

# NC-TOPPS

## TASC CJM Intake 2024

**\*\*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

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Date of Birth

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County of TASC Management:

Gender Assigned at Birth:

☐ Male ☐ Female

1. Date Consumer Referred to TASC

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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2. TASC Referrals

- ☐ Eligible to receive TASC services
- ☐ Not Eligible - no involvement in CJS → (Stop here)
- ☐ Not Eligible - refused to participate → (Stop here)
- ☐ Not Eligible - no SA/MH issue → (Stop here)
- ☐ No Show → (Stop here)

3. State of Arrest → Skip to question 4 if not NC

b. NC County of Arrest:

c. NC Docket Number (current, most serious):

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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4. OPUS Number:

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5. TASC Assessment Date

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6. Is the consumer of Hispanic, Latino, or Spanish origin? ☐ Yes ☐ No → (skip to 7)

b. If **yes**, please specify origin:

- ☐ Hispanic, Mexican American
- ☐ Hispanic, Puerto Rican
- ☐ Hispanic, Cuban
- ☐ Hispanic, Other

7. Which of these groups best describes the consumer?

- ☐ African American/Black ☐ Alaska Native
- ☐ White/Anglo/Caucasian ☐ Asian
- ☐ Multiracial ☐ Pacific Islander
- ☐ American Indian/Native American ☐ Other

8. What is the consumer's current marital status? (include same sex partnerships as living as married)

- ☐ Married ☐ Separated
- ☐ Living as married ☐ Widowed
- ☐ Divorced ☐ Never been married

9. 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

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

- ☐ Yes ☐ No

11. Primary Diagnosis: (Select one or enter primary diagnosis below)

- ☐ F10.10 - Alcohol Use Disorder, Mild
- ☐ F10.20 - Alcohol Use Disorder, Moderate
- ☐ F10.20 - Alcohol Use Disorder, Severe
- ☐ F12.10 - Cannabis Use Disorder, Mild
- ☐ F12.20 - Cannabis Use Disorder, Moderate
- ☐ F12.20 - Cannabis Use Disorder, Severe
- ☐ F14.10 - Cocaine Use Disorder, Mild
- ☐ F14.20 - Cocaine Use Disorder, Moderate
- ☐ F14.20 - Cocaine Use Disorder, Severe
- ☐ F11.10 - Opioid Use Disorder, Mild
- ☐ F11.20 - Opioid Use Disorder, Moderate
- ☐ F11.20 - Opioid Use Disorder, Severe
- ☐ F15.10 - Amphetamine or Other or Unspecified Stimulant Use Disorder, Mild
- ☐ F15.20 - Amphetamine or Other or Unspecified Stimulant Use Disorder, Moderate
- ☐ F15.20 - Amphetamine or Other or Unspecified Stimulant Use Disorder, Severe
- ☐ F18.10 - Inhalant Use Disorder, Mild
- ☐ F18.20 - Inhalant Use Disorder, Moderate
- ☐ F18.20 - Inhalant Use Disorder, Severe
- ☐ F13.10 - Sedative, Hypnotic, or Anxiolytic Use Disorder, Mild
- ☐ F13.20 - Sedative, Hypnotic, or Anxiolytic Use Disorder, Moderate
- ☐ F13.20 - Sedative, Hypnotic, or Anxiolytic Use Disorder, Severe
- ☐ F16.10 - Phencyclidine or Other Hallucinogen Use Disorder, Mild
- ☐ F16.20 - Phencyclidine or Other Hallucinogen Use Disorder, Moderate
- ☐ F16.20 - Phencyclidine or Other Hallucinogen Use Disorder, Severe
- Primary diagnosis if not listed above:

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☐ No diagnosis

☐ MH Only diagnosis → (skip questions 20-23)

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

**12. In the past 3 months, where did the consumer live most of the time?**

- ☐ Homeless → (answer b)
- ☐ Temporary housing → (answer c)
- ☐ Private or permanent residence → (answer d if adult, skip to 13 if adolescent)
- ☐ Residential program → (answer e if adult, answer f if adolescent)
- ☐ Facility/institution → (answer g)
- ☐ Other → (skip to 13)

b. If homeless, please specify the consumer's living situation most of the time in the past 3 months.

