MATCH-ADTC Follow Up Forms (Monthly, Periodic, & Discharge)

English

Required Forms

1. MATCH-ADTC Monthly Session Form ☐

2. Top Problems Assessment ☐

3. Child's Behavior & Functioning*
   Ohio- Caregiver Report (child 5+) ☐
   Ohio- Child Report (child 12+) ☐

4. Chosen Assessment(s) specific to MATCH-ADTC* ☐
   Note: The recommended ongoing assessment for MATCH-ADTC is an age appropriate measure given the child's Primary Problem Area. We suggest the PROMIS for anxiety, SMFQ for Depression; CPSS (7+) or YCPC (under 7) for Trauma; and Ohio for Conduct. Alternate or additional measures can be used based on clinical judgment of primary symptom area targeted by treatment

5. Satisfaction Questions (caregiver or child)* ☐

6. Client Discharge Face Sheet ☐

***Required at periodic and discharge**

MATCH-ADTC Monthly Session Form

VALIDATION REQUIREMENTS AND SYMBOLS EXPLAINED

! This symbol means the field is one of the minimum fields that must be filled out to save the record. No data will be saved unless these fields are completed.

* This symbol means the field is a required field in order to save the record as completed. Although you can save the record, the system does not consider the record to be completed unless ALL of these fields are completed.

Data Entry Person: Greyed-out fields are pulled in from the completed Client Face Sheet-Intake, so you won't have to enter them again here

Direct Service Provider User Information

Clinician First Name:		**Clinician Last Name:**	
Project Name:			

Child Information

First Initial of First Name:		**First Initial of Last Name:**		**Date of Birth:**	

Child Identification Codes

Provider Client ID:		**PSDCRS ID:**	

Session Information

Was there a visit this month? (Circle one)	❒	**Yes**	❒	**No**

Please check all MATCH Modules used this month:

Anxiety							
❒	Getting Acquainted - Anxiety	❒	Fear Ladder	❒	Learning Anxiety - Child	❒	Learning Anxiety - Parent
❒	Practicing	❒	Maintenance	❒	Wrap Up	❒	Cognitive STOP
Depression							
❒	Getting Acquainted - Depression	❒	Learning Depression – Child	❒	Learning Depression - Parent	❒	Problem Solving
❒	Activity Selection	❒	Learning to Relax	❒	Quick Calming	❒	Positive Self
❒	Cognitive BLUE	❒	Cognitive TLC	❒	Plans for Coping	❒	Wrap Up
Trauma							
❒	Safety Planning			❒	Trauma Narrative		
Conduct							
❒	Engaging Parents	❒	Learning about Behavior	❒	One-on-One Time	❒	Praise
❒	Active Ignoring	❒	Effective Instructions	❒	Rewards	❒	Time Out
❒	Making a Plan	❒	Daily Report Card	❒	Looking Ahead	❒	Booster Session
Assessment Measures							
❒	Using measures (administer or share results)						

MATCH-ADTC Monthly Session Form

Collaboration						
During this month, did you communicate with the child's:	❒	DCF Worker	❒	Probation officer	❒	Physician
	❒	School	❒	Other		
Collaboration Notes:						

Functioning						
Compared to the child's condition at the start of MATCH, this child's condition is:	❒	Very much improved since the initiation of treatment	❒	Much Improved	❒	Minimally improved
	❒	No change from baseline (the initiation of treatment)	❒	Minimally worse	❒	Much Worse
	❒	Very much worse since the initiation of treatment				

