



Substance Use Disorder Facilitating Center Quarterly Report

Organization Name: _____

Reporting Period: _____

Organizational point of contact (person completing the report):

Name: _____

Phone number: _____

E-mail: _____

Use the text box to respond to the questions below.

Status of Facilitating Center Development include implementation progress, FTE hired, accomplishments, successes and barriers.

Attach any products or deliverables completed or in draft or send links as appropriate (pictures are also an option).

What would you like to share about the project success at this time?

Number of people receiving SUDS PDS trainings (as appropriate)

Number of people receiving SUDs PDS services (as appropriate)

(Optional) Please tell us some success stories from this last quarter.

Authorized Signature _____ Date: _____

Facilitating Center Services Provided	Quarterly Report Due
July-September	November 14th
October-December	February 14th
January- March	May 15th
April-June	June 30th

Completed forms should be returned electronically to: AMHcontract.Administrator@state.or.us