

Appendix O- Department of Children and Families Recovery Community Organization (RCO) Monthly Report

| Q# | Question | Response |
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| 2 | Today's Date, (MM/DD/YYYY) | |
| 3 | Which Managing Entity is your RCO subcontracted with: | |
| 4 | Name of the RCO you are reporting for | |
| 5 | Month being reported | |
| 7 | Is this an Accredited RCO? (Y/N): | |
| 8 | If "Yes", identify the RCO's Accreditation(s) | |
| 9 | Is this RCO actively working with an Accreditation organization to obtain an Accredited status? (Y/N): | |
| 11 | Is this RCO interested in receiving more information on how to obtain Accreditation status? (Y/N/NA): | |
| 12 | Is this RCO using the Recovery Capital Scale and associated Recovery Planning process? (Y/N): | |
| 13 | Report how many Recovery Capital Scale tools and associated Recovery Plans were completed as of last month, e.g., 12 | |
| 14 | How many paid staff members does this RCO have? | |
| 15 | Does this RCO have Volunteers? (Y/N): | |
| 17 | Did the RCO conduct any Trainings or Activities during the previous month? (e.g., collaborations with community partners and or community outreach events) (Y/N): | |
| 18 | Please tell us: The date(s) the training(s) or activities were conducted, the name of the training(s) or activity event, the location, and a brief description of the training or activity: | |
| 27 | If a Training was conducted, please indicate the number training participants who attended in the following profession categories. Please indicate "0" in the field if none from that profession attended. | Physician: |
| | | Physician Assistant: |
| | | Nurse (RN/ARNP): |
| | | Social Worker: |
| | | Addiction Counselor: |
| | | Peer Specialist: |
| | | Prevention: |
| | | Other: |
| 41 | Would like to report any additional Activities or Trainings completed during the previous month? (Y/N): | |
| 42 | Please tell us: The date(s) the trainings or activities were conducted, the name of the training(s) or activity event, the location, and a brief description of the training or activity: | |
| 43 | If a Training was conducted, please indicate the number training participants who attended in the following profession categories. Please indicate "0" in the field if none from that profession attended: | Physician: |
| | | Physician Assistant: |
| | | Nurse (RN/ARNP): |
| | | Social Worker: |
| | | Addiction Counselor: |
| | | Peer Specialist: |
| | | Prevention: |
| | | Other: |
| 44 | Would your organization like to report any additional Activities or Trainings completed during the previous month? (Y/N): | |
| 45 | Please tell us: The date(s) the trainings or activities were conducted, the name of the training(s) or activity event, the location, and a brief description of the training or activity: | |
| 46 | If a Training was conducted, please indicate the number training participants who attended in the following profession categories. Please indicate "0" in the field if none from that profession attended: | Physician: |
| | | Physician Assistant: |
| | | Nurse (RN/ARNP): |
| | | Social Worker: |
| | | Addiction Counselor: |
| | | Peer Specialist: |
| | | Prevention: |
| | | Other: |

| | | |
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| 33 | Briefly describe your anticipated activities for the next 30 days. (e.g., collaborations with community partners and or community events.): | |
| 34 | Please describe any challenges or barriers you may be experiencing. (e.g., implementation, delivery of services, community collaboration, etc.): | |
| 35 | Please share any additional comments, activities, or successes you would like us to know about: | |