIENT.**

A copy of the TDS form should be retained in the client file.

To Contact the TDS Office If You Have Questions or Need More Forms:

287-6337 or 287-2595
or
e-mail to: stacey.chandler@maine.gov

When you begin running low on forms, call immediately, please do not wait until you are completely out of forms.

TDS Office
Office of Substance Abuse & Mental Health Services
Department of Health & Human Services
41 Anthony Avenue
#11 State House Station
Augusta, Maine 04333-0011

PART 1

TDS FORM A-1

ADMISSION FORM

INSTRUCTIONS

DETAILED INSTRUCTIONS
FOR TDS A-1 ADMISSION FORM

DEFINITION OF A TDS CLIENT:

A TDS client is defined as a substance abuser and/or an affected other/co-dependent on whom your agency opens an individual client record. Specific client definition criterion includes the following:

- X Has a substance abuse related problem;
- X Has completed the screening and intake process;
- X Has been formally admitted for service;
- X Has his/her own client record; and
- X Is receiving substance abuse services.

ALL ITEMS MUST BE COMPLETED UNLESS SPECIFIC INSTRUCTIONS ARE GIVEN NOT TO DO SO.

AGENCY NAME/LOCATION

The name and location of the agency/provider as it appears on license or certification.

CLIENT CODE (made up of Items A. and B.)

A. DATE OF BIRTH

Enter the client's birth date. Record MMDDYYYY. Precede numbers of less than ten with a zero.

EXAMPLE: February 9, 1943 would be **02091943**.

B. LAST FOUR SOCIAL SECURITY NUMBERS

Enter the last four numbers of the client's social security number.

EXAMPLE: John Smith's social security number is 555-55-9789.
You would enter **9789**.

* Combining A and B would make the **client code 020919439789**.

C. **GENDER (check ONE box only)**

- 01 **Male**
 02 **Female**

D. **COUNTY OF RESIDENCE**

Enter the first and last letter of the County the client is residing in at admission. If "Out-of-State" use **OS**. If "Out-of-Country" use **OC**.

AN	Androscoggin	PT	Penobscot
AK	Aroostook	PS	Piscataquis
CD	Cumberland	SC	Sagadahoc
FN	Franklin	ST	Somerset
HK	Hancock	WO	Waldo
KC	Kennebec	WN	Washington
KX	Knox	YK	York
LN	Lincoln	OS	Out-of-State
OD	Oxford	OC	Out-of-Country

E. **FEDERAL IDENTIFIER CODE**

A six digit numeric code. The TDS office accesses the ISATS, enters the agency information and the ISATS assigns a number that identifies the agency by physical location. This number does not track the agency financially; it is used for geographic location.

If you do not know your federal identifier code, please contact the TDS office as soon as possible.

Being in the ISATS system means that an agency will be in the National Directory of Treatment Providers and will receive an NSATS survey once a year.

NOTE: If the agency moves or opens a new location, you must report that information to the TDS office as soon as possible.

For your agency's Federal ID code(s) please contact the TDS office at 287-6337.

F. CONTRACT NUMBER (Funded and Medicaid Agencies ONLY)

If your agency does not have a contract do not zero-fill the contract number field, just skip F.

If agency/provider has a contract (including a MaineCare contract) with The Office of Substance Abuse for a service, enter the contract number assigned.

Note - the contract number provided by your Agreement Administrator is slightly different than the one to be used when reporting to TDS. Your TDS contract number(s) is sent via email to your agency's contact person at the beginning of each State Fiscal Year (SFY). If you have questions about your contract number(s) please contact the TDS office at 287-6337.

For agencies with both non-MaineCare (OSA Funded) and MaineCare contracts, use the MaineCare contract number for services that are not otherwise contracted.

For example:

Agency A has an OSA funded contract for Outpatient Services – 1033-1. It also has a MaineCare contract for outpatient services – 1565-1 and intensive outpatient services – 1565-2 . For outpatient clients, always use the OSA funded contract number of 1033-1. For intensive outpatient services, always use the MaineCare contract number of 1565-2.

G. PRIMARY SERVICE CODE (List on back of form)

Enter the code of the service being provided for this client. This is the primary service you will provide for this client during the current admission.

See specific explanations of primary service setting codes in Appendix C.

- **All** agencies should use the proper primary service code for the service the client is receiving at your agency.
- **All** agencies delivering non-intensive outpatient services to adolescents should use (18) Adolescent Outpatient for all clients who are under 19 years of age, at the time of admission.
- If the Primary Service Code is 13 (Evaluation), then question 33 Primary Presenting Problem must be 03 (Evaluation Only).

Substance Abuse / Affected Clients

REHABILITATION / RESIDENTIAL

03 Hospital (Other than Detoxification)
04 Short-term (30 days or less)
05 Extended Care
06 Halfway House
07 Extended Shelter
15 Adolescent Res. Rehab. Trans.
44 Consumer Run Residence

AMBULATORY

08 Non-Intensive Outpatient
11 Intensive Outpatient
12 Detoxification
13 Evaluation
18 Adolescent Outpatient
38 Adolescent Intensive Outpatient
40 Opioid Replacement Therapy

Primary Service Codes are also listed on the backs of the forms.

H. DATE OF FIRST PHONE CALL/CONTACT

Enter the date the client first contacted your agency to schedule an appointment

Record MMDDYYYY. Precede numbers of less than ten with a zero

I. FIRST FACE TO FACE CONTACT *aka CURRENT ADMISSION DATE*

The day the client is currently being evaluated to enter treatment.

Record MMDDYYYY. Precede numbers of less than ten with a zero.

EXAMPLE: September 1, 2006 would be **09012006**.

J. DATE OF FIRST TREATMENT SESSION

The date of the first CLINICAL TREATMENT SESSION.

- This is the **FIRST** date of TREATMENT, meaning that the evaluation and/or assessment has been done, the modality of treatment has been decided, the treatment plan has been written and treatment is beginning.
 - *Evaluation Only clients:* If you are seeing the client for an Evaluation Only, you should enter the same dates for First Face to Face Contact and First Treatment Session Date.
 - *No show clients:* For NO SHOW treatment clients (meaning you have already assessed/evaluated them, set up their first treatment appointment but they **never** show up), use the same date as the first face to face contact and reflect that they terminated without clinic approval in the Status at Discharge.

Record MMDDYYYY. Precede numbers of less than ten with a zero.

EXAMPLE: September 1, 2006 would be **09012006**.

K. PAYOR CODE (enter ONE code only)

Enter the appropriate payor code for the client. The payor code is based on the primary payor of services. If OSA is the primary payor of the client's services, Enter **01** OSA.

NOTE: If your agency does not have a contract (non-MaineCare) with OSA you cannot enter 01.

- 01 **OSA** - Office of Substance Abuse Clients (only for agencies that receive OSA funds)
- 02 **Human Services** – Other than Adult, Child Protective
- 03 **Corrections** - Probation Parole, Correctional Facilities
- 04 **Human Services** – Adult, Child Protective
- 05 **Self Pay**
- 06 **MaineCare (Medicaid)** – (Use for MaineCare Contracts)
- 07 **Medicare**
- 08 **Blue Cross/Blue Shield**
- 09 **Health Maintenance Organization (HMO)**
- 10 **Other Private Health Insurance**
- 11 **Town Assistance**
- 12 **Workers' Compensation**
- 13 **Veterans' Administration**
- 99 **Other**

1. **HEALTH INSURANCE**

The Insurance may or may not cover Substance Abuse Treatment; however, answer regardless of who is paying for the treatment episode.

- 01 **PRIVATE INSURANCE**
- 02 **BLUE CROSS/BLUE SHIELD**
- 03 **MEDICARE**
- 04 **MAINECARE (MEDICAID)**
- 05 **HEALTH MAINTENANCE ORG. (HMO)**
- 20 **OTHER (e.g., Tricare, Champus)**
- 21 **NONE**

2. **REFERRAL (List on Back of form)**

Enter the primary self-reported source of the referral from the following list of codes. This is the source responsible for the client seeking services. **NOTE:** If you are filling out DEEP paperwork, report client as DEEP referred (08).

If the referring person is a staff person working at an alcohol/drug abuse service agency, please record this as "substance abuse agency."

Note the distinction made between alcohol/drug abuse professionals (e.g., physicians who specialize in alcohol/drug abuse and registered substance abuse counselors) and physicians and other professionals who are not alcohol/drug abuse specialists.

- 01 – **Self**
- 02 - **Family Member**
- 03 – **Employer**
- 04 - **Substance Abuse Professional (Private Practice)**
- 05 - **Substance Abuse Agency**
- 06 - **Physician (Non-substance abuse specialist)**
- 07 - **Other Professional (Non-substance abuse specialist)**
- 08 - **DEEP (Driver Education and Evaluation Program)**
- 09 - **Adult Protective Services - DHHS**
- 10 - **Child Protective Services - DHHS**
- 11 - **Substitute Care Services - DHHS**
- 12 - **Probation/Parole - State of Maine**
- 13 - **Correctional Facility, Maine**
- 14 - **County Jails**
- 15 – **Riverview Psychiatric Ctr./Dorthea Dix Psychiatric Ctr.**
- 16 - **Mental Health Agency**
- 17 - **Friend**
- 18 – **EAP (Employee Assistance Program)**
- 19 – **SAP (Substance Abuse Professional)**

- 20 - **State/Federal Court**
- 21 - **Formal Adjudication Process (Maine PreTrial)**
- 22 - **Self-Help Group**
- 23 - **Hospital**
- 24 - **School**
- 25 - **AIDS Outreach Worker**
- 26 - **Community Probation - DSAT**
- 27 - **Drug Court - DSAT**
- 28 - **Network/JASAE**
- 29 - **Juvenile Drug Court**
- 99 - **Other**

EXAMPLE: John Smith was referred by his physician that was treating him for high blood pressure. Enter **06** Physician (non-substance abuse specialist).

