2026-2027 CFAA Quarterly Report Template
Field-by-Field Directions

General Instructions & Definitions

- Complete all light blue fields in the workbook.
- Do not leave any fields blank; enter "N/A" or "0" where applicable.
- Submit via secure email to BHD.Contracts@oha.oregon.gov within 45 calendar days after the quarter ends.

Quarter	Service Period	Report Due Date
1	01/01/2026 – 03/31/2026	**05/15/2026**
2	04/01/2026 – 06/30/2026	**08/17/2026**
3	07/01/2026 – 09/30/2026	**11/16/2026**
4	10/01/2026 – 12/31/2026	**02/15/2027**
5	01/01/2027 – 03/31/2027	**05/17/2027**
6	04/01/2027 – 06/30/2027	**08/16/2027**

Definitions:

- **Crisis Line:** A confidential telephone or digital service operated or contracted by an LMHA/CMHP to provide immediate support for individuals experiencing a behavioral health crisis.

- **Crisis Stabilization Program:** No-barrier or low-barrier crisis stabilization settings such as:
  - Hospital-Based Behavioral Health Emergency Stabilization Units
  - High-Intensity Behavioral Health Emergency Centers
  - High-Intensity Behavioral Health Extended Stabilization Centers
  - Moderate-Intensity Behavioral Health Crisis Centers
  - Moderate-Intensity Behavioral Health Extended Stabilization Centers
  - Behavioral Health Urgent Care
  - Peer Crisis Respite
  - Sobering Centers

  As identified in SAMHSA's Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services available at: https://988crisissystemshelp.samhsa.gov/sites/default/files/2025-08/SAMHSA_Model_Definitions_508_080525.pdf.

- **Service Priority area described in Subsection 2. of Exhibit B:**
  - **Priority #1:** Aid & Assist, PSRB, Civil Commitment
  - **Priority #2:** Individuals who are 18 years or older, and have a mental illness(es), including co-occurring mental health and Substance Use Disorders, and who as a result of their symptoms from their mental illness: Have had law enforcement contact that could have resulted in an arrest, citation, booking, criminal charge, or transport to jail, but have instead been referred to County for Services; Are in jail and are in need of mental health treatment; or In the previous six months, have been twice detained on an emergency hold under ORS 426.232 or on a warrant of detention under ORS 426.070 but have not yet, as a result, been civilly committed.
  - **Priority #3:** Individuals, who do not otherwise qualify under Priority #1 or #2, who: Are at immediate risk of hospitalization for the treatment of Mental or Emotional Disturbances, or are in need of Services to avoid hospitalization or posing a health or safety risk to themselves or others; Are under 18 years of age who, in accordance with the assessment of professionals in the field of mental health, are at immediate risk of removal from their homes for treatment of Mental or Emotional Disturbances or exhibit behavior indicating high risk of developing disturbances of a severe or persistent nature; Because of the nature of their mental illness, their geographic location or their family income, are least capable of obtaining assistance from the private sector; or In accordance with the assessment of professionals in the field of mental health, are experiencing Mental or Emotional Disturbances but will not require hospitalization in the foreseeable future.
  - **Priority #4:** Individuals, who do not otherwise qualify under Priority #1, #2, or #3, and who have or are at risk of developing a Mental or Emotional Disturbance or Substance Use Disorder.

- **Subsection 3.c.(4)(b) of Exhibit B:** Notwithstanding Section 2 of Exhibit B, the County shall prioritize providing forensic diversion services to:
  - Individuals described in Subsections 2.a and 2.b in Exhibit B;
  - Individuals the court has ordered to be evaluated under ORS 161.365 or ORS 161.370 and are in jail; and
  - Individuals who the court has determined lack trial competency under ORS 161.370 at least twice in the preceding 24 months.

- **Third-party interpreter services:** Third-party interpreter services refer to language interpretation provided by an external vendor or organization, rather than by in-house staff.

Cover Sheet - Provides basic identifying information for your organization and the reporting period.