Session Fidelity Checklist						
Session Structure						
Prior to how many sessions this month did you prepare materials or a session plan?	❒	None (0%)	❒	Some (34-66%)	❒	All (100%)
	❒	A few (1-33%)	❒	Most (67-99%)		
During how many sessions this month did you assign homework?	❒	None (0%)	❒	Some (34-66%)	❒	All (100%)
	❒	A few (1-33%)	❒	Most (67-99%)		
During how many sessions this month did you review homework?	❒	None (0%)	❒	Some (34-66%)	❒	All (100%)
	❒	A few (1-33%)	❒	Most (67-99%)		
During how many sessions this month was a role play used?	❒	None (0%)	❒	Some (34-66%)	❒	All (100%)
	❒	A few (1-33%)	❒	Most (67-99%)		
During how many sessions this month did the child and/or caregiver practice a skill in session?	❒	None (0%)	❒	Some (34-66%)	❒	All (100%)
	❒	A few (1-33%)	❒	Most (67-99%)		
During how many sessions this month did you discuss a COW (crisis of the week)?	❒	None (0%)	❒	Some (34-66%)	❒	All (100%)
	❒	A few (1-33%)	❒	Most (67-99%)		
Since at least one COW was present, during how many sessions this month did you use the COW to illustrate a MATCH skill?	❒	None (0%)	❒	Some (34-66%)	❒	All (100%)
	❒	A few (1-33%)	❒	Most (67-99%)		

Client Initials: _____ Client ID: _____ Date of Completion: ___/____/____

Top Problems Assessment (TPA)

CAREGIVER ASSESSMENT (English)

Please enter each top problem in the text box below.

How much has your child had each of the following problems during the past week? Use a 0 to 4 scale.

0=*not a problem* **4=*a very big problem***

Rank	Top Problem	Rating (0-4)
1		
2		
3		

Client Initials: _____ Client ID: _____ Date of Completion: ___/____/____

Top Problems Assessment (TPA) for MATCH-ADTC

CHILD ASSESSMENT (English)

Please enter each top problem in the text box below.

How much have you had each of the following problems during the past week? Use a 0 to 4 scale.

0=*not a problem* **4=*a very big problem***

Rank	Top Problem	Rating (0-4)
1		
2		
3		

Client Initials: _____ Client ID: _____ Date of Completion: ___/____/____

P

Ohio Mental Health Consumer Outcomes System
Ohio Youth Problem and Functioning Scales (Caregiver: English)

Parent Rating – Short Form

Instructions: Please rate the degree to which your child has experienced the following problems in the past 30 days.	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

(Add ratings together) Total _____

January 2000 (Parent-1)

Response Scale for OHIO Problem Scale

0	1	2	3	4	5
Not at all	Once or twice	Several times	Often	Most of the time	All of the time

Client Initials: _____ Client ID: _____ Date of Completion: ___/____/____

Ohio Youth Problem and Functioning Scales (Caregiver: English)

Parent Rating – Short Form continued

Instructions: Please rate the degree to which your child's problems affect his or her current ability in everyday activities. Consider your child's current level of functioning.	Extreme Troubles	Quite a Few Troubles	Some Troubles	OK	Doing Very Well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

 January 2000 (Parent-2)

(Add ratings together) Total _____

Response Scale for OHIO Functioning Scale

0	1	2	3	4
Extreme troubles	Quite a few troubles	Some troubles	OK	Doing very well

Client Initials: _____ Client ID: _____ Date of Completion: ___/____/____

Y

Ohio Mental Health Consumer Outcomes System
Ohio Youth Problem and Functioning Scales (Child: English)

Youth Rating – Short Form (Ages 12-18)

Instructions: Please rate the degree to which you have experienced the following problems in the past 30 days.	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

(Add ratings together) Total _____

January 2000 (Youth-1)

Response Scale for OHIO Problem Scale

0	1	2	3	4	5
Not at all	Once or twice	Several times	Often	Most of the time	All of the time

Client Initials: _____ Client ID: _____ Date of Completion: ___/____/____

Ohio Youth Problem and Functioning Scales (Child: English)

Youth Rating – Short Form (Ages 12-18) continued

Instructions: Below are some ways your problems might get in the way of your ability to do everyday activities. Read each item and circle the number that best describes your current situation.	Extreme Troubles	Quite a Few Troubles	Some Troubles	OK	Doing Very Well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

(Add ratings together) Total _____

January 2000 (Youth-1)

Response Scale for OHIO Functioning Scale

0	1	2	3	4
Extreme troubles	Quite a few troubles	Some troubles	OK	Doing very well

Client Initials: _____ Client ID: _____ Date of Completion: ___/___/___

CPSS – V Caregiver Report (English)

These questions ask about how your child feels about the upsetting things you described. Choose the number (0-4) that best describes how often that problem has bothered him/ her **IN THE LAST MONTH.**