3. **PRIOR TREATMENT EPISODES (check ONE box only)**

Check the appropriate number of prior treatment for Substance Abuse in any drug or alcohol treatment program.

- 00 **None** No previous treatment episodes.
- 01 **One** One previous treatment episode.
- 02 **Two** Two previous treatment episodes.
- 03 **Three** Three previous treatment episodes.
- 04 **Four** Four previous treatment episodes.
- 05 **Five or More** Five or more previous episodes.

4. **ARE SPECIAL ACCOMMODATIONS NEEDED TO PROVIDE SERVICES? (check YES or NO for each selection)**

- | Yes | No | |
|-----------------------------|-----------------------------|--|
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | (A) Hearing Client is hearing impaired. |
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | (B) Visual Client is visually impaired. |
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | (C) Physical Client is physically impaired. |
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | (D) Language Client's primary language is other than English. |
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | (E) Other Special accommodations not listed here. <i>For example, you provided an illiterate client with audio or video materials</i> |

EXAMPLE: Sign, TTY, Assistive listening devices, Interpreter, etc.

5. **RACE (check ONE box only)**

Check the appropriate self-reported ethnic background. (If a client refuses, the form preparer must check the race code most appropriate).

01 **White**

White. A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

02 **Black or African American**

Black or African American. A person having origins in any of the black racial groups of Africa. Terms such as “Haitian” or “Negro” can be used in addition to “Black or African American.”

03 **American Indian or Alaska Native**

American Indian or Alaska Native. A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

04 **Asian**

Asian. A person having origins in any of the original peoples of the Far East, Southeast, Asia, or the Indian subcontinents including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

05 **Native Hawaiian or other Pacific Islander**

Native Hawaiian or Pacific Islander. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

09 **Other**

6. **ETHNICITY (check ONE box only)**

Check the self-reported ethnic background.

- 01 **Not of Hispanic Origin or Latino**
- 02 **Puerto Rican**
- 03 **Mexican**
- 04 **Cuban**
- 05 **Other Specific Hispanic**
- 06 **Hispanic Specific Origin Not Specified**

7. **VETERAN (check ONE box only)**

DEFINITION: A veteran is an individual who has served on active duty in the Armed Forces with an honorable discharge.

- 01 **Yes**
- 02 **No**

8. **EDUCATION COMPLETED**

Enter the highest grade in school that the client has completed. For those who have a **GED, enter 12**. Remember that these are grades completed, and are not necessarily the number of years of attendance.

NOTE: Codes range from 00 (None) to 20. If more than 20 years have been completed, enter 20. Complete both boxes, using a leading zero if necessary (i.e., 01, 02, etc.).

9. **CURRENT MARITAL STATUS (check ONE box only)**

Check the client's self-reported current marital status on the day of admission.

- 01- **Never married** refers to a client who has never been married.
- 02- **Now married/Cohabiting** the client must be living with a spouse/significant other.
- 03- **Separated** refers to a client and spouse still married but not living together. It does not refer to temporary separation due to employment, military service, or any similar type of separation.
- 04- **Divorced** refers to an individual who is divorced.
- 05- **Widowed** refers to an individual whose spouse is deceased.

10-14. **DEPENDENTS**

ENTER THE NUMBER OF DEPENDENT CHILDREN THE CLIENT HAS IN EACH AGE GROUP LISTED

A client has a dependent child(ren) if the client either has custody (joint or full) of the child(ren); or, is in the process of trying to get custody of the child(ren) from another entity whether that is an ex-spouse, ex-partner, grandparent, Child Protection, the State, etc. If the client **does not have** dependent children please **enter 00**.

- 10. **0 TO 12 months.** Number of dependent children that are 0 to 12 months.
- 11. **13 TO 35 months.** Number of dependent children that are 13 to 35 months.
- 12. **3 TO 5 years.** Number of dependent children that are 3 to 5 years.
- 13. **6 TO 12 years.** Number of dependent children that are 6 to 12 years.
- 14. **13 TO 17 years.** Number of dependent children that are 13 to 17 years.

If No dependents or not in custody, skip # 15 and go to item #16.

15. **IF THE CLIENT HAS DEPENDENT CHILDREN, WHERE ARE THE CLIENT'S CHILDREN WHILE THE CLIENT IS IN TREATMENT?** This question is designed to assess where the children are *residing* during the time period that the client is in treatment. **This question is not asking** who cares for the children when the client attends a particular treatment appointment. **(check ONE box only)**

- 01 **With the client**
- 02 **Spouse/other parent**
- 03 **Grandparents or other relatives**
- 04 **Friend(s)**
- 05 **Babysitter/care giver**
- 06 **Temporary foster care**
- 99 **Other**

16. **PREGNANT AT ADMISSION (check ONE box only)**

If the client is female, is she pregnant?

NOTE: You must enter NO (02) for all males.

Pregnancy should have already been substantiated by a pharmacy home pregnancy test or by a doctor.

- 01 **Yes**
- 02 **No**

If Not pregnant/male, skip # 17 and go to question #18.

17. **IF PREGNANT, IS CLIENT RECEIVING PRENATAL CARE?**
(check ONE box only)

If client is pregnant, is she receiving regular prenatal care check-ups with her physician?

- 01 **Yes**
- 02 **No**

18. **LIVING ARRANGEMENTS AT ADMISSION (check ONE box only)**

Check the self-reported living arrangements at the time of admission.

- 01 **Independent Living, Alone** - an unsupervised living environment.
- 02 **Independent Living, With Others** - living with friends, family, or

03 Dependent Living - a supervised living environment (e.g., boarding home for mentally retarded, correctional facility).

04 Homeless - sleeping in places not meant for human habitation, such as cars, parks, sidewalks and abandoned buildings; also, emergency shelters or are from a transitional or supportive housing for homeless persons who originally came from streets or emergency shelters. This includes persons who ordinarily sleep in one of the above places but are spending a short time (30 consecutive days or less) in a hospital or other institution.

NOTE: A minor child (17 or under) in most cases would be dependent living.

An adult child (18 and over) in most cases would be independent living unless requiring other than "normal" care.

19. **EMPLOYMENT STATUS (check ONE box only)**

Check the self-reported current employment status at the time of admission. Employment refers to work in a paid (salary, wages, tips, etc.) position on a regular basis.

01 Full Time (35 hours or more)

- A. A client who is working for pay at admission and normally works at least 35 hours per week. This includes those who work at part-time jobs that total at least 35 hours per week; or
- B. Those persons temporarily absent from their regular jobs because of illness, vacation, industrial disputes (strikes), or similar reasons.

02 Part Time (17-34 hours)

- A. A client who is working for pay at admission and normally works at least 17 hours but not more than 34 hours per week.

03 Irregular (Less than 17 hours)

- A. A client who is working for pay at admission and normally works fewer than 17 hours per week.

04 **Unemployed (has sought work)**

- A. A client who was not working at admission but had sought work and was available within the preceding 30 days.
- B. A client who was not working at admission, but was not working because they were on layoff, temporarily ill or waiting to start new jobs within the next 30 days.

05 **Unemployed (has not sought work)**

- A. A client who is discouraged from seeking work because of personal or job market factors, and voluntarily idle.

06 **Not in Labor Force**

This refers to clients who are:

- A. Retired; or
- B. Engaged in their own housekeeping, not working while attending school (including adolescents), unable to work because of long-term illness.
- C. Incarcerated or inmate

THESE NEXT THREE CATEGORIES ARE DESIGNED FOR CLIENTS WHO ARE NOT CAPABLE OF HOLDING A PAYING POSITION SUCH AS A CLIENT WITH CMI, LATE STAGE ALCOHOLISM, ETC.

07 **Full Time Volunteer**

- A. A client who volunteers at least 35 hours a week and does not receive monetary compensation for those hours.

08 **Part Time Volunteer**

- A. A client who volunteers at least 17 hours but not more than 34 hours a week and who does not receive monetary compensation for those hours.

09 **Irregular Volunteer**

- A. A client who volunteers less than 17 hours a week and does not receive monetary compensation for those hours.

20. **EMPLOYABILITY FACTOR (check ONE box only)**

Check the appropriate factor listed as it relates to the Employment Status.

- 01 **Employable or working now**
- 02 **Student** (Including pre-school and Headstart)
- 03 **Homemaker**
- 04 **Retired**
- 05 **Unable (to work) for physical or psychological reasons**
(includes clients on SSI or disability)
- 06 **Inmate of Institution**
- 07 **Seasonal Worker**
- 08 **Temporary Layoff**
- 09 **Unable due to skills/resources** (i.e. lack of education, training, interviewing skills, transportation, child care, etc.)
- 10 **Unable due to program requirements** (i.e. Halfway house clients are not allowed to seek employment during part of their treatment)

21. **HOUSEHOLD INCOME (LAST 30 DAYS)**

Enter the amount between **0003-9998** for the client's estimated income for the last 30 days of all individuals living in the household. Household is defined as a group of friends and/or relatives living together as a social group and supporting unit. It does not include hotels, treatment facilities, institutions, etc.

