

NC-TOPPS

TASC CJM Episode Completion 2023

****Use this form for backup only. Enter data into web-based system. (<https://nctopps.ncdmh.net/tasc.htm>)**

Clinician First Initial & Last Name

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Please provide the following information about the consumer:

Consumer ID

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of Birth

		/			/		
--	--	---	--	--	---	--	--

Gender Assigned at Birth

Male Female

1. Date Consumer Discharged from TASC:

		/			/		
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2. Date Consumer Admitted to TASC (this episode):

		/			/		
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3. County of TASC Management: _____

4. Did the consumer complete TASC services?

Yes -> (skip to 5)

No

b. Reason for not completing TASC services:

Probation non-compliance/revocation -> (answer c)

Consumer deceased -> (skip to 5)

Consumer moved/relocated -> (skip to 5)

TASC non-compliance/no-show -> (answer d)

c. Reason for probation non-compliance/revocation:

Technical New crime Absconder

d. Reason for TASC non-compliance/no-show:

Client fails to comply with requirements of jeopardy staffings

Client is arrested or convicted of a charge, which precludes his/her continued participation in TASC

Client acts violently or threatens violence against TASC staff, treatment staff, or another client

Client is in possession of a weapon at TASC or treatment program sites

Client is in possession of drugs or alcohol at TASC or treatment program sites

No contact with TASC in 30 calendar days (requires a minimum of two attempts to contact the client and supervisory review)

5. Is the consumer or a member of the consumer's immediate family or household currently serving in or has served in the Military, Military Reserve or National Guard?

Yes, active Military, Military Reserve or National Guard

Yes, veteran or prior service member

Yes, family member

No

6. At any time in the past, has the consumer been suspected of having a head or brain injury?

Yes No

7. NC Docket Number (current, most serious): (Skip to question 8 if state of arrest for this episode was *not* in North Carolina)

		<input type="checkbox"/> CR <input type="checkbox"/> CRS																	
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8. Primary Diagnosis: (Select one or enter primary diagnosis below)

- 305.00 - Alcohol Use Disorder, Mild
- 303.90 - Alcohol Use Disorder, Moderate
- 303.90 - Alcohol Use Disorder, Severe
- 305.20 - Cannabis Use Disorder, Mild
- 304.30 - Cannabis Use Disorder, Moderate
- 304.30 - Cannabis Use Disorder, Severe
- 305.60 - Cocaine Use Disorder, Mild
- 304.20 - Cocaine Use Disorder, Moderate
- 304.20 - Cocaine Use Disorder, Severe
- 305.50 - Opioid Use Disorder, Mild
- 304.00 - Opioid Use Disorder, Moderate
- 304.00 - Opioid Use Disorder, Severe
- 305.70 - Amphetamine Use Disorder, Mild
- 304.40 - Amphetamine Use Disorder, Moderate
- 304.40 - Amphetamine Use Disorder, Severe
- 305.90 - Inhalant Use Disorder, Mild
- 304.60 - Inhalant Use Disorder, Moderate
- 304.60 - Inhalant Use Disorder, Severe
- 305.40 - Sedative, Hypnotic, or Anxiolytic Use Disorder, Mild
- 304.10 - Sedative, Hypnotic, or Anxiolytic Use Disorder, Moderate
- 304.10 - Sedative, Hypnotic, or Anxiolytic Use Disorder, Severe
- 305.90 - Phencyclidine Use Disorder, Mild
- 304.60 - Phencyclidine Use Disorder, Moderate
- 304.60 - Phencyclidine Use Disorder, Severe

Primary diagnosis if not listed above:

				.		
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No diagnosis

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9. Currently, where does the consumer live most of the time?

Homeless → (answer b)

Temporary housing → (answer c)

Private or permanent residence → (answer d if adult, skip to 10 if adolescent)

Residential program → (answer e if adult, answer f if adolescent)

Facility/institution → (answer g)

Other → (skip to 10)

b. If *homeless*, please specify the consumer's living situation currently.

Sheltered (homeless shelter)

Unsheltered (on the street, in a car, camp)

c. If *temporary housing*, please specify the type of temporary housing the consumer currently lives in.

Transitional housing (time-limited stay)

Living temporarily with other(s)

d. **For Adult TASC consumer only:** If *private residence*, please specify the type of residence the consumer currently lives in.