0	1	2	3	4
Not at all	Once a week or less / a little	2 to 3 times a week / somewhat	4 to 5 times a week / a lot	6 or more times a week / almost always

1.	Having upsetting thoughts or pictures about it that came into your child's head when he/she didn't want them to	0	1	2	3	4
2.	Having bad dreams or nightmares	0	1	2	3	4
3.	Acting or feeling as if it was happening again (seeing or hearing something and feeling as if he/she was there again)	0	1	2	3	4
4.	Feeling upset when he/she remember what happened (for example, feeling scared, angry, sad, guilty, confused)	0	1	2	3	4
5.	Having feelings in his/her body when he/she remembers what happened (for example, sweating, heart beating fast, stomach or head hurting)	0	1	2	3	4
6.	Trying not to think about it or have feelings about it	0	1	2	3	4
7.	Trying to stay away from anything that remind him/her of what happened (for example, people, places, or conversations about it)	0	1	2	3	4
8.	Not being able to remember an important part of what happened	0	1	2	3	4
9.	Having bad thoughts about himself/herself, other people, or the world (for example, "I can't do anything right", "All people are bad", "The world is a scary place")	0	1	2	3	4
10.	Thinking that what happened is his/her fault (for example, "I should have known better", "I shouldn't have done that", "I deserved it")	0	1	2	3	4
11.	Having strong bad feelings (like fear, anger, guilt, or shame)	0	1	2	3	4
12.	Having much less interest in doing things he/she used to do	0	1	2	3	4
13.	Not feeling close to his/her friends or family or not wanting to be around them	0	1	2	3	4
14.	Trouble having good feelings (like happiness or love) or trouble having any feelings at all	0	1	2	3	4
15.	Getting angry easily (for example, yelling, hitting others, throwing things)	0	1	2	3	4
16.	Doing things that might hurt himself/herself (for example, taking drugs, drinking alcohol, running away, cutting himself/herself)	0	1	2	3	4
17.	Being very careful or on the lookout for danger (for example, checking to see who is around him/her and what is around him/her)	0	1	2	3	4
18.	Being jumpy or easily scared (for example, when someone walks up behind him/her, when he/she hear a loud noise)	0	1	2	3	4
19.	Having trouble paying attention (for example, losing track of a story on TV, forgetting what he/she read, unable to pay attention in class)	0	1	2	3	4
20.	Having trouble falling or staying asleep	0	1	2	3	4

Adapted from Foa, E.B.; Johnson, K.M., & Treadwell, K.R.H. The Child PTSD symptom Scale for DSM 5 (2014)

Child PTSD Symptom Scale

0	1	2	3	4
Not at all	Once a week or less/ a little	2 to 3 times a week / somewhat	4 to 5 times a week / a lot	6 or more times a week/almost always

Client Initials: _____ Client ID: _____ Date of Completion: ___/___/___

CPSS – V Child Report (English)

These questions ask about how you feel about the upsetting things you described. Choose the number (0-4) that best describes how often that problem has bothered you **IN THE LAST MONTH.**

0	1	2	3	4
Not at all	Once a week or less / a little	2 to 3 times a week / somewhat	4 to 5 times a week / a lot	6 or more times a week / almost always

