

Protocol Num

Node

Site

Subject Number

Visit week

Visit number

Sequence Number

Phase

Rater

Date

This form collects data from ___/___/___ to ___/___/___

Note: I will be asking you some questions about what services you receive at the treatment program and how much you have to pay for them. I also will be asking you about the services that you have to pay for in order to attend the program. This information will be helpful for us as we evaluate what the treatment costs you and the program. None of these questions apply to time spent filling out assessment forms. Any of the sessions should be recorded more than once.

A. Assessing Treatment Program Costs

1. INDIVIDUAL COUNSELING SESSIONS:

1.a Who is your PRIMARY INDIVIDUAL COUNSELOR? Counselor code:

1.b Which other individual counselors did you see last week? Counselor Codes:

2nd

3rd

1.c How many times did you see your PRIMARY INDIVIDUAL COUNSELOR last week?

number of times

1.d How many times did you see each of your OTHER INDIVIDUAL COUNSELORS last week?

2nd counselor

3rd counselor

1.e How many hours did you spend in total with your PRIMARY COUNSELOR in INDIVIDUAL sessions last week?

- 0 hours
 1 hour
 2 hours
 3 hours
 4 hours
 5 hours
 7 hours
 9 hours
 1/2 hour
 1.5 hours
 2.5 hours
 3.5 hours
 4.5 hours
 6 hours
 8 hours
 10 hours

1.f How many hours did you spent in total with your OTHER COUNSELORS in an INDIVIDUAL session last week?

- 2nd counselor
 1/2 hour
 1.5 hours
 2.5 hours
 3.5 hours
 4.5 hours
 1 hour
 2 hours
 3 hours
 4 hours
 5 hours

- 3rd counselor
 1/2 hour
 1.5 hours
 2.5 hours
 3.5 hours
 4.5 hours
 1 hour
 2 hours
 3 hours
 4 hours
 5 hours



--	--	--	--

Subject Number

--	--

Visit week

2. GROUP COUNSELING SESSIONS:

2.a Group Counseling Sessions: Please, fill in the following table reporting on each GROUP counseling session that you attended last week:

**RA fill in
Therapist Code
using Staff List**

	First Leader	Second	DURATION in hours										Total Number of Patients in session (INCLUDING YOU)														
1.	<table border="1"><tr><td></td><td></td><td></td></tr></table>				<table border="1"><tr><td></td><td></td><td></td></tr></table>				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
			1/2	1	1.5	2	2.5	3	3.5	4	4.5	5	2-3	6-7	10-11	14-15	18-19	4-5	8-9	12-13	16-17	20+					
2.	<table border="1"><tr><td></td><td></td><td></td></tr></table>				<table border="1"><tr><td></td><td></td><td></td></tr></table>				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
			1/2	1	1.5	2	2.5	3	3.5	4	4.5	5	2-3	6-7	10-11	14-15	18-19	4-5	8-9	12-13	16-17	20+					
3.	<table border="1"><tr><td></td><td></td><td></td></tr></table>				<table border="1"><tr><td></td><td></td><td></td></tr></table>				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
			1/2	1	1.5	2	2.5	3	3.5	4	4.5	5	2-3	6-7	10-11	14-15	18-19	4-5	8-9	12-13	16-17	20+					

3. Health Care Provider Visits occurring last week: Please, fill in the following table reporting on any HEALTH CARE VISITS at the program center that you had last week:

3a. Did you receive any Health Care Visits at the Program last week?

No (go to 4) Yes. Please fill in the following table:

Healthcare Visits				Provider code	How long was it? In minutes								
	Medical visit	HIV counseling	Other		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
1.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<table border="1"><tr><td></td><td></td><td></td></tr></table>				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
					15	30	45	60	75	90			
2.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<table border="1"><tr><td></td><td></td><td></td></tr></table>				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
					15	30	45	60	75	90			
3.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<table border="1"><tr><td></td><td></td><td></td></tr></table>				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
					15	30	45	60	75	90			
4.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<table border="1"><tr><td></td><td></td><td></td></tr></table>				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
					15	30	45	60	75	90			
5.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<table border="1"><tr><td></td><td></td><td></td></tr></table>				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
					15	30	45	60	75	90			
6.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<table border="1"><tr><td></td><td></td><td></td></tr></table>				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
					15	30	45	60	75	90			



--	--	--	--

Subject Number

--	--

Visit week

6. In total, how much did you pay (out of pocket) for this treatment last week? (this should exclude any payments for childcare and transportation)

Payment for treatment last week \$

--	--	--

D. Out of Program Health Services Utilization

Note: Questions 7 and 8 refer to services received outside of the treatment programs and refer to the last week.

7. In the last week: How many times have you been in the Emergency Room?

--	--

8. How many nights out of the last 7 days have you been in each of the following?

At your own home/apartment

--	--

At a friend's or relative's house

--	--

Hospital

--	--

Jail or Prison

--	--

Shelter

--	--

Half Way House

--	--

DETOX Out-of-Program

--	--

Other:

--	--

