

**STATE OF FLORIDA
SUBSTANCE ABUSE & MENTAL HEALTH PROGRAM
CFARS FORM**

(* **Mandatory Fields**)

(Reference: Chapter 9, DCF Pam 155-2)

Client's Name:

| | |
|--|-------------------|
| <p>1. *CLIENT SSN: ___ - ___ - _____</p> <p>The SSN must be 9 digits without dashes. It cannot start with 000 or 999. If unavailable use Pseudo-social. Instructions in SAMH Pamphlet</p> | <p>Page 9 - 4</p> |
| <p>2. *CONTRACTOR IDENTIFIER: ___ - _____</p> <p>Federal Tax Identification number</p> | <p>Page 9 - 4</p> |
| <p>3. *PURPOSE OF EVALUATION: ___</p> <p><input type="checkbox"/> 1- Admission <input type="checkbox"/> 3- Discharge</p> <p><input type="checkbox"/> 2- Six Month Assessment <input type="checkbox"/> 4- Administrative Discharge</p> | <p>Page 9 - 4</p> |
| <p>4. *EVALUATION DATE: ___ ___ ___ (Format YYYYMMDD)</p> | <p>Page 9 - 4</p> |
| <p>5. *PROVIDER ID: ___ - _____ (Subcontractor ID)</p> | <p>Page 9 - 4</p> |
| <p>6. PROGRAM EVALUATION PURPOSE: ___ (space filled)</p> | <p>Page 9 - 4</p> |
| <p>7. *EDUCATION LEVEL: ___ (Staff education level/degree)</p> | <p>Page 9 - 4</p> |
| <p>8. *FMHI NUMBER: _____</p> | <p>Page 9 - 4</p> |
| <p>9. *SA HISTORY: ___ <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes</p> | <p>Page 9 - 4</p> |
| <p>Enter the appropriate problem severity code for the following 16 scales. (Numbers 10 through 25)</p> <p>[1] No Problem [4] Slight to Moderate Problem [7] Severe Problem</p> <p>[2] Less than Slight problem [5] Moderate Problem [8] Severe to Extreme Problem</p> <p>[3] Slight Problem [6] Moderate to Severe Problem [9] Extreme Problem</p> | <p>Page 9 - 5</p> |
| <p>10. *DEPRESSION SCALE: ___</p> | <p>Page 9 - 5</p> |
| <p>11. *ANXIETY SCALE: ___</p> | <p>Page 9 - 5</p> |
| <p>12. *HYPER ACTIVE SCALE: ___</p> | <p>Page 9 - 5</p> |
| <p>13. *THOUGHT PROCESS SCALE: ___</p> | <p>Page 9 - 5</p> |
| <p>14. *COGNITIVE PERFORMANCE SCALE: ___</p> | <p>Page 5 - 5</p> |
| <p>15. *MEDICAL SCALE: ___</p> | <p>Page 5 - 5</p> |
| <p>16. *TRAUMATIC STRESS SCALE: ___</p> | <p>Page 5 - 5</p> |
| <p>17. *SUBSTANCE ABUSE SCALE: ___</p> | <p>Page 5 - 5</p> |
| <p>18. *RELATIONSHIP SCALE: ___</p> | <p>Page 5 - 5</p> |
| <p>19. *BEHAVIOR HOME SETTING SCALE: ___</p> | <p>Page 5 - 5</p> |

| | | |
|---|------------------------|------------|
| 20. *ADL FUNCTIONING SCALE: ____ | | Page 9 - 5 |
| 21. *SOCIO-LEGAL SCALE: ____ | | Page 9 - 5 |
| 22. *WORK/SCHOOL SCALE: ____ | | Page 9 - 5 |
| 23. *DANGER TO SELF SCALE: ____ | | Page 9 - 6 |
| 24. *DANGER TO OTHERS SCALE: ____ | | Page 9 - 6 |
| 25. *SECURITY MANAGEMENT SCALE: ____ | | Page 9 - 6 |
| 26. PROVIDER INFO: _____ | | Page 9 - 6 |
| 27. *CONTRACT NUMBER 1 - _ _ _ _ _ | | Page 9 - 6 |
| 28. CONTRACT NUMBER 2 - _ _ _ _ _ | (Must be space filled) | Page 9 - 6 |
| 29. CONTRACT NUMBER 3 - _ _ _ _ _ | (Must be space filled) | Page 9 - 6 |
| 30. MEDICAID REPIPIENT PAID: | (Must be space filled) | Page 9 - 6 |
| 31. MEDICAID PROVIDER ID: | (Must be space filled) | Page 9 - 6 |
| 32. MEDICAID PLAN ID: | (Must be space filled) | Page 9 - 6 |
| 33. SERVICE COUNTY: ____ ____ | | Page 9 - 6 |
| Signature: _____ Date: ____/____/____ | | |