0001 - Refused.

0002 - Unknown.

9999 - More than \$9999.

NOTE: If a client says he or she has absolutely no income enter **0000**.
If the client is a foster child enter **0002** unknown.

YOU MUST NOT LEAVE THIS FIELD BLANK.

EXAMPLE 1: John Smith earns \$150.00 a week or \$600.00 a month. Enter **0600**.

EXAMPLE 2: John Doe is indigent. He occasionally works for a few days here and there, but he is not sure how much he has earned in the last 30 days. Enter **0002**.

22. **PRIMARY SOURCE OF HOUSEHOLD INCOME/SUPPORT
(LAST 30 DAYS)**

Enter the code for the primary source of household income/support in the last 30 days.

- | | |
|---|--------------------------------------|
| 00 - None | 07 - Disability, Other |
| 01 - Wages/Salary
(Includes commissions
and self employment) | 08 - Town Welfare |
| 02 - Retirement | 09 - Child Support |
| 03 - Alimony | 10 - Unemployment Benefits |
| 04 - Food Stamps | 11 - Social Security |
| 05 - TANF | 12 - Dealing Drugs |
| 06 - SSI | 13 - Worker's Compensation |
| | 99 - Other (i.e. investments) |

NOTE: If income is 0000 for question 21, then source of household income should be 00. If you entered other than 0000 for question 21, then source of household income cannot be 00.

23. **SECONDARY SOURCE OF HOUSEHOLD INCOME/SUPPORT (LAST 30 DAYS) IF DIFFERENT FROM PRIMARY**

Enter the code for the secondary source of household income/support in the last 30 days. If different from the Primary. If there is no secondary source of income enter 00.

DO NOT enter the same code twice (unless 00).

- | | |
|---|--------------------------------------|
| 00 - None | 07 - Disability, Other |
| 01 - Wages/Salary
(Includes commissions
and self employment) | 08 - Town Welfare |
| 02 - Retirement | 09 - Child Support |
| 03 - Alimony | 10 - Unemployment Benefits |
| 04 - Food Stamps | 11 - Social Security |
| 05 - TANF | 12 - Dealing Drugs |
| 06 - SSI | 13 - Worker's Compensation |
| | 99 - Other (i.e. investments) |

24. **IS THE CLIENT NOW OR HAS HE/SHE EVER BEEN A DOMESTIC VIOLENCE SURVIVOR? (check ONE box only)**

Answer **Yes** if the client self reports being subjected to domestic violence or if the client has ever sought shelter, required medical attention, called police, or had the police called on his/her behalf because of a domestic violence incident. However, if you, as the clinician, feel that the client is a victim of

domestic violence and none of these scenarios have taken place, still answer **Yes**.

- 01 **Yes**
- 02 **No**

25-28. TREATED FOR MEDICAL REASONS AT THE FOLLOWING LOCATIONS

Enter the number of times the client has been treated at **each** of the following locations.

- 25. **Physician's Office/Clinic (in last 12 months)**
- 26. **Hospital Emergency Room (in last 12 months)**
- 27. **Hospital Inpatient (in last 12 months)**
- 28. **Other (in last 12 months)**

EXAMPLE: John Smith is being treated by a physician. He has had monthly appointments for the last six months. Next to question 25 - Physician's Office- you would enter **06**.

29. MH/MR ISSUES: DIAGNOSIS BASED ON DSM-IV (Co-Occurring Mental Illness - CMI) (check ONE box only)

If the client has been diagnosed with a mental illness/disorder or mental retardation based on DSM-IV criteria, check 01 or 02 appropriately, otherwise check 00.

Diagnosis Based on DSM-IV – Please remember this question is the way OSA and the federal government track how many clients in substance abuse treatment also have a CMI.

- 01 **Diagnosed Mental Illness/Disorder**
- 02 **Mental Retardation**
- 00 **None**

30-31. TREATED FOR MENTAL HEALTH ISSUES AT THE FOLLOWING LOCATIONS.

Number of treatment episodes at these locations. Enter the number of times the client has been admitted for treatment to each of the following locations.

- 30. **Outpatient Mental Health Services (last 12 months)**
- 31. **Psychiatric Admission to a Hospital (last 2 years)**

NOTE: Episodes, not visits/sessions.

EXAMPLE: John Smith had a nervous breakdown six months ago and was hospitalized at JBI until stabilized. After leaving JBI he went to weekly outpatient counseling for his mental health issues. Next to **30** Outpatient Mental Health Services you would enter **01**. Next to **31** you would enter **01**.

32. CONSENT DECREE JANUARY 1, 1989 (check ONE box only)

Was the client a patient at the Augusta Mental Health Institute on January 1, 1989 or after.

- 01 Yes
- 02 No

33. PRIMARY PRESENTING PROBLEM (check ONE box only)

Check the one major condition that led to the client asking for your service.

- 01 Substance Use/Abuse
- 02 Affected/Co-Dependent
- 03 Evaluation Only

If Primary Service Code (Question G) is 13, then this must be answered 03 Evaluation Only

NOTE: IF AFFECTED/CO – DEPENDENT (02), ANSWER TOBACCO RELATED QUESTION 37, AND QUESTIONS 41, 45 & 49 THEN SKIP TO QUESTION 51. DRUG CODES AND CORRESPONDING QUESTIONS DO NOT NEED TO BE FILLED OUT FOR AFFECTED/CO – DEPENDENT CLIENTS.

THERE CAN BE ONLY ONE PRIMARY PROBLEM

34-36. DRUGS USED INAPPROPRIATELY OR ABUSED BY CLIENT THAT LED TO ADMISSION PRIMARY, SECONDARY AND TERTIARY

INSTRUCTIONS: From the following codes (also listed on the back of the TDS form), identify and enter the substance(s) which causes the client's dysfunction at the time of admission.

If the client is a poly drug abuser, rank the substances as primary, secondary and if necessary, tertiary.

Clinical judgment will ultimately determine the ranking of problem substances. In determining the degree of substance abuse, the following considerations should be made:

- X Client's identified substance of choice;
- X Patterns of substance involvement;
- X Degree of present or past physical, mental, or social dysfunction caused by substance involvement; and
- X Degree of present or past physical or psychological dependence on substances, regardless of the frequency of use of a specific substance.

Each client's substance abuse problem(s) is/are to be individually assessed.

34. **Primary**

This is the primary substance abuse problem for which the client was admitted to treatment. **THERE CAN BE ONLY ONE PRIMARY SUBSTANCE.**

EXAMPLE: A poly abuser seeks treatment and reports abuse of both cocaine and alcohol with use of marijuana of at least one to three times a month. Based on the guidelines outlined above, the clinician determines that cocaine is the primary problem. Therefore, in Item 34, cocaine (code **0301**) is recorded as the primary drug.

35. **Secondary**

Record a secondary problem only if a primary problem has been entered. There can be only one secondary problem. If there is no secondary problem enter **0000** None.

Using the example above, alcohol (code **0100**) is recorded as the secondary substance abuse problem.

36. **Tertiary**

Record a tertiary problem only if the primary problem and a secondary problem have been entered. There can be only one tertiary problem. If there is no tertiary problem enter **0000** None.

Again using the example above and following the ranking guidelines the clinician enters marijuana (code **0200**) for the tertiary substance abuse problems.

NOTE: 0000 (NONE) CANNOT BE ENTERED IN PRIMARY SUBSTANCE FOR A CLIENT WHOSE PRIMARY PRESENTING PROBLEM IS SUBSTANCE ABUSE OR EVALUATION ONLY; YOU MUST ENTER A SUBSTANCE ABUSE CODE. HOWEVER, IF THE CLIENT IS AN AFFECTED OTHER/CO-DEPENDENT YOU ENTER 0000 (NONE OR SIMPLY LEAVE BLANK).

NOTE: WHEN 0000 (NONE) IS ENTERED IN THE SECONDARY (#35) OR TERTIARY (#36) BLOCKS OF THIS ITEM, ENTER 00 IN THE CORRESPONDING BLOCKS

OF ITEMS 39, 40, 43, 44, 47 & 48. If **0000** is not entered in the secondary or tertiary blocks, **00** cannot be used in the corresponding blocks.

After all appropriate problem substances have been entered, complete the remaining blocks with zeros. All blocks must be completed.