- ☐ Sheltered (homeless shelter)
- ☐ Unsheltered (on the street, in a car, camp)

c. If temporary housing, please specify the type of temporary housing the consumer lived in most of the time in the past 3 months.

- ☐ 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 lived in most of the time in the past 3 months.

- ☐ Self-owned ☐ Rent without rental assistance
- ☐ Rent with rental assistance ☐ Other

e. **For Adult TASC consumer only:** If residential program, please specify the type of residential program the consumer lived in most of the time in the past 3 months.

- ☐ 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 lived in most of the time in the past 3 months.

- ☐ 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 lived in most of the time in the past 3 months.

- ☐ PRTF (adolescent only)
- ☐ Public institution
- ☐ Private institution
- ☐ Adult care home/assisted living (adult only)
- ☐ Nursing facility (adult only)
- ☐ Correctional facility

**13. 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

**14. Is the consumer currently enrolled in school or courses that satisfy requirements for a certification, diploma or degree?**

- ☐ Yes ☐ No → (skip to 15)

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

- ☐ High School ☐ Technical/Vocational school
- ☐ GED Program, Adult literacy ☐ Other
- ☐ College

**15. In the past 3 months, what best describes the consumer's employment status? (mark only one)**

- ☐ Full-time work (working 35 hours or more a week) → (skip to 16)
- ☐ Part-time work (working less than 35 hours a week) → (skip to 16)
- ☐ Unemployed (seeking work or on layoff from a job) → (skip to 16)
- ☐ Not in labor force (not seeking work)

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

- ☐ Homemaker
- ☐ Student
- ☐ Retired
- ☐ Chronic medical condition which prevents employment
- ☐ None of the above

**16. 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

**17. Does the consumer have a sponsor?**

- ☐ Yes ☐ No → (skip to 18)

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

**18. Referral Source: (mark primary referral)**

- ☐ Judge/Court ☐ Attorney/Self-Referral
- ☐ DAC (probation, CJP post-release) ☐ Other
- ☐ Tailored Plan

**19. Females only : Is the consumer currently pregnant?**

- ☐ Yes ☐ No ☐ Unsure

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**20. If Primary Diagnosis is not MH Only, 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"/> Fentanyl                                   | <input type="checkbox"/> Other Opiates/Opioids | <input type="checkbox"/> Non-Prescription Methadone | <input type="checkbox"/> PCP-Phencyclidine                         | <input type="checkbox"/> Other Hallucinogen |
| <input type="checkbox"/> Other Amphetamine                          | <input type="checkbox"/> Other Stimulant       | <input type="checkbox"/> Benzodiazepine             | <input type="checkbox"/> Other Non-Benzodiazepine Tranquilizer     | <input type="checkbox"/> Barbiturate        |
| <input type="checkbox"/> Other Non-Barbiturate Sedative or Hypnotic | <input type="checkbox"/> Inhalant              | <input type="checkbox"/> Over-the-Counter           | <input type="checkbox"/> Oxycodone (OxyContin, Percocet, Percodan) | <input type="checkbox"/> MDMA (Ecstasy)     |
| <input type="checkbox"/> Prescription Drug                          | <input type="checkbox"/> Ketamine              | <input type="checkbox"/> Spice                      | <input type="checkbox"/> Dilantin                                  | <input type="checkbox"/> GHB/GBL            |
| <input type="checkbox"/> Cannabinoids, Delta THC/Other Synthetic    | <input type="checkbox"/> Other Drug            |   |  |   |