Field Name	Input Type	Instructions
1. LMHA/CMHP	Dropdown Menu	Select your organization from the dropdown menu
2. CFAA #	Dropdown Menu	Select the assigned CFAA number from the dropdown menu
3. Reporting Quarter	Dropdown Menu	Select the applicable reporting quarter from the dropdown menu
4. Date Submitted	Fill-in	Enter the date you are submitting the report
5. Person to Contact with Questions	Fill-in	Enter the first and last name of the person the CFAA Administrator should contact if there are any questions about the report
5a. Email Address	Fill-in	Enter the email address of the contact person listed above
5b. Phone Number	Fill-in	Enter the phone number of the contact person listed above

Notes - Optional section to provide additional context or clarifications.

Field Name	Input Type	Instructions
1. Please use the space below to share any extra details or notes that will help BHD staff understand your submission	Fill-in	OPTIONAL – Enter any additional context or clarifications that will help BHD staff understand your submission

Fiscal Update - Summarizes financial progress for the quarter.

Field Name	Input Type	Instructions
1. What percentage of the total grant funds has been spent to date?	Fill-in	Enter percentage of total CFAA funds expended at the end of the reporting quarter
2. Are there any delays in spending that could impact project milestones or compliance?	Fill-in	Select "yes" or "no" from the dropdown menu
2a. If yes, describe:	Narrative	If "yes" is selected above, describe what is causing the delay, how long it is expected to continue, and what steps are being taken to address the delay
3. Are there any increases in spending that could impact the ability to provide the required services in one or more Core Service Area?	Fill-in	Select "yes" or "no" from the dropdown menu
3a. If yes, describe:	Narrative	If "yes" is selected above, describe what is causing the increase, how long it is expected to continue, and what steps are being taken to address the increase
4. Please use the space below for any additional notes or comments (if necessary):	Fill-in	OPTIONAL – Enter any additional context or clarifications that will help BHD staff understand your submission

Crisis Services - Reports data on CFAA-funded crisis services that are not collected in the quarterly MCIS/MRSS reports.

Crisis Stabilization Programs

Field Name	Input Type	Instructions
1. Please enter the number of individuals, by age, receiving CFAA-funded services in a Crisis Stabilization Program during this reporting quarter.	Table	Enter the aggregate number of individuals served in Crisis Stabilization Programs, by age, during this reporting quarter

Crisis Line Data

Field Name	Input Type	Instructions
2. Please enter the monthly aggregate number of calls received by caller type.	Table	Enter the aggregate number of calls by caller type for each month of the reporting quarter
3. Please enter the monthly aggregate number of calls received by age of the person experiencing the behavioral health crisis.	Table	Enter the aggregate number of calls by age of the person experiencing the behavioral health crisis for each month of the reporting quarter
4. Please enter the monthly aggregate number of calls received by need or presenting issue.	Table	Enter the aggregate number of calls by need or presenting issue for each month of the reporting quarter **Recognizing that it is not possible to include every scenario, please select the category that most accurately represents the caller's presenting issue**
5. Please enter the monthly aggregate number of calls received by the call resolution type.	Table	Enter the aggregate number of calls by the call resolution type for each month of the reporting quarter
6. Please enter the monthly aggregate number of calls received by the	Table	Enter the aggregate number of calls by the preferred language of the caller for each month of the reporting quarter

preferred language of the caller.		
7. Were third-party interpreter services necessary to complete the call?	Table	Enter the number of calls for each month of the reporting quarter that **did** and **did not** require third-party interpreter services to complete the call.
7a. Were third-party interpreter services provided?	Table	Of the calls where third-party interpreter services were necessary to complete the call, enter the number of calls for each month of the reporting quarter that **did** and **did not** receive third-party interpreter services
7b. If third-party interpreter services were needed, but not provided, please indicate why.	Table	Of the calls where third-party interpreter services were necessary to complete the call and those services were not provided, enter the aggregate number of calls by the reason third-party interpreter services were not provided for each month of the reporting quarter
7c. If "Other" selected in #7b., describe below:	Narrative	Enter the appropriate description if “Other” is indicated in the question above
8. Please use the space below for any additional notes or comments (if necessary)	Narrative	OPTIONAL – Enter any additional context or clarifications that will help BHD staff understand your submission

Civil Commitment - Confirmation of data submission in Smartsheet.

