

Record Closeout SUPRT PDF for Adult Clients 18+

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

June 2025

Public reporting burden for this collection of information is estimated to average 20 minutes per response. Send comments regarding this burden estimate, or any other aspect of this collection of information, to Substance Abuse and Mental Health Services Administration (SAMHSA) Reports Clearance Officer, Room 15E57B, 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The control number for this project is 0930-0400.

RECORD MANAGEMENT

Provider email address: _____

Enter the Client ID in the field below. Do not include any words or characters before the client ID; just include the number (example: 999999). Client IDs must originate from your PRG-assigned client ID list.

Client ID: _ _ _ _ _

Which assessment type?

☐ Record closeout

Why are you closing out this client's record?

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

[if **Death** is selected in question above] What is the cause of death?

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

Site name: _____

SUPRT-A Staff Assessment Date:

What is the date of the staff-reported (SUPRT-A) assessment? You must enter the date in this format: yyyy/mm/dd.

Most Recent Service Date:

When did the client most recently receive services under this grant? You must enter the date in this format: yyyy/mm/dd.

E. SERVICES RECEIVED

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

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

BEHAVIORAL HEALTH SERVICES

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

- ☐ Yes
- ☐ No
- ☐ Not documented in records

E1a-p. If yes, please indicate which:

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

E2a-j. [IF E1a_I = MEDICATION FOR SUBSTANCE USE DISORDER IS YES – PROVIDED]

Indicate medication received

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

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

- ☐ Yes
☐ No
☐ Not documented in records

E3a-d. If yes, please indicate which:

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

RECOVERY AND SUPPORT SERVICES

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

- ☐ Yes
- ☐ No
- ☐ Not documented in records

E4a-l. If yes, please indicate which:

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

INTEGRATED SERVICES

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

- ☐ Yes
- ☐ No
- ☐ Not documented in records

E5a-i. If yes, please indicate which:

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