**21. If Primary Diagnosis is not MH Only, 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/<br>Intoxication         | How usually taken<br>(mark only one)   | Substance                                     | Age of First Use/<br>Intoxication         | How usually taken<br>(mark only one)   |
|--|---|--|---|---|--|
| Alcohol                                  | <input type="text"/> <input type="text"/> | N/A  | Barbiturate                                   | <input type="text"/> <input type="text"/> | <input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject<br><input type="checkbox"/> Inhale <input type="checkbox"/> Other |
| Marijuana/Hashish                        | <input type="text"/> <input type="text"/> | N/A  | Other Non-Barbiturate<br>Sedative or Hypnotic | <input type="text"/> <input type="text"/> | <input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject<br><input type="checkbox"/> Inhale <input type="checkbox"/> Other |
| Cocaine/Crack                            | <input type="text"/> <input type="text"/> | <input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject<br><input type="checkbox"/> Inhale <input type="checkbox"/> Other | Inhalant                                      | <input type="text"/> <input type="text"/> | <input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject<br><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<br><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<br><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<br><input type="checkbox"/> Inhale <input type="checkbox"/> Other | Oxycodone (OxyContin,<br>Percocet, Percodan)  | <input type="text"/> <input type="text"/> | <input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject<br><input type="checkbox"/> Inhale <input type="checkbox"/> Other |
| Fentanyl                                 | <input type="text"/> <input type="text"/> | <input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject<br><input type="checkbox"/> Inhale <input type="checkbox"/> Other | MDMA (Ecstasy)                                | <input type="text"/> <input type="text"/> | <input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject<br><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<br><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<br><input type="checkbox"/> Inhale <input type="checkbox"/> Other |
| Non-Prescription<br>Methadone            | <input type="text"/> <input type="text"/> | <input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject<br><input type="checkbox"/> Inhale <input type="checkbox"/> Other | Ketamine                                      | <input type="text"/> <input type="text"/> | <input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject<br><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<br><input type="checkbox"/> Inhale <input type="checkbox"/> Other | Spice   | <input type="text"/> <input type="text"/> | <input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject<br><input type="checkbox"/> Inhale <input type="checkbox"/> Other |
| Other Hallucinogen                       | <input type="text"/> <input type="text"/> | <input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject<br><input type="checkbox"/> Inhale <input type="checkbox"/> Other | Dilantin                                      | <input type="text"/> <input type="text"/> | <input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject<br><input type="checkbox"/> Inhale <input type="checkbox"/> Other |
| Other Amphetamine                        | <input type="text"/> <input type="text"/> | <input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject<br><input type="checkbox"/> Inhale <input type="checkbox"/> Other | GHB/GBL                                       | <input type="text"/> <input type="text"/> | <input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject<br><input type="checkbox"/> Inhale <input type="checkbox"/> Other |
| Other Stimulant                          | <input type="text"/> <input type="text"/> | <input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject<br><input type="checkbox"/> Inhale <input type="checkbox"/> Other | Cannabinoids, Delta<br>THC/Other Synthetic    | <input type="text"/> <input type="text"/> | <input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject<br><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<br><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<br><input type="checkbox"/> Inhale <input type="checkbox"/> Other |
| Other Non-Benzodiazepine<br>Tranquilizer | <input type="text"/> <input type="text"/> | <input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject<br><input type="checkbox"/> Inhale <input type="checkbox"/> Other |   |   |  |

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**22. If Primary Diagnosis is not MH Only, please mark the frequency of use for each substance the consumer used in the past 12 months and past month.**

| Substance  | Past 12 Months - Frequency of Use |                          |                          |                          |                          | Past Month - Frequency of Use |                          |                          |                          |                          |
|--|-----------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|  | Not Used                          | 1-3 times monthly        | 1-2 times weekly         | 3-6 times weekly         | Daily                    | Not Used                      | 1-3 times monthly        | 1-2 times weekly         | 3-6 times weekly         | Daily                    |
| Tobacco/vaping use<br>(any tobacco/vaping products)                                      | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heavy alcohol use<br>(>=5(4) drinks per sitting)   | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <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"/> | <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"/> | <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"/> | <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"/> | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fentanyl use   | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other opiates/opioids use  | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other drug use <input type="text"/> <input type="text"/><br>(enter code from list below) | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

