

Procedure #1: Call In

Process Description:

Client calls in for services

Participants:

- Front Desk

Inputs:

Outputs:

Reports:

Steps:

1. Front desk receives call and begins pre-screening steps.

Comments:

Related Documents in Appendix:

Procedure #5: Pre-Screen (referral and insurance)

Process Description:

Client calls in for service front desk will determine if client is eligible

Participants:

- Front Desk
- Client

Inputs:

- Intake Screening Form

Outputs:

- Completed Intake Screening Form

Reports:

Steps:

1. Front desk answers phone call
2. Front Desk will ask a series of questions to determine if Client is eligible to receive services (Residential or Out-Patient). Criteria is no referral, Medicaid eligible, county and eligible and or a block grant.
3. If client is eligible for Out-Patient services, they will move to Step 7
4. If client is eligible for residential services, they will be referred to an Intake Specialist.
5. If client is not eligible Front Desk will refer Client to appropriate agency (CBOC, FDCI, MPRI, Foster Care), or to Billing for advice (step 17)

Comments:

Related Documents in Appendix:

5-1 [Intake Screening Form](#)

Procedure #6: Pre-Screen (referral and insurance)

Process Description:

Client calls in for service front desk will determine if client is eligible

Participants:

- Front Desk

Inputs:

-

Outputs:

Reports:

Steps:

1. Front desk answers phone call
2. Front Desk will ask a series of questions to determine if Client is eligible to receive services (Residential or Out-Patient). Criteria is no referral, Medicaid eligible, county and eligible and or a block grant.
3. If client is eligible for Out-Patient services, they will move to Step 7
4. If client is eligible for residential services, they will be referred to an Intake Specialist.
5. If client is not eligible Front Desk will refer Client to appropriate agency (CBOC, FDCI, MPRI, Foster Care), or to Billing for advice (step 17)

Comments:

Related Documents in Appendix:

[5-1 Intake Screening Form](#)

Procedure #7: Complete Brief Screening (REMI)

Process Description:

Front Desk will go over the REMI brief screen with the client

Participants:

- Front Desk
- Client

Inputs:

- REMI Medicaid Eligibility check
- REMI Demographics
- REMI Substance Use

Outputs:

- REMI Brief Screen Print

Reports:

Steps:

1. Front desk will ask all question on the REMI Website and input answers
2. Front Desk will then print out REMI Brief Screen

Comments:

Related Documents in Appendix:

7-1 [REMI Brief Screen](#)

Procedure #8: Create client folder

Process Description:

Front Desk staff creates a new folder for each client. Client number created by combination of program – year and sequential number. Where they will insert copy of Brief Screen. They also gather blank releases, STI form, Financial Responsibility Worksheet, Consent to Treatment Form, TB and blank Intake Progress note. After putting together client folder with all blank forms folder goes into file cabinet

Participants:

- Front Desk

Inputs:

- Completed REMI brief screening screens (list)

Outputs:

- Client Folder

Reports:

Steps:

1. Front Desk creates new blank Client folder with all blank forms. Client number created from (program / year / sequential number)

Related Documents in Appendix:

- 8-1 [Emergency Release](#)
- 1-2 [Criminal Justice Release](#)
- 8-2 [Reciprocal Release](#)
- 8-3 [Medical Release](#)
- 8-4 [ADAM Release](#)
- 8-5 [Outpatient Consent to Treatment form](#)
- 8-6 [Determination of Financial Responsibility](#)
- 8-7 [TB-HIV Risk Assessment](#)
- 8-8 [STI Risk Assessment](#)
- 8-9 [Outpatient Intake Progress Note](#)
- 8-10 [Biopsychosocial Assessment](#)

Procedure #9: Schedule intake assessment

Process Description:

Front Desk will schedule appointment with client using the Company Outlook Calendar

Participants:

- Front Desk

Inputs:

- Outlook Calendar

Outputs:

- Scheduled appointment

Reports:

Steps:

1. Front desk schedules client soonest appointment using Outlook Calendar
2. Appointments are shaded and preset by the therapists

Comments:

Related Documents in Appendix:

Procedure #10: full intake assessment

Process Description:

Client meets with Therapist to complete a full intake assessment. Therapist and client will meet for 2 hours to complete assessment. Asking questions to be able to determine level of care needed.