CODES:

- 0000 **None** (FOR USE WITH SECONDARY and TERTIARY ONLY UNLESS AFFECTED OTHER/CO-DEPENDENT).
- 0100 **Alcohol.**
- 0200 **Marijuana:** This includes **THC** and any other Cannabis sativa preparations.
- 0301 **Cocaine**
- 0302 **Crack**
- 0400 **Heroin/Morphine**
- 0500 **Methadone**
- 0550 **Buprenorphine/Suboxone**
- 0601 **Codeine**
- 0602 **D-Propoxyphene**
- 0603 **Oxycodone (Percodan)**
- 0604 **Oxycontin**
- 0605 **Meperidine HCL**
- 0606 **Hydromorphone**
- 0607 **Other Narcotic Analgesics**
- 0608 **Pentazocine**
- 0700 **PCP or PCP Combination**
- 0801 **LSD**
- 0802 **Other Hallucinogens**
- 0900 **Methamphetamine/Speed**
- 1001 **Amphetamine**
- 1002 **Methylphenidate (Ritalin)**
- 1003 **Methylenedioxymethamphetamine (MDMA, Ecstasy)**
- 1100 **Other Stimulants**
- 1809 **Bath Salts**
- 1201 **Alprazolam (Xanax)**
- 1202 **Chlordiazepoxide (Librium)**
- 1203 **Clorazepate (Tranzene)**
- 1204 **Dizapam (Valium)**
- 1205 **Flurazepam (Dalmane)**
- 1206 **Lorazepam (Ativan)**
- 1207 **Triazolam (Halcoin)**
- 1208 **Other Benzodiazepines**
- 1301 **Meprobamate (Miltown)**
- 1302 **Other Tranquilizers**
- 1401 **Phenobarbital**
- 1402 **Secobarbital/Amobarbital (Tuinal)**

- 1403 **Secobarbital (Seconal)**
- 1501 **Ethchlorvynol (Placidyl)**
- 1502 **Glutethimide (Doriden)**
- 1503 **Methaqualone**
- 1504 **Other Non-Barbiturate Sedatives**
- 1505 **Other Sedatives**
- 1506 **Flunitrazepam (Rohypnol)**
- 1507 **GHB/GBL**
- 1508 **Ketamine (Special K)**
- 1509 **Clonazepam (Klonopin, Rivotril)**
- 1601 **Aerosols**
- 1602 **Nitrites**
- 1603 **Other Inhalants**
- 1604 **Solvents**
- 1605 **Anesthetics**
- 1700 **Over the Counter – General**
- 1701 **Diphenhydramine (Benadryl)**
- 1801 **Diphenylhydantoin Sodium (Phenytoin, Dilantin)**
- 1802 **Other Drugs**

37. **Tobacco (check ONE box only)**

01 Yes

02 No

Was client using a tobacco product at admission?

IF **NO** ENTER **00** in QUESTIONS **41, 45 AND 49**

38-40. FREQUENCY OF USE OF DRUGS BY CLIENT (In last 30 days)
DO NOT USE FOR TOBACCO FREQUENCY

INSTRUCTIONS: Enter one of the following codes to indicate the frequency of use prior to admission for each substance recorded in Item 34-36. (Tobacco has its own set of frequency codes)

*IF CODE **0000** NONE WAS ENTERED IN ITEMS **35** AND **36** FOR SECONDARY OR TERTIARY PROBLEM(S), ENTER CODE **00** IN THE CORRESPONDING BLOCK OF ITEMS FOR **39** AND **40**. IF CODE **02** (NO) WAS ENTERED IN ITEM **37** (TOBACCO) ENTER CODE **00** IN THE CORRESPONDING BLOCK OF ITEM **41**.*

IF CLIENT IS AN AFFECTED OTHER/CO-DEPENDENT LEAVE BLANK.

00 **Not applicable** (No substance in items 35-36. Cannot be used on #38)

02 **No past month use**

03 **Once in the last 30 days**

- 04 **2-3 days per month**
- 05 **Once per week**
- 06 **2-3 days per week**
- 07 **4-6 days per week**
- 08 **Once daily**

41. **TOBACCO FREQUENCY** (For use with question #41 only)

- 00 **None**
- 10 **About half a pack/can/pouch a day or less**
- 11 **About a pack/can/pouch a day**
- 12 **About one and a half packs/cans/pouches a day**
- 13 **About 2 packs/cans/pouches a day**
- 14 **More than 2packs/cans/pouches a day**

42-45. **ROUTE OF ADMINISTRATION**

INSTRUCTIONS: Enter route or method of use codes listed on the back of the TDS form and below as they apply to the primary, secondary and tertiary substance(s) recorded in Items 34-37. If more than one route or method of use exists, enter the most frequent route.

IF CODE 0000 NONE WAS ENTERED IN ITEMS 35 AND 36 FOR SECONDARY OR TERTIARY PROBLEM(S), ENTER CODE 00 IN THE CORRESPONDING BLOCK OF ITEMS FOR 43 AND 44. IF CODE 02 (NO) WAS ENTERED IN ITEM 37 (TOBACCO) ENTER CODE 00 IN THE CORRESPONDING BLOCK OF ITEM 45.

IF CLIENT IS AN AFFECTED OTHER/CO-DEPENDENT LEAVE BLANK EXCEPT FOR TOBACCO ITEM 41.

CODES:

- 00 **Not Applicable** (No substance in Item 35-36).(Cannot be used on #42 unless it's an affected other/co-dependent))
- 01 **Oral** (Swallowed, ingested or chewed)
- 02 **Smoking**
- 03 **Inhalation** (Snorted OR Sniffed)
- 04 **Injection** (IV or Intramuscular)
- 05 **Other**

46-49. **AGE OF FIRST USE**

Enter age of first use for the drugs identified in 34-36 and for tobacco (37).

*IF CODE 0000 NONE WAS ENTERED IN ITEMS 35 AND 36 FOR SECONDARY OR TERTIARY PROBLEM(S), ENTER CODE 00 IN THE CORRESPONDING BLOCK OF ITEMS 47 and 48.
IF CODE 02 (NO) WAS ENTERED IN ITEM 37 (TOBACCO) ENTER CODE 00 IN THE CORRESPONDING BLOCK OF ITEM 45.*

IF THE FREQUENCY OF USE OF THE PRIMARY SUBSTANCE (question 38) IS 02 NO USE PAST MONTH, PLEASE ANSWER QUESTIONS 50 AND 51 BELOW, OTHERWISE SKIP TO QUESTION 52.

50. **PLEASE INDICATE THE REASON THAT BEST DESCRIBES WHY THE CLIENT HAS NOT USED IN THE 30 DAYS PRIOR TO ADMISSION? (check ONE box only)**

- 01 Recovery With Risk of Relapse
- 02 Client Reports No Problem
- 03 Self-Initiating Detoxification
- 04 Incarcerated/Institutionalized
- 05 Inpatient Treatment Program
- 06 OUI Client
- 07 Medication
- 08 Other

51. **WHEN DID THE CLIENT LAST USE ALCOHOL AND/OR OTHER DRUGS? (check ONE box only)**

- 01 In Last 3 Months
- 02 In Last 6 Months
- 03 In Last 12 Months
- 04 In Last 24 Months
- 05 In Last 5 Years
- 06 More Than 5 Years Ago

52. **INJECTION DRUG USE (check ONE box only)**

Check the box that reflects the client's injection drug use.

- 01 Never
- 02 In Last 6 Months
- 03 In Last 5 Years
- 04 Prior to Last 5 Years

NOTE: IF 01 (NEVER), SKIP QUESTION #53

If any Routes of Administration (questions 42-44) are answered with a code of 04 (Injection) then 01 (Never) must not be used.

53. SHARED NEEDLE USE (check ONE box only)

If the client has used needles, did he/she share needles in the past year?

- 01 Yes
- 02 No

If Injection Drug Use (question 52) is answered 02, 03 or 04 then this question must be answered.

54. MEDICATION ASSISTED TREATMENT? (check ONE box only)

- 01 No
- 02 Methadone
- 03 LAAM
- 04 Buprenorphine/Suboxone/Subutex
- 05 Campral
- 06 Naltraxone
- 07 Vivitrol
- 08 Antabuse

Check the appropriate box if the client being served is/will receive medicated assisted treatment as part of his/her treatment at either your facility or at another facility.

55. IN YOUR LIFETIME, HOW MANY TIMES HAVE YOU GAMBLED (BET) WITH MONEY OR POSSESSIONS (i.e., casino, race track or online, lottery tickets or sporting events)

- 00 0 Times (if 0 Skip question 56)
- 01 1-2 Times
- 02 3-9 Times
- 03 10-19 Times
- 04 20-39 Times
- 05 40 or More Times

56. HAS THE MONEY OR TIME THAT YOU SPENT ON GAMBLING LED TO FINANCIAL PROBLEMS OR PROBLEMS IN YOUR FAMILY, WORK, SCHOOL OR PERSONAL LIFE?

- 01 Yes
- 02 No

57. **FREQUENCY OF ATTENDANCE AT SELF-HELP PROGRAMS IN 30 DAYS PRIOR TO ADMISSION**

Description: The number of times the client has attended a self-help program (AA, NA, and other self-help/mutual support group) in the 30 days preceding the date of admission to treatment services.

- 01 No attendance in the past month
- 02 1-3 times in past month (less than once per week)
- 03 4-7 times in past month (about once per week)
- 04 8-15 times in past month (2 or 3 times per week)
- 05 16-30 times in past month (4 or more times per week)
- 06 Some attendance in past month, but frequency unknown

58. **CURRENT LEGAL STATUS (Other than DEEP) (check ONE box only)**

This is for criminal actions. This does not refer to such things as divorce proceedings in the court system or minor traffic infractions.

- 00 **No legal involvement** - Client has no legal involvement at admission.
- 01 **Probation/Parole** - Client is on probation or parole at admission.
- 02 **Furloughed** - Client is in a furlough program.
- 03 **Awaiting court** - Client is currently awaiting trial.
- 04 **Serving sentence** - Client is currently serving his or her sentence in a correctional facility, jail, prison, etc.
- 05 **Formal Adjudication/Maine Pre-Trial**
- 06 **Driver's License Revocation** (Not DEEP involved)
- 99 **Other** - Any legal status the client may have that is not covered by the other answers.

59. **DOMESTIC VIOLENCE OFFENDER (Check one Box Only)**

- 01 Yes
- 02 No

60. **TOTAL NUMBER OF ARRESTS IN THE LAST 12 MONTHS**

Enter the **total** number of times the client has been arrested (regardless of reason) in the last 12 months.

NOTE: This number should be equal to or greater than the question 60.