Field Name	Input Type	Instructions
1. Have all applicable individuals been added to the assigned Smartsheet, and is the information complete?	Dropdown Menu	Select “yes” or “no” from the dropdown menu
1a. If no, please use the space below describe why:	Narrative	Enter the appropriate description if “No” is indicated in the question above
2. Please use the space below for any additional notes or comments (if necessary)	Narrative	OPTIONAL – Enter any additional context or clarifications that will help BHD staff understand your submission

Forensic Diversion - Documents services for individuals receiving forensic diversion services.

Field Name	Input Type	Instructions
1. Please indicate the number of Individuals described in Subsection 3.c.(4)(b) of Exhibit B served during this quarter	Fill-in	Of the individuals listed in the table below, enter the total number who meet the terms outlined in Subsection 3.c.(4)(b) of Exhibit B in the CFAA
1a. How many of the Individuals in Question #1 had an attempt made to contact and complete BH screening within 7 business days of the applicable court order?	Fill-in	Enter the number of individuals in question #1 who had an attempt made to contact and complete a behavioral health screening within 7 business days of the applicable court order
1b. How many of the Individuals in Question #1 had an attempt made to contact and complete BH screening within 7 business days of the court, CMHP, a party, or OHA identifying the Individual as someone who the court determined lacked trial competency under ORS 161.370 at least twice in the preceding 24 months?	Fill-in	Enter the number of individuals in question #1 who had an attempt made to contact and complete a behavioral health screening within 7 business days of the CMHP becoming aware that the court had determined that they lacked trial competency under ORS 161.370 at least twice in the preceding 24 months
2. Please indicate the number of Individuals who have been determined by a certified forensic Evaluator to not need hospital level of care or who the CMHP has determined may be	Fill-in	Of the individuals listed in the table below, enter the number of Individuals who have been determined by a certified forensic Evaluator to not need hospital level of care or who the CMHP has determined may be appropriate for community placement.

appropriate for community placement		
2a. How many of the Individuals in Question #2 had a transition plan developed within 14 calendar days of the applicable determination?	Fill-in	Enter the number of individuals in question #2 who had a transition plan developed within 14 calendar days of the applicable determination
3. Please complete the fields in the table below for each Individual receiving Forensic Diversion Services during this quarter	Table	Enter the information listed in 3a. through 3s. for each individual receiving Forensic Diversion Services.
3a. Beginning Date of Services	Fill-in	Enter the date the individual started receiving Forensic Diversion Services
3b. Ending Date of Services	Fill-in	Enter the date the individual stopped receiving Forensic Diversion Services
3c. Medicaid ID # (if applicable)	Fill-in	If the individual is enrolled in Medicaid, enter their Medicaid ID number
3d. Last Name	Fill-in	Enter the individual's last name
3e. First Name	Fill-in	Enter the individual's first name
3f. Date of Birth	Fill-in	Enter the individual's date of birth
3g. Gender	Dropdown Menu	Select the individual's gender from the dropdown menu
3h. Race	Dropdown Menu	Select the individual's race from the dropdown menu
3i. Ethnicity	Dropdown Menu	Select the individual's ethnicity from the dropdown menu
3j. Referral Source/ Intercept Point	Dropdown Menu	Select the appropriate referral source/intercept point for the individual from the dropdown menu
3k. Number of Arrests in Reporting Period	Fill-in	Enter the number of times the CMHP is aware that the individual was arrested during the reporting period
3l. Behavioral Health Screening Provided?	Dropdown Menu	Select "yes" or "no" from the dropdown menu
3m. Mental Health Treatment Provided?	Dropdown Menu	Select "yes" or "no" from the dropdown menu
3n. Substance Use Treatment Provided?	Dropdown Menu	Select "yes" or "no" from the dropdown menu
3o. Case Management Provided?	Dropdown Menu	Select "yes" or "no" from the dropdown menu

3p. Received Crisis Services?	Dropdown Menu	Select “yes” or “no” from the dropdown menu
3q. Medication Management Provided?	Dropdown Menu	Select “yes” or “no” from the dropdown menu
3r. Benefit Assistance Provided?	Dropdown Menu	Select “yes” or “no” from the dropdown menu
3s. Housing Supports Provided?	Dropdown Menu	Select “yes” or “no” from the dropdown menu
4. Please use the space below for any additional notes or comments (if necessary)	Narrative	OPTIONAL – Enter any additional context or clarifications that will help BHD staff understand your submission

Outpatient & Community-Based Services - Reports data related to the Required Metrics in the Outpatient and Community-Based Services Core Service Area.

