# Questionnaire: Substance Use Treatment Follow Up

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**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)
   - ○ Other

2. *Original Admission Date*

3. *Health Insurance*
   (Please select one.)
   - ○ Private Insurance
   - ○ Blue Cross/Blue Shield
   - ○ Medicare
   - ○ MaineCare (Medicaid)
   - ○ Health Maintenance Organization (HMO)
   - ○ Other (e.g. TRICARE)
   - ○ None
   - ○ Unknown
   - ○ Not collected

4. *Payment Source*
   (Please select one.)
   - ○ DHSS - Office of Behavioral Health
   - ○ DHSS - Child/Adult Protective
   - ○ DHHS - Other
   - ○ Self-Pay
   - ○ Corrections
   - ○ MaineCare (Medicaid)
   - ○ Medicare
   - ○ Other Government payments
   - ○ Veteran's Administration
   - ○ Worker's Compensation

- ○ Blue Cross/Blue Shield
- ○ Other Private Health Insurance
- ○ Other
- ○ None
- ○ Not Collected

5. *Follow Up Date*

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