61. **ARRESTS IN THE PRIOR 30 DAYS**

Enter the number of times the client has been arrested for any reason in the 30 days prior to entering treatment.

62. **OUI ARRESTS IN THE LAST TWELVE MONTHS**

Enter the number of times the client has been arrested for operating under the influence in the last 12 months.

63. **WILL CLIENT USE TREATMENT/EVALUATION TO SATISFY DEEP REQUIREMENTS?**

(check ONE box only)

- 01 Yes
- 02 No
- 99 Affected/Other

IF NO OR AFFECTED OTHER, GO TO QUESTION 65

If Client was DEEP referred, the answer must be 01 YES.

If you did not answer yes to question 63, skip question 64 and go to question 65.

64. **DEEP STATUS (check ONE box only)**

Check the client's appropriate status. This information can/will be provided by the DEEP office.

- 01 First Offender
- 02 Multiple Offender - Previous OUI.
- 03 .00 (Youthful) Offender - Youthful offender at time of arrest

65. **GLOBAL ASSESSMENT OF FUNCTIONING (GAF) SCALE.**

Enter the appropriate level of functioning based on the GAF scale.

See Appendix E.

66. **CLIENT AGREE TO A FOLLOW-UP? (check ONE box only)**

- 01 Yes
- 02 No

DATE FORM COMPLETED: (MM/DD/YYYY)

FORM COMPLETED BY: (Last Name/First)

This form is to be signed by interviewer. **THIS FIELD MUST BE ENTERED.**

FORM EDITED BY: (Last Name/First)

PART 2

TDS FORM D-1

DISCHARGE FORM

INSTRUCTIONS

DETAILED INSTRUCTIONS FOR TDS D-1 DISCHARGE FORM

Upon discharge, the counselor must reassess the client. Except for items A through I and questions 6-8, data from the TDS A-1 Admission Form cannot be copied onto the TDS D-1 Discharge Form.

The TDS D-1 Discharge Form is to be completed within thirty (30) days of the last client treatment contact date for all clients who have been admitted on the standard TDS A-1 Admission form - unless a reason for leaving the client file open is documented in the client file. No client file should remain open longer than 90 days if the client is not receiving treatment.

When searching (Episode List by Client) for the admission form in TDS to discharge the client it is best to use just the client ID and the last four social security numbers.

AGENCY NAME/LOCATION

The name and location of the agency/provider **as it appears on license or certification**

CLIENT CODE (MUST MATCH ADMISSION)

A. DATE OF BIRTH

Enter the client's birth date. Record MMDDYYYY. Precede numbers of less than 10 with a zero.

EXAMPLE: February 9, 1943 would be **02091943**.

B. LAST FOUR SOCIAL SECURITY NUMBERS

Enter the last four numbers of the client's social security number.

EXAMPLE: John Smith's social security number is 005-23-9789: you would enter **9789**.

C. GENDER (MUST MATCH ADMISSION)

- 01 Male
 02 Female

D. COUNTY OF RESIDENCE (MUST MATCH ADMISSION)

Enter the first and last letter of the County the client is residing in at admission. If "Out-of-State" use **OS**. If "Out-of-Country" use **OC**.

AN	Androscoggin	PT	Penobscot
AK	Aroostook	PS	Piscataquis
CD	Cumberland	SC	Sagadahoc
FN	Franklin	ST	Somerset
HK	Hancock	WO	Waldo
KC	Kennebec	WN	Washington
KX	Knox	YK	York
LN	Lincoln	OS	Out-of-State
OD	Oxford	OC	Out-of-Country

E. FEDERAL IDENTIFIER CODE (MUST MATCH ADMISSION)

Enter the six digit numeric code provided by the federal government to the OSA. The code identifies the agency by physical location. If you do not have a federal identifier code listed in the appendices, please contact the TDS office as soon as possible.

F. CONTRACT NUMBER (OSA Funded and MaineCare Agencies Only)

If agency/provider has a contract with The Office of Substance Abuse, enter the contract number assigned. If the agency/provider has a MaineCare contract enter the contract number assigned.

REMEMBER: The contract number should be updated at discharge for the fiscal year (July 1-June 30) the client is discharged in. Example: Client entered treatment on June 1, 2005 (contract number 25999-1) and was

discharged on July 30, 2005, which is a different fiscal year (contract number 26999-1).

G. PRIMARY SERVICE CODES (List on back of form)

See specific explanations of primary service setting codes in **Appendix B**. This is the primary service you provided for this client.

Substance Abuse / Affected Clients

REHABILITATION / RESIDENTIAL

03	Hospital (Other than Detoxification)
04	Short-term (30 days or less)
05	Extended Care
06	Halfway House
07	Extended Shelter
15	Adolescent Res. Rehab. Trans.
44	Consumer Run Residence

AMBULATORY

08	Non-Intensive Outpatient
11	Intensive Outpatient
12	Detoxification
13	Evaluation
18	Adolescent Outpatient
38	Adolescent Intensive Outpatient
40	Opioid Replacement Therapy

Primary Service Codes are also listed on the backs of the forms.

H. FIRST FACE TO FACE CONTACT AKA CURRENT ADMISSION DATE (MUST MATCH ADMISSION)

The day the client was admitted into treatment.

I. LAST FACE TO FACE CONTACT

The date of the last face to face contact with the client.

1. LIVING ARRANGEMENTS AT DISCHARGE

Check the self-reported or known living arrangements at the time of discharge.

- 01 **Independent Living, Alone** - an unsupervised living environment.
- 02 **Independent Living, With Others** - living with friends, family, or spouse/partner
- 03 **Dependent Living** - a supervised living environment (e.g., boarding home for persons with mental retardation, correctional facility).
- 04 **Homeless** - sleeping in places not meant for human habitation, such as cars, parks, sidewalks and abandoned buildings; also, emergency shelters or those from a transitional or supportive housing for homeless persons who originally came from streets or emergency shelters. This includes persons who ordinarily sleep in one of the above places but are spending a short time (30 consecutive days or less) in a hospital or other institution.

NOTE: A minor child (17 or under) in most cases would be dependent living.

An adult child (18 and over) in most cases would be independent living unless requiring other than "normal" care.

2. EMPLOYMENT STATUS (check ONE box only)

Check the self-reported current employment status at the time of discharge. Employment refers to work in a paid (salary, wages, tips, etc.) position on a regular basis.

01 Full-Time (35 hours or more)

- A. Client who is working for pay at discharge and normally works 35 hours or more per week. This includes those who work at part-time jobs that total at least 35 or more hours per week; or
- B. Those persons temporarily absent from their regular jobs because of illness, vacation, industrial disputes (strikes), or similar reasons.

02 Part-Time (17-34 hours)

- A. Client who is working for pay at discharge and normally works at least 17 hours but not more than 34 hours per week.

03 Irregular (less than 17 hours)

- A. Client who is working for pay at discharge and normally works fewer than 17 hours per week.

04 Unemployed (has sought work)

- A. Client who was not working at discharge but had sought work and was available for work within the preceding 30 days.
- B. Client who was not working at discharge, but was not working because they were on layoff, temporarily ill or waiting to start new jobs within the next 30 days.

05 Unemployed (has not sought work)

- A. Client who is discouraged from seeking work because of personal or job market factors, and voluntarily idle.

06 Not in Labor Force

This refers to clients who are:

- A. Retired; or
- B. Engaged in their own housekeeping, not working while attending school (including adolescents), unable to work because of long-term illness.
- C. Incarcerated; inmate

THESE NEXT THREE CATEGORIES ARE DESIGNED FOR CLIENTS WHO ARE NOT CAPABLE OF HOLDING A PAYING POSITION SUCH AS THOSE WHO HAVE CO-OCCURRING MENTAL ILLNESSES, LATE STAGE ALCOHOLISM, ETC.

07 Full-Time Volunteer

- A. A client who volunteers at least 35 hours a week and does not receive monetary compensation for those hours.

08 Part-Time Volunteer

- A. A client who volunteers at least 17 hours but not more than 34 hours a week and who does not receive monetary compensation for those hours.

09 Irregular Volunteer

- A. A client who volunteers less than 17 hours a week and does not receive monetary compensation for those hours.

3. EMPLOYABILITY FACTOR (check ONE box only)

Check the appropriate factor listed below as it relates to the Employment Status.

Listed on next page

- 01 - Employable or working now
- 02 - Student
- 03 - Homemaker
- 04 - Retired
- 05 - Unable (to work) due to physical or psychological reasons
- 06 - Inmate of Institution (Incarcerated)
- 07 - Seasonal Worker
- 08 - Temporary Layoff
- 09 - Unable (due to) skills/resources
- 10 - Unable (due to) program requirements

4. **IF THE CLIENT HAS DEPENDENT CHILDREN, WHERE WERE THE CLIENT'S CHILDREN WHILE THE CLIENT WAS IN TREATMENT? (Check ONE box only)**

If no dependents, skip question 4 and go to question 5

- 01 With the Client
- 02 Spouse/Other Parent
- 03 Grandparents/Relatives
- 04 Friend(s)
- 05 Babysitter/Care Giver
- 06 Temporary Foster Care
- 99 Other

5. **MH/MR ISSUES: DIAGNOSIS BASED ON DSM-IV**

If the client has been diagnosed with a mental illness/disorder or mental retardation based on DSM-IV criteria, check 01 or 02, otherwise check 00 NONE. (Check ONE Box Only)

- 01 Diagnosed Mental Illness/Disorder
- 02 Mental Retardation
- 00 None

NOTE: This item can be different at discharge than it was at admission.