Field Name	Input Type	Instructions
1. Please indicate the number of Individuals enrolled in EASA during this quarter who were offered an appointment with a licensed medical provider within seven (7) business days of enrollment.	Fill-in	Enter the number of individuals who were offered an appointment with a licensed medical provider within seven (7) business days of enrollment in EASA
2. Please indicate the number of Individuals enrolled in EASA offered supported employment or supported education services during this quarter.	Fill-in	Enter the number of individuals enrolled in EASA who were offered supported employment or supported education services during this reporting quarter
3. Please indicate the number of Individuals enrolled in EASA and their families that have access to structured family psychoeducational groups during this quarter.	Fill-in	Enter the number of individuals enrolled in EASA and their families who have access to structured family psychoeducational groups during this quarter
4. Please provide aggregate numbers of Individuals screened for 1915i Home and Community-Based Services during this quarter in the table below	Table	Enter the aggregate number of individuals receiving Outpatient & Community-Based Services that are screened, potentially eligible, and referred for 1915i Home & Community Based Services during this quarter
4a. Number of Individuals Screened	Fill-in	Enter the aggregate enter the aggregate number of individuals, by age, who are receiving Outpatient & Community-Based Services and were screened for 1915i Home & Community Based Services during this quarter

4b. Number of Individuals Potentially Eligible	Fill-in	Of the individuals screened in question #4a., enter the aggregate number of individuals, by age, who were potentially eligible for 1915i Home & Community Based Services during this quarter
4c. Number of Individuals Referred	Fill-in	Of the individuals who were potentially eligible in question #4b., enter the aggregate number of individuals, by age, who were referred for 1915i Home & Community Based Services during this quarter
5. For CMHPs that operate ACT programs directly: Please indicate the number of Individuals deemed eligible for ACT during this quarter.	Fill-in	For CMHPs that operate ACT programs directly, enter the number of individuals deemed eligible for ACT during this quarter.
5a. How many of those Individuals were sent a letter of acceptance per OAR 309-019-0248?	Fill-in	Of those individuals in question #5, enter the number who were sent a letter of acceptance per OAR 309-019-0248
6. Please provide aggregate number of Individuals who received barrier removal services during this quarter by Service Priority area described in Subsection 2. of Exhibit B.	Table	Enter the aggregate number of individuals served who received barrier removal services during this quarter by Service Priority area described in Subsection 2. of Exhibit B
6a. Phone or internet bills	Fill-in	Enter the aggregate number of individuals, by Service Priority area described in Subsection 2. of Exhibit B, who received assistance with phone or internet bills
6b. Transportation	Fill-in	Enter the aggregate number of individuals, by Service Priority area described in Subsection 2. of Exhibit B, who received assistance with transportation
6c. Interpreter Services	Fill-in	Enter the aggregate number of individuals, by Service Priority area described in Subsection 2. of Exhibit B, who received assistance with interpreter services
6d. Medical Services or Medications	Fill-in	Enter the aggregate number of individuals, by Service Priority area described in Subsection 2. of

		Exhibit B, who received assistance with medical services or medications
6e. Costs associated with obtaining/ continuing representative payee services	Fill-in	Enter the aggregate number of individuals, by Service Priority area described in Subsection 2. of Exhibit B, who received assistance with Costs associated with obtaining/ continuing representative payee services
6f. Costs associated with obtaining/ continuing guardianship services	Fill-in	Enter the aggregate number of individuals, by Service Priority area described in Subsection 2. of Exhibit B, who received assistance with costs associated with obtaining/continuing guardianship services
6g. Other (please describe below)	Fill-in	Enter the aggregate number of individuals, by Service Priority area described in Subsection 2. of Exhibit B, who received assistance with other barrier removal services
7. If "Other" selected in #6g., describe below	Narrative	Enter the appropriate description if "Other" is indicated in question 6g
8. Was at least one workforce development training in geriatric Behavioral Health competencies provided this quarter?	Dropdown Menu	Select "yes" or "no" from the dropdown menu
8a. If yes, please provide a description below including the topic and the number of participants.	Narrative	Enter the appropriate description if "Yes" is indicated in question 8.
8b. If no, please use the space below describe why	Narrative	Enter the appropriate description if "No" is indicated in question 8a.
9. Please use the space below for any additional notes or comments (if necessary)	Narrative	OPTIONAL – Enter any additional context or clarifications that will help BHD staff understand your submission