1.	Having upsetting thoughts or pictures about it that came into your head when you didn't want them to	0	1	2	3	4
2.	Having bad dreams or nightmares	0	1	2	3	4
3.	Acting or feeling as if it was happening again (seeing or hearing something and feeling as if you are there again)	0	1	2	3	4
4.	Feeling upset when you remember what happened (for example, feeling scared, angry, sad, guilty, confused)	0	1	2	3	4
5.	Having feelings in your body when you remember what happened (for example, sweating, heart beating fast, stomach or head hurting)	0	1	2	3	4
6.	Trying not to think about it or have feelings about it	0	1	2	3	4
7.	Trying to stay away from anything that reminds you of what happened (for example, people, places, or conversations about it)	0	1	2	3	4
8.	Not being able to remember an important part of what happened	0	1	2	3	4
9.	Having bad thoughts about yourself, other people, or the world (for example, "I can't do anything right", "All people are bad", "The world is a scary place")	0	1	2	3	4
10.	Thinking that what happened is your fault (for example, "I should have known better", "I shouldn't have done that", "I deserved it")	0	1	2	3	4
11.	Having strong bad feelings (like fear, anger, guilt, or shame)	0	1	2	3	4
12.	Having much less interest in doing things you used to do	0	1	2	3	4
13.	Not feeling close to your friends or family or not wanting to be around them	0	1	2	3	4
14.	Trouble having good feelings (like happiness or love) or trouble having any feelings at all	0	1	2	3	4
15.	Getting angry easily (for example, yelling, hitting others, throwing things)	0	1	2	3	4
16.	Doing things that might hurt yourself (for example, taking drugs, drinking alcohol, running away, cutting yourself)	0	1	2	3	4
17.	Being very careful or on the lookout for danger (for example, checking to see who is around you and what is around you)	0	1	2	3	4
18.	Being jumpy or easily scared (for example, when someone walks up behind you, when you hear a loud noise)	0	1	2	3	4
19.	Having trouble paying attention (for example, losing track of a story on TV, forgetting what you read, unable to pay attention in class)	0	1	2	3	4
20.	Having trouble falling or staying asleep	0	1	2	3	4

Adapted from Foa, E.B.; Johnson, K.M., & Treadwell, K.R.H. The Child PTSD Symptom Scale for DSM 5 (2014)

Child PTSD Symptom Scale

0	1	2	3	4
Not at all	Once a week or less/ a little	2 to 3 times a week / somewhat	4 to 5 times a week / a lot	6 or more times a week/almost always

Pediatric Anxiety – Short Form 8a

Please respond to each question or statement by marking one box per row.

In the past 7 days…	**Never**	**Almost Never**	**Sometimes**	**Often**	**Almost Always**
I felt like something awful might happen..	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I felt nervous.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I felt scared	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I felt worried.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I worried when I was at home	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I got scared really easy	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I worried about what could happen to me ..	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I worried when I went to bed at night	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Response Scale for PROMIS

1	2	3	4	5
Never	Almost	Sometimes	Often	Almost Always

Parent Proxy Anxiety – Short Form 8a

Please respond to each question or statement by marking one box per row.

In the past 7 days…	**Never**	**Almost Never**	**Sometimes**	**Often**	**Almost Always**
My child felt nervous.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
My child felt scared.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
My child felt worried.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
My child felt like something awful might happen.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
My child worried when he/she was at home	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
My child got scared really easy	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
My child worried about what could happen to him/her	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
My child worried when he/she went to bed at night	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Response Scale for PROMIS

1	2	3	4	5
Never	Almost	Sometimes	Often	Almost Always

Client Initials: _____ Client ID: _____ Date of Completion: ___/____/____

SHORT MOOD AND FEELINGS QUESTIONNAIRE (Caregiver: English)

I'm going to ask you some questions about how your child might have been feeling or acting recently.

For each question, please answer how much your child has felt or acted this way ***in the past two weeks***.

If a sentence was true about your child most of the time, check TRUE.
If it was only sometimes true, check SOMETIMES.
If a sentence was not true about your child, check NOT TRUE

	True	Sometimes	Not True
	2	**1**	**0**
1. S/he felt miserable or unhappy.	☐	☐	☐
2. S/he didn't enjoy anything at all.	☐	☐	☐
3. S/he felt so tired s/he just sat around and did nothing.	☐	☐	☐
4. S/he was very restless.	☐	☐	☐
5. S/he felt s/he was no good any more.	☐	☐	☐
6. S/he cried a lot.	☐	☐	☐
7. S/he found it hard to think properly or concentrate.	☐	☐	☐
8. S/he hated him/herself.	☐	☐	☐
9. S/he felt s/he was a bad person.	☐	☐	☐
10. S/he felt lonely.	☐	☐	☐
11. S/he thought nobody really loved him/her.	☐	☐	☐
12. S/he thought s/he could never be as good as other kids.	☐	☐	☐
13. S/he felt s/he did everything wrong.	☐	☐	☐

Response Scale for SMFQ

0	1	2
Not True	Sometimes	True

Client Initials: _____ Client ID: _____ Date of Completion: ___/___/____

SHORT MOOD AND FEELINGS QUESTIONNAIRE (Child: English)

This form is about how you might have been feeling or acting recently.