Participants:

- Front Desk
- Clinician

Inputs:

- Pre-Gain Assessment
- Gain Assessment – computer
- Biopsychosocial – paper
- SASSI
- Completed Releases
- All completed forms from Intake Folder

Outputs:

- Level of Care Determination (ASAM)
- Bio/Phy/Soc

Reports:

Steps:

1. Client comes in for scheduled appointment
2. Client fills out forms from intake folder
3. Clinician goes over all releases and have client sign
4. Clinician meets with client performs biopsychosocial/Gain/Sassi
5. Clinician determines substance use disorder diagnosis criteria met for services and make determination of level of care based on assessment and ASAM criteria

Comments:

Related Documents in Appendix:

10-1 [Sassi assessment](#)

10-2 [Gain assessment Full](#)

10-3 [Gain Pre Assessment](#)

Procedure #11: complete client folder Process

Description:

Clinician will finalize client folder after performing Intake assessment. Clinician will update Remi and Progress note to finalize billing for the session and set up next appointment for client

Participants:

- Clinician

Inputs:

- Remi screen update
- Remi Initial Auth.
- Remi level of Care update
- Clinical Summary
- Mental status exam
- Date of last use
- PCP update
- Upload assessment to Remi
- Outputs:
- Intake Progress note
- Completed Client folder

Reports:

Steps:

1. Clinician reviews new client folder to ensure all documents have been signed
2. Clinician types clinical summary and uploads to REMI (pdf)
3. Clinician updates date of last use into REMI
4. Clinician updates Level of Care Determination on REMI
5. Clinician submits Authorization on Remi for services

Comments:

Related Documents in Appendix:

11-1 [Remi Initial, Admission, Authorization, Level of Care, and Date of last use.](#)

11-5 [Outpatient Intake progress note](#)

Procedure #12: Schedule Outpatient Orientation

Process Description:

Front Desk will schedule appointment with assigned Clinician using Outlook calendar

Participants:

- Front Desk

Inputs:

- Outlook Calendar

Outputs:

- Scheduled appointment

Reports:

Steps:

1. Front desk schedules client appointment for Outpatient Orientation (Step 19) using Outlook Calendar

Comments:

Related Documents in Appendix:

Procedure #19: Outpatient orientation

Process Description:

Client will meet with Clinician and create a treatment plan. Go over all rules and expectations for treatment and review of the Biopsychosocial assessment

Participants:

- Clinician
- Client

Inputs:

- Group Schedule Note – Orange copy
- Treatment Plan Form
- Orientation checklist
- Group Therapy Guidelines and Practices
- Treatment Contract

Outputs:

- Treatment Plan – Signed and uploaded to REMI
- Outpatient Orientation Group Progress Note – purple
- Group Schedule Note – Blue copy

Reports:

Steps:

1. Client meets with Clinician and reviews Biopsychosocial
2. Clinician will have client sign Group Therapy Guidelines and Practices
3. Client will sign Orientation checklist
4. Client will sign Treatment Contract and clinician will upload to REMI.
5. Clinician creates Treatment plan with client
6. Clinician will fill out both Blue and Orange Group Schedule Notes

7. Clinician will fill out Purple Outpatient Group Orientation Progress Note

Comments:

Related Documents in Appendix:

19-1 [Treatment Contract](#)

19-2 [Group Therapy Guidelines and Practices](#)

19-3 [Outpatient Group Orientation Progress Note](#)

19-4 [Group Orientation Checklist](#)

19-5 [Treatment Plan Fillable](#)

19-6 [Group Placement Form \(blue\)](#)

19-7 [Client Group Reminder \(salmon\)](#)

19-8 [Feeling Word List](#)

19-9 [AA Meeting List](#)

19-10 [AI-Anon Meeting List](#)

19-11 [Capital Area NA Meeting List](#) - This gets updated Monthly

19-12 [Cocaine Anonymous](#)

19-13 [Prescription drug websites](#)

Procedure #30: Therapist PRC referral Outpatient

Process Description:

Clinician will fill out referral form for client to receive PRC services as needed

Participants:

- Clinician
- Peer Recovery Coach

Inputs:

- PRC authorization in REMI

Outputs:

- Peer Recovery Coach/Case Management Referral form

Reports:

Steps:

1. Clinician will fill out PRC referral form and put in PRC mailbox or email
2. Clinician will fill out Authorization for PRC services in REMI

Comments:

Related Documents in Appendix:

30-1 [Referral form case management-peer recovery coach](#)

30-2 [REMI Authorization screen](#)

Procedure #31: Outpatient Group Sessions

Process Description:

Clinician runs a group therapy session with clients 1-2 times per week. 1 and half hour group sessions

Participants:

- Clinician
- Clients

Inputs:

- Group Therapy Progress Note Form
- Attendance Form

Outputs:

- Updated Group Therapy Form
- Updated Attendance Form

Reports:

Steps:

1. Clinician holds group therapy 1-2 times per week
2. Hour and a half session with multiple clients
3. Clinician will take attendance for billing
4. Clinician fills our Group Progress note for each client to turn in for billing.

Comments:

Related Documents in Appendix:

31-1 [Group Progress Note](#)

31-2 [Attendance sheet](#)

Procedure #32: Moral Recognition Therapy (MRT)

Process Description:

Clinician holds group therapy 1-2 times per week on MRT

Participants:

- Clinician (MS level/LARA Licensed, MRT trained)
- Client

Inputs:

- Group Progress Note
- Attendance Form

Outputs:

- Completed group therapy form
- Completed attendance form

Reports:

Steps:

1. Clinician runs an MRT group 1-2 per week
2. Hour and a half group
3. Clinician fills out Attendance Form
4. Clinician fills out Group Progress Note for each individual Client to turn in for billing

Comments:

Related Documents in Appendix:

32-1 [Attendance sheet](#)

32-2 [Group Progress Note](#)

Procedure #33: Outpatient Individual Session

Process Description:

Clinician will hold individual session with client bi-weekly. They will review and update client's treatment plan during the session.

Participants:

- Clinician
- Client

Inputs:

- Treatment Plan
- Individual Progress Note
- Monthly Referral
- REMI Reauthorization (60-90 days)

Outputs:

- Treatment Plan Update (every 90 days)
- Individual Progress Note completed
- Monthly Referral Update
- REMI Reauthorization (60-90 days) completed

Reports:

Steps:

1. Clinician will set individual appointment using Outlook Calendar
2. Clinician meets with client for 30-60 minutes
3. Clinician and client review and treatment plan and update every 90 days
4. Clinician creates individual progress note and submits for billing
5. Monthly referral update created and sent if needed

Comments:

Related Documents in Appendix:

33-1 [Outpatient Individual Session Progress Note](#)

- 33-2 [Treatment Plan](#)
- 33-3 [REMI authorization](#)
- 33-4 [Client progress report](#)

Procedure #34 / 35: PRC Needs Assessment

Process Description:

Peer Recovery Coach meets with client to fill out Needs Assessment to determine the client's needs.

Services provided by the Peer Recovery Coach

- Transportation
- Clothing
- Employment assistance
- Housing
- Peer Support
- Community Engagement

Participants:

- Peer Recovery Coach
- Client

Inputs:

- PRC Needs Assessment
- PRC Intake Progress Note

Outputs:

- PRC Treatment Plan
- Progress Note Completed

Reports:

Steps:

1. PRC meets with client and goes over the Needs Assessment with Client
2. PRC creates Intake Progress Note to submit for billing

Comments:

Related Documents in Appendix:

- 34-1 [Needs Assessment CM-PRC](#)
- 34-2 [Peer Recovery Coach Intake Progress Note](#)
- 34-3 [Peer Recovery Coach Treatment Plan](#)

Procedure #36: PRC Support Group

Process Description:

Peer Recovery Coach will facilitate a weekly support group with clients in Outpatient and Residential.