Residential & Housing Support Services - Reports data related to the Required Metrics in the Residential and Housing Support Services Core Service Area.

Field Name	Input Type	Instructions
1. Please provide aggregate numbers of Individuals screened for 1915i Home and Community-Based Services during this quarter in the table below	Table	Enter the aggregate number of individuals receiving Residential & Housing Support Services that are screened, potentially eligible, and referred for 1915i Home & Community Based Services during this quarter
1a. Number of Individuals Screened	Fill-in	Enter the aggregate enter the aggregate number of individuals, who are receiving Outpatient & Community-Based Services and were screened for 1915i Home & Community Based Services during this quarter
1b. Number of Individuals Potentially Eligible	Fill-in	Of the individuals screened in question #1a., enter the aggregate number of individuals, by age, who were potentially eligible for 1915i Home & Community Based Services during this quarter
1c. Number of Individuals Referred	Fill-in	Of the individuals who were potentially eligible in question #1b., enter the aggregate number of individuals who were referred for 1915i Home & Community Based Services during this quarter
2. Please provide aggregate numbers of Individuals who were discharged from residential treatment during this quarter in the table below:	Table	Enter the aggregate number of individuals, by residential treatment type, who were discharged and offered transition support services.
2a. Number of Individuals discharged from residential treatment services.	Fill-in	Enter the aggregate number of individuals who were discharged from residential treatment during this reporting quarter, by residential type.
2b. Number of Individuals who were offered Services to assist with their transition to outpatient Services prior to discharge from residential treatment.	Fill-in	Of the individuals in 2a., enter the aggregate number who were offered services to assist with their transition prior to discharge.

3. Please provide aggregate number of Individuals who received barrier removal services during this quarter by Service Priority area described in Subsection 2. of Exhibit B.	Table	Enter the aggregate number of individuals served who received barrier removal services during this quarter by Service Priority area described in Subsection 2. of Exhibit B
3a. Rental Assistance	Fill-in	Enter the aggregate number of individuals, by Service Priority area described in Subsection 2. of Exhibit B, who received assistance with rental assistance
3b. Housing Support Services	Fill-in	Enter the aggregate number of individuals, by Service Priority area described in Subsection 2. of Exhibit B, who received assistance with housing support services
3c. Room & Board Payments	Fill-in	Enter the aggregate number of individuals, by Service Priority area described in Subsection 2. of Exhibit B, who received assistance with room & board payments
3d. Utility Bills & Deposits	Fill-in	Enter the aggregate number of individuals, by Service Priority area described in Subsection 2. of Exhibit B, who received assistance with utility bills & deposits
3e. Phone or Internet Bills	Fill-in	Enter the aggregate number of individuals, by Service Priority area described in Subsection 2. of Exhibit B, who received assistance with phone or internet bills
3f. Moving & Storage Costs	Fill-in	Enter the aggregate number of individuals, by Service Priority area described in Subsection 2. of Exhibit B, who received assistance with moving and storage costs
3g. Household Goods & Supplies	Fill-in	Enter the aggregate number of individuals, by Service Priority area described in Subsection 2. of Exhibit B, who received assistance with household goods and supplies
3h. Cleaning or Pest Management Services	Fill-in	Enter the aggregate number of individuals, by Service Priority area described in Subsection 2. of Exhibit B, who received assistance with cleaning or pest management services
3i. Interpreter Services	Fill-in	Enter the aggregate number of individuals, by Service Priority area described in Subsection 2. of