For each question, please check how much you have felt or acted this way ***in the past two weeks***.

If a sentence was true about you most of the time, check TRUE.
If it was only sometimes true, check SOMETIMES.
If a sentence was not true about you, check NOT TRUE.

	True	Sometimes	Not True
	2	**1**	**0**
1. I felt miserable or unhappy.	☐	☐	☐
2. I didn't enjoy anything at all.	☐	☐	☐
3. I felt so tired I just sat around and did nothing.	☐	☐	☐
4. I was very restless.	☐	☐	☐
5. I felt I was no good any more.	☐	☐	☐
6. I cried a lot.	☐	☐	☐
7. I found it hard to think properly or concentrate.	☐	☐	☐
8. I hated myself.	☐	☐	☐
9. I was a bad person.	☐	☐	☐
10. I felt lonely.	☐	☐	☐
11. I thought nobody really loved me.	☐	☐	☐
12. I thought I could never be as good as other kids.	☐	☐	☐
13. I did everything wrong.	☐	☐	☐

Response Scale for SMFQ

0	1	2
Not True	Sometimes	True

Client Initials: _____ Client ID: _____ Date of Completion: ___/____/____

Satisfaction Questionnaire

P

Parent Rating –OHIO SATISFACTION SCALE (English)

Instructions: Please circle your response to each question.

1. How satisfied are you with the mental health services your child has received so far?

1. Extremely satisfied
2. Moderately satisfied
3. Somewhat satisfied
4. Somewhat dissatisfied
5. Moderately dissatisfied
6. Extremely dissatisfied

2. To what degree have you been included in the treatment planning process for your child?

1. A great deal
2. Quite a bit
3. Moderately
4. Somewhat
5. A little
6. Not at all

3. Mental health workers involved in my case listen to and value my ideas about treatment planning for my child.

1. A great deal
2. Quite a bit
3. Moderately
4. Somewhat
5. A little
6. Not at all

4. To what extent does your child's treatment plan include your ideas about your child's treatment needs?

1. A great deal
2. Quite a bit
3. Moderately
4. Somewhat
5. A little
6. Not at all

Total: _____

Client Initials: _____ Client ID: _____ Date of Completion: ___/____/____

Satisfaction Questionnaire

Y

Youth Rating – OHIO SATISFACTION SCALE

Form Completed By: ☐ Caregiver ☐ Child ☐ Other: _____

Instructions: Please circle your response to each question.

1. How satisfied are you with the mental health services you have received so far?

1. Extremely satisfied
2. Moderately satisfied
3. Somewhat satisfied
4. Somewhat dissatisfied
5. Moderately dissatisfied
6. Extremely dissatisfied

2. How much are you included in deciding your treatment?

1. A great deal
2. Quite a bit
3. Moderately
4. Somewhat
5. A little
6. Not at all

3. Mental health workers involved in my case listen to me and know what I want.

1. A great deal
2. Quite a bit
3. Moderately
4. Somewhat
5. A little
6. Not at all

4. I have a lot of say about what happens in my treatment.

1. A great deal
2. Quite a bit
3. Moderately
4. Somewhat
5. A little
6. Not at all

Total: _____

Discharge Facesheet (MATCH-ADTC & TF-CBT)

! This symbol means the field is one of the minimum fields that must be filled out to save the record. No data will be saved unless these fields are completed.

* This symbol means the field is a required field in order to save the record as completed. Although you can save the record, the system does not consider the record to be completed unless ALL of these fields are completed.