6. **HOW MANY PSYCHIATRIC ADMISSIONS TO A HOSPITAL DID THE CLIENT HAVE DURING TREATMENT?**

INSTRUCTIONS: Enter the number of psychiatric admissions the client had during treatment to any hospital.

7-9. **PRIMARY, SECONDARY AND TERTIARY DRUGS LISTED ON THE ADMISSION FORM.**

INSTRUCTIONS: Enter the same codes, in the same order, as listed on the client's A-1 admission form. (*Note-when you pull up the client record in TDS these codes are carried over from the A-1 form*)

If the client is an affected other, skip to question 9.

7. **Primary:**

Enter the code associated with substance identified at admission as the client's primary drug problem. This is the primary substance abuse problem for which the client was admitted to treatment.

8. **Secondary:**

Enter the code associated with substance identified at admission as the client's secondary drug problem.

9. **Tertiary:**

Enter the code associated with substance identified at admission as the client's tertiary drug problem.

10. **TOBACCO (check ONE box only)**

- 01 **Yes**
- 02 **No**

NOTE: If 01 Yes is selected at admission, it must also be selected at discharge. If the client quit smoking while in treatment you can reflect that on question 13-frequency of use. *If the client quit smoking while in treatment answer 01 Yes and reflect they stopped with the frequency code of 09- "Not currently smoking".*

11-13. FREQUENCY OF USE OF DRUGS BY CLIENT (IN LAST 30 DAYS)

If client is Affected/Co-Dependent, go to question 14.

INSTRUCTIONS: Enter one of the following codes to indicate the frequency of use in the last 30 days of treatment for **each substance** recorded in Items 7-9.

IF CODE 0000 NONE WAS ENTERED IN ITEMS 8 AND 9 FOR SECONDARY OR TERTIARY PROBLEM(S), ENTER CODE 00 IN THE CORRESPONDING BLOCK OF ITEMS FOR 12 AND 13.

- 00 **NONE** (No substance listed in item 8-9). **(Cannot be used on #11)**
- 02 **No use past month** ****see note below****
- 03 **Once in the last 30 days**
- 04 **2-3 days per month**
- 05 **Once per week**
- 06 **2-3 days per week**
- 07 **4-6 days per week**
- 08 **Daily**

****Some treatment programs (*IOP and Residential Service Settings*) aren't a full 30 days, so if the clients' treatment lasted for a minimum of 3 weeks and they remained abstinent during treatment and have completed treatment (as defined on page 48), you can enter 02 (No Use Past Month)****

14. TOBACCO PRODUCTS ONLY

INSTRUCTIONS: Enter one of the following codes to indicate the frequency of use of tobacco in the last 30 days of treatment.

- 00 **NONE** (Only for someone who did not smoke in treatment)
- 09 **Not currently smoking** (Discharge Only)
- 10 **About half a pack/can/pouch a day or less**
- 11 **About a pack/can/pouch a day**
- 12 **About a one and a half packs/can/pouches a day**
- 13 **About 2 packs/cans/pouches a day**
- 14 **More than 2 packs/cans/ pouches a day**

NOTE: If client answered **01** (YES) at admission; and upon discharge client is no longer smoking, you should still enter (01) YES on item 10; to

reflect that the client quit smoking enter **09** (NOT currently smoking.) in item 14., If the client **NEVER** smoked, you would use the 00 **NONE**.

15. ASSISTANCE RECEIVED DURING TREATMENT.

INSTRUCTIONS: Please check whether the client **did (01 Yes)** or **did not (02 No)** receive assistance with the services listed below during treatment.

These services were not necessarily delivered by your agency, but you some how aided the client in accessing these services.

- | | | | | | |
|-----------------------------|-----------------------------|------------------------------------|-----------------------------|-----------------------------|--------------------------------------|
| YES | NO | | YES | NO | |
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | A. Medical Care | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | L. Drug and Alcohol Education |
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | B. Prescription Medications | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | M. Financial Counseling |
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | C. Acupuncture | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | N. Academic Services |
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | E. Client Urine Testing | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | O. Vocational Services |
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | F. HIV Risk Reduction | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | P. Legal Services |
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | G. Child Care | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | Q. Tuberculosis Services |
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | H. Transportation to Tx | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | R. Prenatal Care |
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | I. Employment/Counseling | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | S. Child/Counseling/Services |
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | J. Crisis Intervention | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | T. Smoking Cessation Serv. |
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | K. Housing Assistance | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | U. Mental Health Services |
| | | | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | Z. Other |

NOTE: DO NOT LEAVE ANY ITEM BLANK.

16. TYPE OF THERAPY – Based on Evidence Based Practice

- 00 None (For Evaluations)
- 01 Cognitive Behavioral Therapy
- 02 Motivational Interviewing
- 03 DSAT (Differential Substance Abuse Treatment)
- 04 CYT (Cannabis Youth Treatment)
- 05 Co-Occurring Integrated Treatment

17. MEDICATION ASSISTED TREATMENT

- 01 No
- 02 Methadone
- 03 LAAM
- 04 Buprenorphine/Suboxone/Subutex
- 05 Campral

- 06 Naltraxone
- 07 Vivitrol
- 08 Antabuse

18. **PARTICIPATED IN SCHOOL OR TRAINING WHILE IN TREATMENT
(check ONE box only)**

- 01 Yes
- 02 No

INSTRUCTIONS: Check **01 Yes** or **02 No** to indicate whether the client was/is currently enrolled in school (e.g., at any level) or in a formal training program (e.g., barber school, secretarial school, carpenter apprenticeship, back-to-work training program), during treatment or at the time of discharge. Students who attended school in the spring and will be going back in the fall are still considered to be in school during the summer.

NOTE: OUI education classes or other educational programs operated by a provider or DEEP should not be considered enrolled in school or a training program.

19. **FREQUENCY OF ATTENDANCE AT SELF-HELP PROGRAMS IN 30 DAYS PRIOR TO DISCHARGE**

Description: The number of times the client has attended a self-help program (AA, NA, and other self-help/mutual support group) in the 30 days preceding the date of discharge from treatment services.

- 01 No attendance in the past month
- 02 1-3 times in past month (less than once per week)
- 03 4-7 times in past month (about once per week)
- 04 8-15 times in past month (2 or 3 times per week)
- 05 16-30 times in past month (4 or more times per week)
- 06 Some attendance in past month, but frequency unknown

20. **DID YOU RECOMMEND A SELF-HELP GROUP? (check ONE box only)**

SELF HELP - any non-therapeutic support that enhances the client's efforts in recovery. AA, NA, and AL Anon are the most common, however, **any group or activity that promotes behavioral change facilitating sobriety/recovery is acceptable**; church groups, retreats, social groups, etc. Did the clinician recommend that the client start, or continue to attend, a substance abuse related self-help group upon discharge?

- 01 Yes
- 02 No

21. **"DELIBERATE" REFERRAL TO SUBSTANCE ABUSE SERVICES (@ discharge) (check ONE box only)**

INSTRUCTIONS: Place a check next to the appropriate service to indicate the primary substance abuse service the client was referred to at discharge. Referral requires "deliberate action."

DEFINITION: "Deliberate Action" means your program has transported the client, written letters, made telephone calls to set up appointments, or taken similar action to see that the client actually is seen by the program you are referring them to, a simple suggestion to a client to go somewhere for help is not considered a referral for the purpose of TDS. **If you are referring them to a different level of treatment or program having to do with Substance Abuse Treatment within YOUR agency, that counts as a referral.**

- 00 None
- 01 Detoxification
- 02 Diagnosis & Evaluation
- 03 In Home Family Support
- 04 Extended Care
- 05 Extended Shelter
- 06 (Emergency) Shelter
- 07 Outpatient Counseling (general)
- 08 Intensive Outpatient
- 09 Residential Rehab (short-term)
- 10 Half and Quarterway House
- 11 Adolescent Res. Rehab Transitional
- 12 Substance Abuse Professional
- 13 Consumer Run Residence
- 99 Other

22. **IF REFERRED – REFERRED AGENCY CODE**

Enter the code established by the TDS office for the licensed substance abuse agency that the client has been referred to. The codes are listed in **Appendix C**. The list of Referred Agency Codes is a constant work in progress so if the agency is not listed, contact the TDS office for a code.

NOTE: If 00 (None) is used in question 20 (Deliberate Referral); 00 must be entered for this question.

23. **"DELIBERATE" REFERRAL TO OTHER THAN SUBSTANCE ABUSE TREATMENT (AT DISCHARGE)**

Place a check next to each item listed to indicate whether the client **did (01 Yes)** or **did not (02 No)** get referred to the service.

- | YES | NO | |
|-----------------------------|-----------------------------|---|
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | A. Mental Health Provider |
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | B. Other Health Care Provider |
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | C. Voc. Rehab/Job Replacement |
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | D. HIV Antibody Counseling and Testing |
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | E. School Counselor |
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | Z. Other |

24. **ARRESTS (ENTER NUMBER OF ARRESTS IN THE PAST 30 DAYS)**

Number of times the client has been arrested in the past 30 days.

25. **OUI ARRESTS DURING TREATMENT**

Number of times the client has been arrested for operating under the influence during treatment.

26. **HAS THE DEGREE OF PRESENTING PHYSICAL OR PSYCHOLOGICAL DEPENDENCE ON THE ALCOHOL AND/OR OTHER DRUG SUBSTANCE(S) IMPROVED AT DISCHARGE BASED ON DOCUMENTATION IN THE CLIENT'S RECORD? (check ONE box only)**

Clinical judgment will ultimately determine your response to this question.