Participants:

- Peer Recovery Coach
- Clients

Inputs:

- Group Progress Note
- Attendance Sheet

Outputs:

- Completed Progress Note
- Completed Attendance Sheet

Reports:

Steps:

1. Peer Recovery Coach facilitates a weekly group for an Hour and a half
2. Peer Recovery Coach takes attendance for billing
3. Peer Recovery Coach write Group Progress Note for each individual client for billing

Comments:

Related Documents in Appendix:

36-1 [Peer Recovery Coach Group Progress Note](#)

36-2 [Attendance Sheet](#)

Procedure #44: Insurance Verification

Process Description:

If insurance coverage is questioned during screening process with front office billing will assist in verifying insurance coverage

Participants:

- Billing

Inputs:

- MSHN (Medicaid/Healthy Michigan Plan)
- Block Grant
- Full Fee
- Family Dependency Court
- MI Prison Reentry Program
- REMI Insurance verification page
- CHAMPS insurance verification page

Outputs:

Reports:

Steps:

1. Front office will call billing if insurance coverage is in question
2. Billing will run clients Name and D.O.B through Remi insurance verification
3. If necessary, billing will run client's info through CHAMPS verification page.
4. Billing will contact front office and give approval or denial

Comments:

Opportunity to have Front office run verification or ACH

Related Documents in Appendix:

44-1 [REMI Insurance verification](#)

44-2 [CHAMPS insurance verification page](#)

Procedure #62: Weekly REMI billing

Process Description:

Billing using REMI to bill weekly services

Participants:

- Billing

Inputs:

- SOS services rendered Report
- Attendance Sheet
- Remi Claim Submission Page

Outputs:

Reports:

Steps:

1. Billing prints SOS services rendered report
2. Billing uses Attendance spreadsheet to get dates and times of services
3. Billing inputs information into REMI claim submission page and submits claims for payment

Comments:

Related Documents in Appendix:

62-1 [REMI billing page](#)

62-2 [Full Month SOS Service Rendered Report](#)

Procedure #64: Successful Client Program Completion

Process Description:

Client successfully completes treatment with MMRS

Participants:

- Clinician

Inputs:

- Discharge Plan

Outputs:

- Completed Discharge Plan

Reports:

Steps:

1. Clinician creates discharge plan

Comments:

Related Documents in Appendix:

64-1 [Transition Plan](#)

64-2 [Sustained Recovery Plan](#)

Procedure #65: Supervisor Approval of Discharge Plan

Process Description:

Clinician and supervisor discuss clients discharge plan for approval or adjustment

Participants:

- Clinician
- Supervisor

Inputs:

- Discharge Plan

Outputs:

- Approved discharge plan

Reports:

Steps:

1. Clinician and supervisor review discharge plan
2. Clinician sets up appointment with client for Discharge

Comments:

Related Documents in Appendix:

65-1 [Transition Plan](#)

65-2 [Sustained recovery Plan](#)

Procedure #67: Client Discharge Meeting

Process Description:

Clinician hold session with client to review the discharge process

Participants:

- Clinician
- Client

Inputs:

- Exit survey
- Transition Plan
- Helping Hands Contract

Outputs:

Reports:

Steps:

1. Clinician will review treatment plan with client
2. Clinician Has client sign helping hands contract
3. Client completes exit survey

Comments:

Related Documents in Appendix:

67-1 [Client Satisfaction Survey](#)

67-2 [Outpatient Discharge Progress note](#)

Procedure #68: Post Discharge Steps

Process Description:

Final steps taken by clinician to complete the clients discharge from services

Participants:

- Clinician

Inputs:

- Discharge Summary
- REMI discharge page
- Discharge Progress Note
- Discharge letter to PO/Referral

Outputs:

Reports:

Steps:

1. Clinician completes discharge summary
2. Clinician completes REMI discharge page
3. Clinician completes a Discharge progress note
4. Clinician fills out discharge letter to PO/Referral
5. Clinician will review file to ensure file is complete

Comments:

Related Documents in Appendix:

68-1 [Discharge Summary 2020](#)

68-2 [REMI discharge](#)

68-3 [Outpatient Discharge Progress Note](#) (this is completed with the client in Procedure #67)

68-4 [Discharge letter templates](#) – this letter differs from client to client depending on the situation and if they had a referral source.