		Exhibit B, who received assistance with interpreter services
3j. Other (describe below)	Fill-in	Enter the aggregate number of individuals, by Service Priority area described in Subsection 2. of Exhibit B, who received assistance with other barrier removal services
4. If "Other" selected in #3j., describe below	Narrative	Enter the appropriate description if “Other” is indicated in question 3j
5. Please use the space below for any additional notes or comments (if necessary)	Narrative	OPTIONAL – Enter any additional context or clarifications that will help BHD staff understand your submission

Behavioral Health Promotion & Prevention (BHPP) - Reports data related to the Required Metrics in the Behavioral Health Promotion & Prevention Core Service Area.

Field Name	Input Type	Instructions
1. How many trainings/community events were held this quarter?	Fill-in	Enter the number of trainings/community events held this quarter
1a. How many people attended? (estimates accepted when appropriate)	Fill-in	Enter the number of people who attended the trainings/community events held this quarter
1b. Please indicate the number of pre/post surveys offered during Behavioral Health Promotion & Prevention activities this quarter.	Fill-in	Of the people indicated in 1a., enter the number who were offered pre/post surveys during this quarter
1c. Please indicate the number responding that report an increased understanding of mental health, substance use prevention, and available resources.	Fill-in	Of the people offered pre/post surveys in 1b, enter the number who reported an increased understanding of mental health, substance use prevention, and available resources
1d. Please indicate the number responding that report a change in attitude toward mental health, substance use, or coping strategies.	Fill-in	Of the people offered pre/post surveys in 1b, enter the number who reported a change in attitude toward mental health, substance use, or coping strategies
1e. Please indicate the number responding that report an increased likelihood of engaging in behavior change such as accessing counseling Services or delaying or decreasing use of alcohol and other drugs.	Fill-in	Of the people offered pre/post surveys in 1b, enter the number who reported an increased likelihood of engaging in behavior change such as accessing counseling Services or delaying or decreasing use of alcohol and other drugs
2. Please use the space below to provide a brief narrative summary of the	Narrative	Enter a brief narrative summary of the Behavioral Health Promotion & Prevention services/activities provided this quarter

Behavioral Health Promotion & Prevention services/activities provided this quarter.		
3. Please use the space below for any additional notes or comments (if necessary)	Narrative	OPTIONAL – Enter any additional context or clarifications that will help BHD staff understand your submission

SUPTRS 10a - Enter admissions, persons served, mean, median by level of care.

Field Name	Input Type	Instructions
1. Withdrawal Management (24-Hour Care): Hospital Inpatient	Fill-in	Enter the number of admissions and people served whose services were supported, in whole or in part by SUPTRS Block Grant funds, through hospital inpatient withdrawal management
2. Withdrawal Management (24-Hour Care): Free-Standing Residential	Fill-in	Enter the number of admissions and people served whose services were supported, in whole or in part by SUPTRS Block Grant funds, through free-standing residential withdrawal management
3. Rehabilitation/ Residential: Hospital Inpatient	Fill-in	Enter the number of admissions and people served whose services were supported, in whole or in part by SUPTRS Block Grant funds, through hospital inpatient rehabilitation/residential
4. Rehabilitation/ Residential: Short-Term (up to 30 days)	Fill-in	Enter the number of admissions and people served whose services were supported, in whole or in part by SUPTRS Block Grant funds, through short-term (up to 30 days) rehabilitation/residential
5. Rehabilitation/ Residential: Long-Term (over 30 days)	Fill-in	Enter the number of admissions and people served whose services were supported, in whole or in part by SUPTRS Block Grant funds, through long-term (over 30 days) rehabilitation/residential
6. Ambulatory (Outpatient): Outpatient	Fill-in	Enter the number of admissions and people served whose services were supported, in whole or in part by SUPTRS Block Grant funds, through ambulatory outpatient
7. Ambulatory (Outpatient): Intensive Outpatient	Fill-in	Enter the number of admissions and people served whose services were supported, in whole or in part by SUPTRS Block Grant funds, through ambulatory intensive outpatient
8. Ambulatory (Outpatient): Withdrawal Management	Fill-in	Enter the number of admissions and people served whose services were supported, in whole or in part by SUPTRS Block Grant funds, through ambulatory withdrawal management
9. MOUD: Withdrawal Management with Opioid Agonist Meds	Fill-in	Enter the number of individuals who received MOUD: withdrawal management with opioid agonist meds, funded in whole or in part by SUPTRS Block Grant funds