Data Entry Person: Greyed-out fields are pulled in from the completed Client Face Sheet-Intake, so you won't have to enter them again here

Direct Service Provider User Information

Clinician First Name:		**Clinician Last Name:**	
Project:		**Treatment Model Site:**	

Child Information

Grade (current): *	

Child Identification Codes

Provider's Unique Client ID:			**PSDCRS ID:**		
Which EBP?	❒	MATCH-ADTC	❒	TF-CBT	

Discharge Information

How many visits during this case:		**Discharge Date: *** _____/_____/_____
% of the total time spent with the child ONLY during this case:		**The total time spent for these three % questions should equal 100%**
% of the total time spent with the caregiver ONLY during this case:		**The total time spent for these three % questions should equal 100%**
% of the total time spent with the child and caregiver TOGETHER during this case:		**The total time spent for these three % questions should equal 100%**

CGI: Considering your experience, how severe are the child's emotional, behavioral, and/or cognitive concerns at discharge? (Circle one)*	Normal Slightly Severe Mildly Severe Moderately Severe Markedly Severe Very Severe Among the most severe symptoms that any child may experience		**CGI: Compared to the child's condition at intake, this child's condition is ____ (Circle one): ***	Very much improved Much improved Minimally improved No change Minimally worse Much worse Very much worse	

Discharge Reason: *	❒	Successfully completed selected EBP Model requirements-no more treatment needed	❒	Referred for other EBP (outpatient) within agency	❒	Family moved out of area
	❒	Successfully completed selected EBP Model requirements-continue with other treatment	❒	Referred for other non-EBP (outpatient) within agency	❒	Referred to other agency (outpatient)
	❒	Family discontinued treatment	❒	Referred to higher level of care	❒	Assessment Only-no treatment needed
	Other (specify):					

Discharge Facesheet (MATCH-ADTC & TF-CBT)

System Involvement						
Child/Family involved with DCF? *			❒	Yes	❒	No
If child / family is involved with DCF, please complete ALL of the following questions:						
DCF Case ID: (if available)			**DCF Person Link ID: (if available)**			
DCF Status: **DCF Regional Office:**	❒	Child Protective Services – In-Home	❒	Family with Service Needs – (FWSN) In-Home	❒	Not DCF – On Probation
	❒	Child Protective Services – Out of Home	❒	Family with Service Needs (FWSN) Out of Home	❒	Not DCF – Other Court Involved
	❒	Dual Commitment (JJ and Child Protective Services)	❒	Juvenile Justice (delinquency) commitment	❒	Termination of Parental Rights
	❒	Family Assessment Response	❒	Not DCF	❒	Voluntary Services Program
Youth involved with Juvenile Justice (JJ) System? *			❒	Yes	❒	No
If youth is involved with JJ, please complete ALL of the following questions:						
CSSD Client ID: (if available)			**CSSD Case ID: (if available)**			
CSSD Case Type:			❒	Delinquency	❒	Family with Service Needs (Status Offense)
CSSD Case Status:	❒	Administrative Supervision	❒	Juvenile probation	❒	Restore Probation
	❒	Extended Probation	❒	Non-Judicial FWSN Family Service Agreement	❒	Suspended Order
	❒	Interim Orders	❒	Non-Judicial Supervision (NJS)	❒	Waived PDS - Probation
	❒	Judicial FWSN Supervision	❒	Non-Judicial Supervision Agreement	❒	
Court District:						
Court Handling Decision:			❒	Judicial	❒	Non-Judicial
Treatment Information: School						
Since the start of EBP treatment…						
Child's school attendance: *	❒	Good (few or no days missed)	❒	No School Attendance: Child Too Young for School	❒	No School Attendance: Other
	❒	Fair (several days missed)	❒	No School Attendance: Child Suspended/Expelled from School		
	❒	Poor (many days missed)	❒	No School Attendance: Child Dropped Out of School		
Suspended or expelled: *			❒	Yes	❒	No
IEP: * Does the child have an Individual Education Plan (special education)?			❒	Yes	❒	No
Treatment Information: Legal						
Since the start of EBP treatment…						
Arrested: * Has the child been arrested since start of treatment?			❒	Yes	❒	No
Detained or incarcerated: * Has the child been detained or incarcerated since start of treatment?			❒	Yes	❒	No
Treatment Information: Medical						

Discharge Facesheet (MATCH-ADTC & TF-CBT)

Since the start of EBP treatment…				
Alcohol and/or drugs problems: *	❒	Yes	❒	No
Evaluated in ER/ED for psychiatric issues: *	❒	Yes	❒	No
Certified medically complex: *	❒	Yes	❒	No

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