#### Other Drug Codes

5=Non-prescription Methadone 10=Other Amphetamine 14=Barbiturate 22=Oxycodone(OxyContin, Percocet, Percodan) 58=Spice  
7=PCP-Phencyclidine 11=Other Stimulant 15=Other Sedative or Hypnotic 29=MDMA (Ecstasy) 59=Dilantin  
8=Other Hallucinogen 12=Benzodiazepine 16=Inhalant 46=Ketamine 61=GHB/GBL  
9=Methamphetamine 13=Other Tranquilizer 17=Over-the-Counter 57=Prescription Drug 62=Cannabinoids

**23. If Primary Diagnosis is not MH Only, substances related to arrest: (mark all that apply)**

- ☐ None ☐ Fentanyl ☐ Inhalant  
☐ Alcohol ☐ Other opiate ☐ Over-the-counter  
☐ Marijuana ☐ Hallucinogen ☐ Prescription Drug  
☐ Cocaine ☐ Amphetamine  
☐ Heroin ☐ Tranquilizer

**24. 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; answer b if greater than zero)

b. Indicate the type(s) of crime from arrest(s) in the past month: (mark all that apply)

- ☐ Violent felony ☐ Violent misdemeanor  
☐ Property felony ☐ Property misdemeanor  
☐ Drug felony ☐ Drug misdemeanor  
☐ Other felony ☐ Other misdemeanor

**25. Please indicate the consumer's DAC Supervision Level.**

- ☐ Level 1 ☐ Level 4  
☐ Level 2 ☐ Level 5  
☐ Level 3

**26. Please indicate the consumer's DAC Need Level.**

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

**27. TASC Priority Population:**

- ☐ Intermediate punishment offender  
☐ Offender who completed a DAC program  
☐ Community punishment violator  
☐ Other DAC referral  
☐ Other CJS/Judicial referral

**28. Most serious crime type related to TASC referral:**

- ☐ Violent felony ☐ Violent misdemeanor  
☐ Property felony ☐ Property misdemeanor  
☐ Drug felony ☐ Drug misdemeanor  
☐ Other felony ☐ Other misdemeanor

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

- ☐ Wheelchair/Mobility equipment or services  
☐ Equipment or services due to a physical disability  
☐ Equipment or services due to being deaf/hard of hearing  
☐ Sign language interpreter  
☐ Foreign language interpreter  
☐ Equipment or services due to being visually impaired  
☐ Child care  
☐ Equipment or services due to being a frail senior  
☐ Other  
☐ None of the above/NA

# NC-TOPPS

## TASC CJM Intake 2024

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

### 30. Services and Supports Recommended: (mark all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Peer support services   | <input type="checkbox"/> Pre-treatment education                     |
| <input type="checkbox"/> Family/Parenting classes  | <input type="checkbox"/> SA Outpatient -> (answer b)                 |
| <input type="checkbox"/> Faith-based services  | <input type="checkbox"/> SA Intensive Outpatient (IOP) -> (answer c) |
| <input type="checkbox"/> Self-care/Wellness activities (ex. Yoga, Guided Meditation, Exercise) | <input type="checkbox"/> SA Day Treatment                            |
| <input type="checkbox"/> Transportation services   | <input type="checkbox"/> Residential                                 |
| <input type="checkbox"/> Housing services  | <input type="checkbox"/> Therapeutic community                       |
| <input type="checkbox"/> Financial wellness/Education programs                                 | <input type="checkbox"/> AA/NA/Self help                             |
| <input type="checkbox"/> Harm reduction services   | <input type="checkbox"/> Specialty courts                            |
| <input type="checkbox"/> Syringe Services Programs (SSPs)                                      | <input type="checkbox"/> DART Center                                 |
| <input type="checkbox"/> Primary care/Medical services   | <input type="checkbox"/> Black Mountain                              |
| <input type="checkbox"/> Drug and other education classes                                      | <input type="checkbox"/> Crisis Services                             |
| <input type="checkbox"/> CBI -> (answer a)   | <input type="checkbox"/> Medication Management                       |
| <input type="checkbox"/> Mental health services  | <input type="checkbox"/> Other                                       |
| <input type="checkbox"/> Detox   |  |

#### 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

### 31. Is this a TASC Assessment ONLY case?

- ☐ Yes -> (end of assessment)   ☐ No

#### b. Level of Care Management:

- ☐ Level I   ☐ Level II   ☐ Level III