NOTE: If the client was admitted as an evaluation only, your response must be 02. If the client was admitted as an affected other, your response must be 99.

- 01 **Yes**
 02 **No**
 99 **Affected Other**

27. **GLOBAL ASSESSMENT OF FUNCTIONING (GAF) SCALE.**

Enter the appropriate level of functioning (at discharge) based on the GAF scale.

See Appendix E.

28. **STATUS AT DISCHARGE**

Enter the status of the client at the time of discharge from the following codes (also listed on the back of the TDS form).

If you answer 30 (client left due to lack of child care) go to next question, otherwise skip to question 29.

- 01 **Client termination (discharge) without clinic agreement**
(i.e., client leaves without explanation).
- 02 **Treatment is complete.** *SEE DEFINITION on page 45*
- 03 **Further treatment is not appropriate for client at this facility.**
- 04 **Non-compliance with rules and regulations.**
- 05 **Client refused service/treatment.**
- 06 **Unable to follow program requirements.**
- 30 **Client left treatment due to lack of childcare**
- 07 **Client discharged for medical and/or psychological TX.**
- 08 **Client moved out of a catchment area.**
- 09 **Client cannot get to facility for further service/treatment.**
- 10 **Client cannot come for service/treatment during facility hours.**
- 11 **Client incarcerated.**
- 12 **Client deceased.**
- 13 **Parents/legal guardian withdrew client.**
- 14 **Termination due to program cut/reduction.**
- 15 **Treatment completed for affected other/co-dependent.**
- 16 **Treatment not completed for affected other/co-dependent.**
- 17 **Evaluation only.**
- 21 **Evaluation Incomplete**
- 22 **Clients inability to pay/Loss of Health Insurance**
- 23 **Transferred to Another Substance Abuse Treatment Program/facility**

NOTE: ONLY USE CODES 15 and 16 FOR THE AFFECTED OTHER/CO-DEPENDENT.

Completion of Treatment is Defined as:

Client achieves at least 2/3 of his/her most current agreed upon treatment plan and the clinician is in agreement with the discharge. The plan should include objectives specific to client need and might include the following:

- X Abstinent during treatment
- X Significant reduction in problematic use
- X Willingness to voluntarily seek continuing care as necessary
- X Participation in self-help

29. **IF CLIENT LEFT DUE TO LACK OF CHILD CARE, WHAT WAS THE REASON?** (Only answer if question 27 was code 30 (*client left program due to lack of child care*))

Place a check next to the reason that best describes why the client had problems attaining/maintaining child care while they were in treatment.

(Check ONE box only)

- 01 **Accessibility**
- 02 **Money/Cost**
- 03 **Length of stay/treatment**
- 99 **Other**

30. **PRIMARY EXPECTED SOURCE OF PAYMENT**

Enter the code for the primary funds or reimbursement you expect to receive for services provided to the client. This includes State contract/grant sources e.g., OSA, DOC, and DHHS.

NOTE: If 01 Office of Substance Abuse is indicated, a contract number **must** be entered into **F**, at the top of the admission form.

- 00 **None** (can not use on #29 Primary)
- 01 **OSA** Office of Substance Abuse
- 02 **Human Services** (Other than Child, Adult Protective)
- 03 **Corrections**
- 04 **Human Services** (Child, Adult Protective)
- 05 **Self-pay**
- 06 **MaineCare** (Medicaid)

- 07 **Medicare**
- 08 **Blue Cross/Blue Shield**
- 09 **Health Maintenance Organization (HMO)**
- 10 **Other Private Health Insurance**
- 11 **Town Assistance**
- 12 **Workers' Compensation**
- 13 **Veteran's Administration**
- 99 **Other**

31. SECONDARY EXPECTED SOURCE OF PAYMENT

If different than Primary Source.

Enter the code for the secondary funds or reimbursement you expect to receive for services provided to the client. This includes State contract/grant sources. e.g., OSA, DOC, and DHHS.

- 00 **None** (for use with Secondary and Tertiary only)
- 01 **OSA** Office of Substance Abuse
- 02 **Human Services** (Other than Child, Adult Protective)
- 03 **Corrections**
- 04 **Human Services** (Child, Adult Protective)
- 05 **Self-pay**
- 06 **MaineCare** (Medicaid)
- 07 **Medicare**
- 08 **Blue Cross/Blue Shield**
- 09 **Health Maintenance Organization (HMO)**
- 10 **Other Private Health Insurance**
- 11 **Town Assistance**
- 12 **Workers' Compensation**
- 13 **Veteran's Administration**
- 99 **Other**

32. TERTIARY EXPECTED SOURCE OF PAYMENT

If different than Primary and/or Secondary Source

Enter the code of the tertiary funds or reimbursement you expect to receive for services provided to the client. This includes State contract/grant sources e.g., OSA, DOC, and DHHS.

- 00 **None** (can only be used for Secondary and Tertiary)
- 01 **OSA** Office of Substance Abuse
- 02 **Human Services** (Other than Child, Adult Protective)

- 03 **Corrections**
- 04 **Human Services** (Child, Adult Protective)
- 05 **Self-pay**
- 06 **MaineCare** (Medicaid)
- 07 **Medicare**
- 08 **Blue Cross/Blue Shield**
- 09 **Health Maintenance Organization** (HMO)
- 10 **Other Private Health Insurance**
- 11 **Town Assistance**
- 12 **Workers' Compensation**
- 13 **Veteran's Administration**
- 99 **Other**

33. **TOTAL NUMBER OF UNITS AND COST PER UNIT (list on back of form)**

Enter the code(s) associated with the service(s) provided to the client, the number of units delivered to the client, and the cost per unit. The cost per unit should be the amount in the agency's contract with the State of Maine. If the agency does not have a contract with the State of Maine, please use the agency or provider normal cost per unit regardless of the charge to the client.

Codes

REHABILITATION/RESIDENTIAL

- 03 Hospital (PS = 03)
- 04 Short-Term Res/Rehab (PS = 04)
- 05 Extended Care (PS = 05)
- 06 Halfway House (PS = 06)
- 07 Extended Shelter (PS = 07)
- 11 Consumer Run Residence (PS = 44)
- 21 Res. Rehab. Adolescent Transitional (PS = 15)

AMBULATORY

- 08 Individual (PS = 08,18)
- 09 Family (PS = 08,18)
- 10 Group (PS = 08,18)
- 13 Intensive Outpatient (PS = 11)
- 15 Evaluation (PS = 13)
- 16 Opioid Replacement Therapy (PS = 40)

PS = Primary Service Code

Units:

Individual, group, family units and evaluation need to be reported in 15 minute increments.

Intensive outpatient units need be reported in daily increments.

Opioid Replacement Therapy, one dose equals one unit.

EXAMPLE: John had weekly sessions with a counselor and attended group once a week for four weeks. John's units would be as follows:

<u>Code</u>	<u>Units</u>	<u>Cost</u>
08	0016	017.81
10	0016	006.25

Cost Per Unit: *As set by Agency with certain guidelines and/or restrictions.*
Should be reported to TDS like the example above.

DATE FORM COMPLETED: (MM/DD/YYYY)

FORM COMPLETED BY:

This form is to be signed by interviewer. **THIS FIELD MUST BE ENTERED.**

FORM EDITED BY:

All forms are to be edited for accuracy and completeness. To be signed by person editing completed forms. This may be the same person who filled out the forms originally.

A copy of the TDS form should be retained in the client file.

To Contact the TDS Office:

Tds.helpdesk@maine.gov

(207) 287-2595 Or (207) 287-6337

TDS Office
Office of Substance Abuse
11 SHS
41 Anthony Avenue
Augusta, Maine 04333-0011

APPENDIX A

Attorney General's Opinion

(Attorney General's Opinion Page is not available electronically.)

APPENDIX B
Service Definitions

SERVICE SETTING DEFINITIONS

DETOXIFICATION

Medical Model - Hospital Inpatient

Detoxification - Medical Model is a component which provides persons having acute problems related to withdrawal from alcohol or other drugs with immediate assessment, diagnosis and medically assisted detoxification, as well as appropriate referral and transportation for continuing treatment. The program shall provide services on a 24-hour per day basis.

RESIDENTIAL REHABILITATION (30 days or less)

Residential Rehabilitation is a component which provides substance abuse treatment services in a full (24 hours) residential setting. The Residential Rehabilitation component shall provide a scheduled program which consists of diagnostic, educational, and counseling services; and treatment shall refer clients to support services as needed.

EXTENDED CARE

Extended care is a component which provides a long-term supportive environment for individuals with serious and extensive problems resulting from A+D abuse. The Extended Care Component requires sustained abstinence and provides minimal treatment and ongoing living experience within the facility/program or re-entry into the treatment system. The term of residency is usually in excess of 180 days.

HALFWAY HOUSE

A Halfway House is a community-based, peer-oriented residential program that provides treatment and supportive services in a chemical free environment for persons involved in a recovery process. Programs are varied in character each designed to relate to the target group served, taking into consideration the needs of the individual. Thus, the Halfway House shall address the cultural, social, and vocational needs of the clients it serves. The program will provide transitional assistance in bridging the gap between the A+D use and recovery.

SERVICE SETTING DEFINITIONS (Continued)

ADOLESCENT RESIDENTIAL REHABILITATION

Provides recovery through a "therapeutic community" model which emphasizes personal growth through family and group support and interaction. Therapy focuses on attitudes, skills, and habits, conducive to facilitating the recipient's transition back to the family and community.