Self-owned

Rent with rental assistance

Rent without rental assistance

Other

e. **For Adult TASC consumer only:** If *residential program*, please specify the type of residential program the consumer currently lives in.

Alternative family living Licensed supervised apartment

Group home Family care home

Residential treatment center Halfway house

f. **For Adolescent TASC consumer only:** If *residential program*, please specify the type of residential program the consumer currently lives in.

Foster home

Therapeutic foster home

Level III group home

Level IV group home

State-operated residential treatment center

Substance abuse residential treatment facility

Halfway house

g. If *facility/institution*, please specify the type of facility the consumer currently lives in.

PRTF (adolescent only)

Public institution

Private institution

Adult care home/assisted living (adult only)

Nursing facility (adult only)

Correctional facility

10. What is the highest grade the consumer completed or degree s/he received in school?

Grade K, 1, 2, 3, 4, or 5 Some college or technical/vocational school

Grade 6, 7, or 8 2-year college/assoc. degree

Grade 9, 10, 11, or 12 (no diploma) 4-year college degree

GED Graduate work, no degree

High school diploma Professional degree or more

11. Was a GED or other degree(s) completed during TASC?

Yes No

12. Is the consumer currently enrolled in school or courses that satisfy requirements for a certification, diploma or degree? Yes No → (skip to 13)

b. If **yes**, mark all that apply:

High School Technical/Vocational school

GED Program, Adult literacy Other

College

13. What best describes the consumer's employment status at Episode Completion? (mark only one)

Full-time work (working 35 hours or more a week) → (skip to 14)

Part-time work (working less than 35 hours a week) → (skip to 14)

Unemployed (seeking work or on layoff from a job) → (skip to 14)

Not in labor force (not seeking work)

b. If *not seeking work*, what best describes the consumer's current status?

Homemaker Chronic medical condition which prevents employment

Student

Retired None of the above

14. In the past 3 months, how often did the consumer participate in ...

a. positive community/leisure (extracurricular) activities?

Never A few times More than a few times

b. recovery-related support or self-help groups?

Never → (answer c)

A few times

More than a few times

b-1. In the past month, how many times did the consumer attend recovery-related support or self-help groups?

Did not attend in past month

1-3 times (less than once per week)

4-7 times (about once per week)

8-15 times (2 or 3 times per week)

16-30 times (4 or more times per week)

some attendance, but frequency unknown

c. organized religious activities?

Never A few times More than a few times

15. Does the consumer have a sponsor?

Yes No → (skip to 16)

b. In the past month, how often did the consumer have contact with his/her sponsor?

Never A few times More than a few times

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16. Please indicate the consumer's Primary (required), Secondary (if applicable), and Tertiary (if applicable) substance problems by entering a "1" for Primary, "2" for Secondary, and "3" for Tertiary.

<input type="checkbox"/> Alcohol	<input type="checkbox"/> Marijuana/ Hashish	<input type="checkbox"/> Cocaine/Crack	<input type="checkbox"/> Methamphetamine	<input type="checkbox"/> Heroin
<input type="checkbox"/> Other Opiates/ Opioids	<input type="checkbox"/> Non-Prescription Methadone	<input type="checkbox"/> PCP-Phencyclidine	<input type="checkbox"/> Other Hallucinogens	<input type="checkbox"/> Other Amphetamines
<input type="checkbox"/> Other Stimulants	<input type="checkbox"/> Benzodiazepine	<input type="checkbox"/> Other Non- Benzodiazepine Tranquilizers	<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Other Non-Barbiturate Sedatives or Hypnotics
<input type="checkbox"/> Inhalants	<input type="checkbox"/> Over-the-Counter	<input type="checkbox"/> Prescription Drug	<input type="checkbox"/> Other Drug	<input type="checkbox"/> Mental Health only, no co-occurring substance use -> (skip to 19)

17. Please indicate the consumer's age at first use/intoxication and how each substance was taken (if applicable) for the Primary, Secondary (if applicable), and Tertiary (if applicable) substance(s).

