BH SUD COC SERVICE ARRAY
RFP 21-1 (pg. 2-23 to 2-24):
Quarterly Program Report

The PROVIDER shall:

- Submit the Annual Report in the format specified by ADAD, Annual Program Reports and Quarterly Program Reports.

- Refer to Section 5, Attachments C-1 and C-2 for sample Annual Program Reports and Quarterly Program Reports. ADAD reserves the right to revise these reports, as needed.

Procedure:

1. Complete the Quarterly Report form.
    a. In the modalities and services of your contract, please select all that apply.

2. Email the completed Quarterly Report form no later than 30 days from the due date below to doh.adad.treatment@doh.hawaii.gov

3. In the email subject line please type "(ASO #, Agency Initials, Y# Q# Report)."
    i. For example: "22-000, HI, Y2 Q3 Report"
    ii. Letter meaning: Y→Year and Q→Quarter

For contracts beginning October 1: Report	Timeframe	Due Date
Quarter 1	Oct 1 – Dec 31	Jan 31
Quarter 2	Jan 1 – Mar 31	Apr 30
Quarter 3	Apr 1 – Jun 30	Jul 31
Quarter 4	Jul 1 – Sep 30	Oct 31
Annual	Oct 1 – Sep 30	Nov 15

BH SUD COC SERVICE ARRAY
Quarterly Program Report

Report Submission Date: ☐

ASO Log Number & Provider Initials: ☐

Contract Year: ☐ Year 1 ☐ Year 2 ☐ Year 3 ☐ Year 4

Quarter: ☐ Q1 ☐ Q2 ☐ Q3 ☐ Q4

Level of Care: Modalities and Services provided during this Quarter:

Pretreatment

- ☐ Outreach
- ☐ Addiction Care Coordination
- ☐ Screening
- ☐ Interim Services
- ☐ Motivational Enhancement
- ☐ Stabilization Bed

Treatment

- ☐ Assessment
- ☐ Health and Wellness Planning
- ☐ Intensive Outpatient
- ☐ Stabilization Bed
- ☐ Opioid Recovery Services
  - ☐ Health Maintenance
  - ☐ Urinalysis
  - ☐ Toxicology Screening
  - ☐ Medication Dosing
  - ☐ Urinalysis Confirmatory
- ☐ Placement Determination/Referral
- ☐ Day Treatment
- ☐ Outpatient
- ☐ Childcare

Residential Treatment

- ☐ Medically Monitored Inpatient Withdrawal Management
- ☐ Clinically Managed Residential Withdrawal Management
- ☐ Clinically Managed High-Intensity Residential Services

Recovery Support Services

- ☐ Therapeutic Living Program (TLP)
- ☐ Group Recovery Homes
- ☐ Stabilization Bed
- ☐ Clean and Sober Housing
- ☐ Continuing Care Services

Other

- ☐ Transportation services
- ☐ Cultural Activities
- ☐ Contingency Management
- ☐ Translation Services
- ☐ Child Care

Staff Training: Please Indicate all Staff Training for the Quarter

Date	Duration of Training	Training Topic	# of Attendees

Projections for the next three (3) months:

Month:						
Funding Source						
Projected Amount Per Funding Source						
Total of Projection:						

Month:						
Funding Source						
Projected Amount Per Funding Source						
Total of Projection:						

Month:						
Funding Source						
Projected Amount Per Funding Source						
Total of Projection:						

Additional comments:

Success Stories: Please share with us any "success stories" that illustrates the effectiveness of your intervention(s); and/or stories that illustrate the impact your services have made in the lives of your clients. Please assure client privacy by using an alias. ADAD reserves the right to use your response without notice or warning.

Waitlist Information: Describe coordination activities with Hawai'i CARES.

BH COC SYSTEM COORDINATION OUTCOME MEASURES

Hawai'i CARES Referral Data	Q1	Q2	Q3	Q4	TOTAL
Number of clients referred from agency to Hawai'i CARES					
Number of clients referred from Hawai'i CARES and accepted by agency					
Number of clients referred from Hawai'i CARES and rejected by agency					
Number of clients referrals rejected by Hawai'i CARES due to administrative justification					
Number of clients referrals rejected by Hawai'i CARES due to clinical justification					

This reported was prepared by:

Name, Title, and Date:

This reported was verified by:

Name, Title, and Date: