STATE OF FLORIDA
SUBSTANCE ABUSE & MENTAL HEALTH PROGRAM
CFARS FORM

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

Client's Name:

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

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: _____/_____/_____	