

## **6-month Reassessment SUPRT PDF for Youth Clients 12–17**

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

June 2025

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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?

☐ 6-month Reassessment

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.

\_\_\_\_\_

The next set of questions contains SUPRT-C consent information followed by sections to be answered by the client (or their caregiver/proxy), if they agree to complete the assessment.

If the client does not agree to complete the assessment, complete the staff-reported SUPRT-A sections.

## SUPRT-C: CONSENT INFORMATION

### CLIENT CONSENT – YOUTH

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

#### **What is this form about?**

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

#### **How is my information used?**

SAMHSA does not collect your name or information that can identify you. The Privacy Act of 1974, 5 U.S.C § 552a, also requires SAMHSA to protect the privacy of your information. SAMHSA collects this information from all persons served. SAMHSA looks for trends or patterns in the data. SAMHSA combines information collected to see if services need to be improved.

#### **Do I have to fill in this form?**

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

If you choose to participate, you may:

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

#### **How long does it take to fill in the form?**

It should take you about 5 minutes.

#### **How do I agree to participate?**

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

#### **Does the client/caregiver agree to complete the assessment?**

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

#### ***[if No]* Why not? Choose the primary reason.**

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

#### **SUPRT-C Client Assessment Date:**

**What is the date the client-reported (SUPRT-C) assessment? You must enter the date in this format: yyyy/mm/dd.**

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**The client-reported SUPRT-C sections begin on the next page. Clients can skip (leave blank) any question they do not wish to answer.**

## B. SOCIAL DRIVERS OF HEALTH

### B1. [NOT ASKED ON YOUTH SUPRT]

### B2. What is your living situation today?

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

### B3. Which of the following best describes your current living situation? *If you are living in more than one place, select the response based on where you live most of the time or where you have been living the longest.*

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

### B4. [NOT ASKED ON YOUTH SUPRT]

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

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

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

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

**B7. [NOT ASKED ON YOUTH SUPRT]**

**Thank you for completing this reassessment form.**

Public reporting burden for this collection of information is estimated to average 5 minutes per response. Send comments regarding this burden estimate, or any other aspect of this collection of information, to the Substance Abuse and Mental Health Services Administration (SAMHSA) Reports Clearance Officer, Room 15E57B, 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The control number for this project is 0930-0400.

**This is the end of the client-reported SUPRT sections (SUPRT-C).**

**The next sections (SUPRT-A) must be completed by program staff.**

## SUPRT-A

**This is the beginning of the staff-reported SUPRT sections (SUPRT-A).**

**These sections collect administrative information and must be completed by the provider based on information available in client records. Data/information collected for another grant program can be used if it was collected within 30 days before the client's first date of services received with the current program.**

### B. BEHAVIORAL HEALTH HISTORY

**B1. What insurance does the client or guarantor have? SELECT ALL THAT APPLY**

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

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

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

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

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

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

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

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

- ☐ Suicide risk
- ☐ Other risk of harm to self or others (e.g. NSSI, homicidal thoughts)
- ☐ Mental health
- ☐ Substance use other than overdose
- ☐ Overdose
- ☐ Other [Select this response option if client had multiple behavioral health crises or requested crisis responses for different reasons]
- ☐ Not documented in records or not documented in records using this standard

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

## C. BEHAVIORAL HEALTH SCREENINGS

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

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

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

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

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

**C3. [IF QUESTION C2 IS "YES"] During the screening and assessment process, what was the reported use for the following substances? If the client refused to answer or could not recall their substance use at screening or assessment, select "Not documented". If a client has reported recent and past use, only record what they have used recently.**

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



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

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

## D. BEHAVIORAL HEALTH DIAGNOSIS

Please indicate the client's current behavioral health diagnoses using the most current version of the International Classification of Diseases, 10<sup>th</sup> Revision, Clinical Modification (ICD-10-CM) codes or corresponding Diagnostic Statistical Manual of Mental Disorders (e.g. DSM-5), as made by a clinician and documented in a clinical record.

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

Enter ICD-10-CM/DSM-5 code F10-F19- or indicate no diagnosis |\_|\_|\_|\_|\_|

Enter ICD-10-CM/DSM-5 code F10-F19- or indicate no diagnosis |\_|\_|\_|\_|\_|

Enter ICD-10-CM/DSM-5 code F10-F19- or indicate no diagnosis |\_|\_|\_|\_|\_|

☐ No diagnosis

**D2. Mental health diagnosis (record up to 3)**

Enter ICD-10-CM/DSM-5 code F20-F99- or indicate no diagnosis |\_|\_|\_|\_|\_|

Enter ICD-10-CM/DSM-5 code F20-F99- or indicate no diagnosis |\_|\_|\_|\_|\_|

Enter ICD-10-CM/DSM-5 code F20-F99- or indicate no diagnosis |\_|\_|\_|\_|\_|

☐ No diagnosis

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

Enter ICD-10-CM/DSM-5 code Z55-Z65 or Z69-Z76- or indicate no diagnosis |\_|\_|\_|\_|\_|

Enter ICD-10-CM/DSM-5 code Z55-Z65 or Z69-Z76- or indicate no diagnosis |\_|\_|\_|\_|\_|

Enter ICD-10-CM/DSM-5 code Z55-Z65 or Z69-Z76- or indicate no diagnosis |\_|\_|\_|\_|\_|

☐ No diagnosis

### OTHER HEALTH STATUS QUESTIONS

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

**D4. Is the client currently pregnant?**

☐ Yes

☐ No

☐ Not applicable

☐ Not documented in records or not documented in records using this standard

**D5. [NOT APPLICABLE FOR THIS GRANT]**

**D6. In the previous 30 days, did the client experience an overdose or take too much of a substance that resulted in needing supervision or medical attention?**

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

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

**SELECT ALL THAT APPLY**

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

**D7. [D7–D7b NOT APPLICABLE FOR THIS GRANT]**

**D8. [D8–D8a NOT APPLICABLE FOR THIS GRANT]**

## 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. 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"/>

**E2. [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. 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. 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. 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"/>