OUTPATIENT - Non-Intensive (General Outpatient)

Outpatient Care is a component which provides assessment, and treatment services. These services may also be provided to the affected others whether or not the primary abuser is receiving treatment.

INTENSIVE OUTPATIENT

Intensive Outpatient is a component which provides an intensive and structured program of substance abuse assessment, diagnosis and treatment services in a setting which does not include an overnight stay. The program includes a structured sequence of multi-hour clinical and educational sessions scheduled for three or more per week, with a minimum of nine hours per week per client.

DETOXIFICATION - Ambulatory

Outpatient treatment services providing for safe withdrawal in an ambulatory setting (pharmacological or non-pharmacological).

EVALUATION

Systematic clinical process intended to determine the status of a clients' substance use/abuse. To then assess his/her need for treatment and when treatment is indicated to outline the modality of treatment. The term "diagnosis" refers to medical diagnosis, and "evaluation" to educational, social, psychological, etc., evaluations performed by licenses/recognized individuals within the profession.

SHELTER

Shelter is a service which provides food, lodging, and clothing for abusers of alcohol and other drugs, with the purpose of protecting and maintaining life and motivating them to seek substance abuse treatment. Shelter is a pre-treatment service usually operated in connection with a Detoxification component. At a minimum, will be available 24 hours per day.

DEEP

Risk Reduction Program (Adult Offender Program)

Under 21 Program (Teen Offender Program)

**APPENDIX C
REFERRED AGENCY CODES**

<u>Agency</u>	<u>Code</u>	<u>Agency</u>	<u>Code</u>
None	00	D.L.M. Health Services	G5
Acadia Family Center	88	Down East Community Hosp.	V3
Acadia Health Care, Inc.	24	Downeast Health Care	17
ACCESS	16	Eagle Lake Health Ctr.	18
Allies, Inc.	4B	East Grand Health Clinic (AMHC)	73
Aroostook Mental Health Center	05	Eastern Maine Med.-Chemical Dep.	19
Riverview (AMHI)	03	Eastport Health Center	20
Dirigo Counseling Clinic	AQ	Eureka Counseling	AA
Dorthea Dix Psychiatric Ctr. (BMHI)	07	Evergreen (Franklin Mem. Hospital)	E8
Bangor Pre-Release Center	K5	Facing Change, PA	86
Bellville Associates	81	Families United	70
Blue Hill Memorial Hospital	08	First Light Counseling	AB
Blue Willow Counseling	Y5	Full Circle Wellness	AV
Calais Regional Hospital	97	Food Addiction & Chemical Depend	H4
CAP Quality Care	W6	Gateway Recovery Assoc	78
Cary Medical Center	U9	Great Falls Recovery	2F
Casco Bay Substance Abuse	A1	Higher Ground	1M
Catholic Charities ME Counseling	09	Houlton Band of Maliseet Indians	25
Catholic Charities ME/St. Francis	T5	Houlton Regional Hospital	V4
Central Maine Counseling Svcs.	71	Independence Project	Z5
Central Me. Indian Assoc. (CMIA)	11	Ingraham	M5
Charles A. Dean Mem. Hosp.	V2	Jails (if not listed elsewhere)	H6
Charlotte White Center	AI	Jordan House	F6
Choice Skyward/Pen Bay Med. Ctr.	10	Katahdin Valley Health Ctr.	27
City of Portland	80	Kennebec Behavioral Health	K7
Common Ground Counseling	Y4	Kennebec Valley Medical Ctr.	J6
Common Ties	L9	Kennebec Valley Reg. Health Assoc.	28
Community Care	AU	KidsPeace	Z8
Community Concepts	J5	Life by Design, Inc.	Y6
Community Counseling Ctr.	74	Limestone	49
Community Health & Counseling	12	Lubec, Regional Medical Center at	48
Cornerstone BHC	1D	Lutheran Family Services	29
Counseling Services, Inc.	06	Maine Correctional Center	31
Crisis and Counseling	13	Maine General Med Ctr/Serene	Q5
Crooked River Counseling	Y8	MaineGen Men's Res	23
Crossroads for Women	14	MaineGen Women's Res.	Q6
Danzig Counseling Svcs.	Z2	MaineGeneral Counseling (Healthreach)	39
Day One (James Harrod Center)	F7	Maine State Prison	75
Day One LCYDC (MYC)	F8	Manna, Inc.	Z7
Day One MUYDC	W0	Mayo Regional Hospital	33
Day One Outpatient	15	Mcgeachy Hall - MMC	J1
DEEP	16	Mercy Hosp., The Recovery Center at	34
Discovery House Bangor	3B	Merrimack River Med Svcs(CSAC)	Y1
Discovery House of Central ME	49	Mid-Coast Hospital / ARC	01
Discovery House of Maine	I3	Milestone – Old Orchard Beach	P8
Discovery House of Washington Cty.	XX	Milestone - Portland	37

<u>Agency</u>	<u>Code</u>
Millinocket Regional Hospital	69
Mt. Desert Island Hospital	38
New Beginnings	84
Northeast Occupational Exchange	Q9
Northern Maine Medical Center	V5
Open Door Recovery Ctr.	41
Our Father's House	2M
Out of State Facility	42
Oxford House (3/4 Way House)	43
Partners for Change	R3
Passamaquoddy Indian Township	44
Penobscot Cty Metro Treatment of ME	AH
Penobscot Nation Health	45
Penobscot Valley Hospital	D6
Mid Coast Mh/Choice Skyward	K1
Phoenix House of New England	X2
Pleasant Point Health Ctr.-Perry	J3
Preble Street Resource Ctr	K3
Private Practitioner (Other)	47
Project Atrium	W7
PROP-Women's Program	L1
Recovery Assoc. of Southern ME, Inc.	M7
Regional Medical Ctr. At Lubec	48
River Valley Counseling	2B
Rumford Community Hospital	E1
Saco River Health Svcs.	AZ
Safe Harbor/Miles Mem. Hosp.	52
Searsport Counseling	M1
Sebasticook Valley Hospital	53
Serenity House	54
Spectrum Health Systems, Inc.	26
Spring Harbor	S1
St. Andres	G4
St. Mary's Hospital	50
St. Francis House	T5
Stephens Memorial Hospital	P2
Suboxone Prescribing Physician	SP
Substance Abuse Svcs of Ellsworth	S2
Sweetser	Y2
Togus VA Hospital	57

<u>Agency</u>	<u>Code</u>
Tri-County Mental Health Center	58
UMO (Substance Abuse Svcs)	H3
Unknown	98
Veteran's Center of Bangor	H8
Veteran's Center of Lewiston	G6
Veteran's Center of Portland	F3
Wabanaki Mental Health	L8
Waldo Cty Gen Hospital (Coastal)	77
Wellspring	60
Westbrook Community Hospital	61
York County Shelter	64
York Hospital-Cottage Program	65

***** APPENDIX D *****

Federal Identification Codes For

Part IV - DEEP Programs

***** Appendix D Part I, Part II and Part III have been removed; because agencies often open and close this section has been removed because it's a constant work in progress. For a list of your agency's Federal ID Code(s) please contact the TDS office at 287-6337.**

Part IV (DEEP Risk Reduction Programs only)

Under 21 (DEEP TEEN)

Auburn	999901
Augusta	999902
Bangor	999903
Houlton	999904
Machias	999905
Madawaska	999906
Portland	999907
Presque Isle	999908
Rockland	999909
Sanford	999910
Skowhegan	999911
South Paris	999912
Topsham	999913
Waterville	999914

Prime for Live (DEEP ADULT)

Auburn	999990
Augusta	999991
Bangor	999992
Bath	999921
Belfast	999928
Biddeford	999916
Brunswick	999931
Calais	999932
Damariscotta	999933
Dover-Foxcroft	999922
Ellsworth	999929
Farmington	999925
Gorham	999994
Greenville	999934
Houlton	999930
Lincoln	999935
Machias	999923
Millinocket	999924
Newport	999926
Portland	999915
Presque Isle	999993
Rockland	999918
Rumford	999920
Sanford	999917
Skowhegan	999927
Waterville	999919

APPENDIX E

Global Assessment

Assessment of

Functioning (GAF)

Scale

Global Assessment of Functioning (GAF) Scale

The GAF Scale reports the clinician's judgment of the individuals overall level of functioning and is useful in tracking the clinical progress of individuals on global terms, using a single measure. The GAF Scale measures only psychological, social, and occupational functioning. Do not include impairment due to physical or environmental limitations. Rating for TDS should reflect current functioning, i.e., at time of admission and at time of discharge. The GAF is AXIS V of the DSM-IV multi-axial classification.

Code: (Note; Use intermediate codes when appropriate. E.g., 45, 68, 72)

100 ↓ 91	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.
90 ↓ 81	Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interest and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).
80 ↓ 71	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in school work).
70 ↓ 61	Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.
60 ↓ 51	Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).
50 ↓ 41	Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).
40 ↓ 31	Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
30 ↓ 21	Behavior is considerably influenced by delusion or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day, no job, home, or friends).
20 ↓ 11	Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).
10 ↓ 1	Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.
0	Inadequate information.

Reprinted with permission from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Copyright 1994 American Psychiatric Association.



Substance Abuse and Mental Health Services

*An Office of the
Department of Health and Human Services*

Paul R. LePage, Governor

Mary C. Mayhew, Commissioner