MID-MICHIGAN RECOVERY SERVICES, INC.
AUTHORIZATION & CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION
CRIMINAL JUSTICE SYSTEM RELEASE

I, _____, authorize the Mid-Michigan Recovery Services Inc.

and Court Representative/Designee: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

The purpose of this release is to allow for *mutual discussion of information regarding my treatment status including assessment results, recommendations, attendance, participation, progress, as well as legal status and other related information.*

I understand that my alcohol and/or other drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and other Drug Abuse Patient Records, 42 C.F.R. Part 2, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164; and the Mental Health Code, Section 330.1748 of Public Act 258. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPAA privacy law. The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, noted above, however will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from re-disclosure. I also understand I may revoke this authorization at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows:

When there has been a formal and effective termination or revocation of my release from confinement, probation, parole, or other proceeding, or one year after formal discharge from treatment,

or _____
(Specify other time when consent can be revoked and/or expires)

I understand that authorizing the disclosure of this health information is voluntary and that I can refuse to sign this authorization; however, my request to release information will not be fulfilled. I understand I may inspect or copy the information to be used or disclosed. I understand that the covered entity seeking this authorization is not conditioning treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization.

I understand that I am entitled to receive a copy of this authorization after it is signed.

Signature of Participant

_____/_____/_____
Date

Staff Signature (Credentials or Position)

_____/_____/_____
Date

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or other drug abuse patient.

INTAKE SCREENING

First Name: _____ D.O.B _____

Last name: _____

Address: _____

County: _____

Phone number: _____

What type of insurance do you have? _____

SSN: _____

Referral? _____

Are you currently pregnant? Y / N Injecting: Y / N Veteran: Y / N

What substance have you been using?

TYPE	HOW WERE YOU USING THE SUBSTANCE	AGE/FIRST STRTED USING	HOW OFTEN	LAST USE

Has there been an overdose in the past 30 days? Y / N

Do you have a history of Tremors or Seizures? Y / N

Client has given verbal consent to verify their insurance

IDENTIFYING INFORMATION				
NAME	DOB	AGE	CASE #	GENDER
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
ADDRESS				
[REDACTED]				

CONTACT DATE
08/19/2020

TIME CONTACT STARTED
11:25AM

CONTACT TYPE
 Face-to-Face Phone

CALLER INFORMATION (COMPLETE IF CALLER IS NOT THE CONSUMER)		
FIRST NAME	LAST NAME	PHONE AND EXTENSION
[REDACTED]	[REDACTED]	[REDACTED]
CALLER'S RELATIONSHIP TO CONSUMER	IS THE CALLER LEGALLY AUTHORIZED TO REQUEST SERVICES ON BEHALF OF CONSUMER?	
Self	<input type="checkbox"/> Yes <input type="checkbox"/> No	

CONSUMER INFORMATION			
FIRST NAME	MIDDLE NAME	LAST NAME	GENDER
[REDACTED]	[REDACTED]	[REDACTED]	<input checked="" type="checkbox"/> M <input type="checkbox"/> F
AKA / OTHER IDENTIFYING INFORMATION	SSN	DATE OF BIRTH	PRIMARY PHONE
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
			<input type="checkbox"/> Do not leave a message
			ALTERNATE PHONE
			[REDACTED]
<input type="checkbox"/> Do Not Mail			
REFERRAL SOURCE	COUNTY OF RESIDENCE	VETERAN STATUS	
Individual	Ingham	Not a veteran	

DESIGNATED SUBSTANCE USE PRIORITY POPULATIONS
PREGNANT
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
PLEASE SELECT WHICH OF THE FOLLOWING IS TRUE FOR THIS INDIVIDUAL:
<input type="checkbox"/> Parent at Risk of Losing a Child
<input type="checkbox"/> Injecting Substance User
<input type="checkbox"/> Individual Under Supervision of MDOC and Referred by MDOC or Individual Being Released Directly from an MDOC Facility Without Supervision and Referred by MDOC
<input checked="" type="checkbox"/> None of the above

