**GREATER ACCESS TO APPROPRIATE MENTAL HEALTH SERVICES TRACKING GRID**

(To be completed at baseline/when clients enter the program, then periodically as his/her situation evolves over time, and then, finally, as the client exits the program)

Client’s Name/ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Mental Health Services Were Provided Beginning on these Dates**  | **Type of Mental Health Service Provided** | **Diagnosis/Reason for Treatment**  | **Average No. of Hours of Service that are Provided Each Week** | **No. of Weeks the Service was Provided** | **Was the effectiveness of the services evaluated?**  |
| **Date of program entry:** | Inpatient Treatment ProgramOutpatient Treatment ProgramPsychiatric Assessment/ServicesIndividual TherapyGroup TherapyPeer Support GroupOther (please define): | PTSDDepressionAnxietyOther (please define): |  |  | Services were evaluated: Yes/NoDid symptoms:IncreaseDecrease Stay the same |
| **Date of first update:** | Inpatient Treatment ProgramOutpatient Treatment ProgramPsychiatric Assessment/ServicesIndividual TherapyGroup TherapyPeer Support GroupOther (please define): | PTSDDepressionAnxietyOther (please define): |  |  | Services were evaluated: Yes/NoDid symptoms:IncreaseDecrease Stay the same |
| **Date of second update:** | Inpatient Treatment ProgramOutpatient Treatment ProgramPsychiatric Assessment/ServicesIndividual TherapyGroup TherapyPeer Support GroupOther (please define): | PTSDDepressionAnxietyOther (please define): |  |  | Services were evaluated: Yes/NoDid symptoms:IncreaseDecrease Stay the same |
| **Date of third update:** | Inpatient Treatment ProgramOutpatient Treatment ProgramPsychiatric Assessment/ServicesIndividual TherapyGroup TherapyPeer Support GroupOther (please define): | PTSDDepressionAnxietyOther (please define): |  |  | Services were evaluated: Yes/NoDid symptoms:IncreaseDecrease Stay the same |
| **Date for final period of services:** | Inpatient Treatment ProgramOutpatient Treatment ProgramPsychiatric Assessment/ServicesIndividual TherapyGroup TherapyPeer Support GroupOther (please define): | PTSDDepressionAnxietyOther (please define): |  |  | Services were evaluated: Yes/NoDid symptoms:IncreaseDecrease Stay the same |