Questionnaire: Substance Use Treatment Follow Up

Instructions: THIS QUESTIONNAIRE IS REQUIRED TO BE MARKED AS COMPLETED PRIOR TO SUBMISSION

Follow Up Profile

1. Follow Up Type (Please select one.)		
()	Opioid Replacement Therapy (Annual)	
0	Other	
0	Other	
2. Original Admission Date		
3. Health Insurance		
(Please select one.)		
0	Private Insurance	
0	Blue Cross/Blue Shield	
0	Medicare	
0	MaineCare (Medicaid)	
0	Health Maintenance Organization (HMO)	
0	Other (e.g. TRICARE)	
0	None	
0	Unknown	
0	Not collected	
4. Payment Source		
(Please select one.)		
0	DHSS - Office of Behavioral Health	
0	DHSS - Child/Adult Protective	
0	DHHS - Other	
0	Self-Pay	
0	Corrections	
0	MaineCare (Medicaid)	
0	Medicare	
0	Other Government payments	
0	Veteran's Administration	
0	Worker's Compensation	
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Blue Cross/Blue Shield
Other Private Health Insurance
Other
None
Not Collected

5. Follow Up Date