10. MOUD: Continuous MOUD & Other Services in Outpatient Settings	Fill-in	Enter the number of individuals who received MOUD: continuous MOUD & other services in outpatient settings, funded in whole or in part by SUPTRS Block Grant funds
11. Please use the space below for any additional notes or comments (if necessary)	Narrative	OPTIONAL – Enter any additional context or clarifications that will help BHD staff understand your submission

SUPTRS 10b - Aggregate counts for recovery support services by age, sex, and service type.

Field Name	Input Type	Instructions
1. **Peer-to-Peer Support Individual**	Fill-in	Enter the number of individuals, by age and gender, who received individual peer-to-peer support services that were funded in whole or in part by SUPTRS Block Grant funds
2. **Peer-Led Support Group**	Fill-in	Enter the number of individuals, by age and gender, who received peer-led support group services that were funded in whole or in part by SUPTRS Block Grant funds
3. **Peer-Led Training or Peer Certification Activity**	Fill-in	Enter the number of individuals, by age and gender, who received peer-led training or peer certification activities that were funded in whole or in part by SUPTRS Block Grant funds
4. **Recovery Housing**	Fill-in	Enter the number of individuals, by age and gender, who received recovery housing that was funded in whole or in part by SUPTRS Block Grant funds
5. **Recovery Support Service Childcare Fee or Family Caregiver Fee**	Fill-in	Enter the number of individuals, by age and gender, who received recovery support service, childcare fees, or family caregiver fees that were funded in whole or in part by SUPTRS Block Grant funds
6. **Recovery Support Service Transportation**	Fill-in	Enter the number of individuals, by age and gender, who received recovery support service transportation that was funded in whole or in part by SUPTRS Block Grant funds
7. **Secondary School, High School, or Collegiate Recovery Program Service or Activity**	Fill-in	Enter the number of individuals, by age and gender, who received secondary school, high school, or collegiate recovery program services or activities that were funded in whole or in part by SUPTRS Block Grant funds
8. **Recovery Social Support or Social Inclusion Activity**	Fill-in	Enter the number of individuals, by age and gender, who received recovery social support or social inclusion activities that were funded in whole or in part by SUPTRS Block Grant funds
9. **Other Approved Recovery Support Event or Activity***	Fill-in	Enter the number of individuals, by age and gender, who received other approved recovery support events or activities that were funded in whole or in part by SUPTRS Block Grant funds

10. Please use the space below for any additional notes or comments (if necessary)	Narrative	OPTIONAL – Enter any additional context or clarifications that will help BHD staff understand your submission

***Other Approved Recovery Support Events or Activities include:**

- Recovery Health and Wellness Educational Event or Activity;
- Peer-Led Recovery Educational Workshop or Event;
- Culturally Based Recovery Practice or Creative and Expressive Arts Recovery Activity;
- Peer-Led Recovery Educational Workshop or Event; Recovery Friendly Workplace (RFW) Initiative, Activity, or Supportive Employment Service;
- Recovery Friendly Workplace (RFW) Initiative, Activity, or Supportive Employment Service;
- Recovery Community Organization (RCO) or Recovery Community Center (RCC) Service or Activity

SUPTRS 11a - Admissions by age, sex, race, ethnicity; include pregnancy status.

Field Name	Input Type	Instructions
1. Age/Gender/Race of Individuals Served with SUPTRS Block Grant Funds	Table	Enter the number of individuals – by age, gender, and race – served in whole or in part by SUPTRS Block Grant funds
2. Age/Gender/Ethnicity of Individuals Served with SUPTRS Block Grant Funds	Table	Enter the number of individuals – by age, gender, and ethnicity – served in whole or in part by SUPTRS Block Grant funds
3. Please use the space below for any additional notes or comments (if necessary)	Narrative	OPTIONAL – Enter any additional context or clarifications that will help BHD staff understand your submission