Substance	Age of First Use/ Intoxication	How usually taken (mark only one)
Alcohol _____	<input type="text"/> <input type="text"/>	N/A
Marijuana/Hashish _____	<input type="text"/> <input type="text"/>	N/A
Cocaine/Crack _____	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Methamphetamine _____	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Heroin _____	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Other Opiates/Opioids _____	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Non-Prescription Methadone _____	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
PCP-phencyclidine _____	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Other Hallucinogens _____	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Other Amphetamines _____	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Other Stimulants _____	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Benzodiazepine _____	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Other Non- Benzodiazepine Tranquilizers _____	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Barbiturates _____	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Other Non-Barbiturate Sedatives or Hypnotics _____	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Inhalants _____	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Over-the-Counter _____	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Prescription Drug _____	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Other Drug _____	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other

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18. Please mark the frequency of use for each substance in the past month.

Substance	Past Month - Frequency of Use				
	Not Used	1-3 times monthly	1-2 times weekly	3-6 times weekly	Daily
Tobacco use (any tobacco products)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy alcohol use (>=5(4) drinks per sitting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Less than heavy alcohol use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana or hashish use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine or crack use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other opiates/opioids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Drug Use <input type="text"/> <input type="text"/> (enter code from list below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Other Drug Codes**
- | | | |
|------------------------------|----------------------------------------------|----------------------|
| 5=Non-prescription Methadone | 13=Other Tranquilizer | 30=Prescription Drug |
| 7=PCP | 14=Barbiturate | |
| 8=Other Hallucinogen | 15=Other Sedative or Hypnotic | |
| 9=Methamphetamine | 16=Inhalant | |
| 10=Other Amphetamine | 17=Over-the-Counter | |
| 11=Other Stimulant | 22=Oxycodone (OxyContin, Percocet, Percodan) | |
| 12=Benzodiazepine | 29=MDMA (Ecstasy) | |

19. Drug test results from all sources in the past 3 months (or since admission if consumer was not in TASC for 3 months):

a. Number Conducted b. Number Positive
(enter 0, if none & skip to 20)

c. How often did each substance appear for all tests conducted?

Alcohol	THC	Opiates	Benzo.
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Cocaine	Amphetamines	Barbiturates	
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	

20. In the past month, how many times has the consumer been arrested (or had a petition filed for adjudication) for any offense including DWI?

-> (enter 0, if none)

21. Please indicate the consumer's DAC Supervision Level.

- Level 1
 Level 2
 Level 3
 Level 4
 Level 5

22. Please indicate the consumer's DAC Need Level.

- Extreme (L1)
 High (L2)
 Moderate (L3)
 Low (L4)
 Minimal (L5)

23. Date of Last Face-to-Face Contact with Consumer:

/ /

24. Level of Care Management prior to Episode Completion:

- Level I Level II Level III

25. Does the consumer have a special need for any of the following? (mark all that apply)

- | | |
|-------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Wheelchair/Mobility needs | <input type="checkbox"/> Visually impaired |
| <input type="checkbox"/> Physical disability | <input type="checkbox"/> Child care |
| <input type="checkbox"/> Deaf/Hard of hearing | <input type="checkbox"/> Frail senior |
| <input type="checkbox"/> Sign language interpreter | <input type="checkbox"/> Other |
| <input type="checkbox"/> Foreign language interpreter | <input type="checkbox"/> None of the above/NA |

26. Services and Supports Rendered: (mark all that apply)

- | | |
|----------------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Drug and other education classes | <input type="checkbox"/> Therapeutic community |
| <input type="checkbox"/> CBI -> (answer a) | <input type="checkbox"/> AA/NA/Self help |
| <input type="checkbox"/> Mental health services | <input type="checkbox"/> Drug treatment court |
| <input type="checkbox"/> Detox | <input type="checkbox"/> DART Cherry |
| <input type="checkbox"/> Pre-treatment education | <input type="checkbox"/> Black Mountain |
| <input type="checkbox"/> SA outpatient -> (answer b) | <input type="checkbox"/> Crisis Services |
| <input type="checkbox"/> SA Intensive Outpatient (IOP) -> (answer c) | <input type="checkbox"/> Medication Management |
| <input type="checkbox"/> SA Day Treatment | <input type="checkbox"/> Other |
| <input type="checkbox"/> Residential | <input type="checkbox"/> None |

a. If CBI, who is funding/paying for CBI services?

- TECS
 Non-TECS

b. If SA Outpatient, who is funding/paying for SA Outpatient services?

- TECS
 Non-TECS

c. If SA Intensive Outpatient (IOP), who is funding/paying for SA Intensive Outpatient (IOP) services?

- TECS
 Non-TECS