CRISIS SITUATIONS
PLEASE INDICATE IF ANY OF THE FOLLOWING CONDITIONS EXIST FOR THIS PERSON (MULTIPLE FIELDS MAY BE SELECTED IF APPLICABLE). IF ANY OF THE CONDITIONS EXIST, THE PERSON MUST BE OFFERED A FACE-TO-FACE APPOINTMENT WITHIN 24 HOURS OR A REFERRAL WITH WARM HANDOFF TO A PROVIDER WHO CAN OFFER A FACE-TO-FACE APPOINTMENT WITHIN 24 HOURS.
<input type="checkbox"/> Suicidal/Homicidal
<input type="checkbox"/> Other Mental Health Crisis
<input type="checkbox"/> Referral from Hospital Emergency Room
<input type="checkbox"/> Recent Overdose (Last 30 days)
<input checked="" type="checkbox"/> None of the above

ROUTINE
This individual is considered a ROUTINE referral and must be offered a face-to-face appointment within 14 days of requesting services.

PRESENTING PROBLEM NARRATIVE - WHAT BRINGS YOU TO REQUEST SERVICES?
Client is seeking Outpatient Services.

INSURANCE INFORMATION	
MEDICAID ID #	<input type="checkbox"/> Medicare ID:
[REDACTED]	<input type="checkbox"/> Commercial:
<input type="checkbox"/> Medicaid	

<input type="checkbox"/> Medicaid Spend-Down	<input type="checkbox"/> VA
<input checked="" type="checkbox"/> Healthy Michigan Plan	<input type="checkbox"/> Other Payment Source:
HEALTH PLAN Meridian Health	<input type="checkbox"/> Enrolled in SSI, SSDI or SDA
INSURANCE COMMENTS	<input type="checkbox"/> No Insurance

SUBSTANCE USE

SUBSTANCE USE CHART

Substance	Route	Substance Rank	Age At First Use	Frequency of Use / Amount	Date of Last Use
Alcohol	Oral	1st	12	No use in the past month	09/12/2019

IS THERE A HISTORY OF OVERDOSE IN THE LAST 30-DAYS?

Yes No

HISTORY OF DTS/SEIZURES

Denies

DANGEROUSNESS
(Items highly significant for hospitalization)

Self Others Inability to Care for Self Inability To Recognize Need for Tx

DETAILS

DISPOSITION

- Eligible for Level of Care Determination
- Referred to another Provider
- Call Discontinued
- Individual Refused Level of Care Determination
- Not Eligible for Level of Care Determination

STOP DATE
08/19/2020

STOP TIME
11:29AM

SIGNATURES

Electronically Signed By:

STAFF SIGNATURE / CREDENTIALS

DATE

MID-MICHIGAN RECOVERY SERVICES, INC.

**AUTHORIZATION & CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION
RELEVANT TO EMERGENCY SITUATIONS**

I _____, authorize **MID-MICHIGAN RECOVERY SERVICES, INC.**

to disclose information listed below to:

Name: _____

Address: _____

Relationship: _____

Phone: _____

Specific information to be disclosed:

*name and location of client and action taken in the event of an emergency,
including life-threatening situations to self and/or others.*

The purpose for the authorized communication in this consent is:

to inform the individual listed above, of emergency situations and actions(s) taken.

I understand that my alcohol and/or other drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and other Drug Abuse Patient Records, 42 C.F.R. Part 2, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164; and the Mental Health Code, Section 330.1748 of Public Act 258. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may redisclose the information and it may no longer be protected by the HIPAA privacy law. The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, noted above, however will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from redisclosure. I also understand I may revoke this authorization at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows:

on the date of my discharge from treatment.

I understand that authorizing the disclosure of this health information is voluntary and that I can refuse to sign this authorization; however, my request to release information will not be fulfilled. I understand I may inspect or copy the information to be used or disclosed. I understand I may inspect or copy the information to be used or disclosed. I understand that the covered entity seeking this authorization is not conditioning treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization.

Signature of Participant

____/____/____
Date

Staff Signature (credentials or position)

____/____/____
Date

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or other drug abuse patient.

**MID-MICHIGAN RECOVERY SERVICES, INC.
RECIPROCAL AUTHORIZATION & CONSENT FOR RELEASE OF
CONFIDENTIAL INFORMATION**

I, _____, authorize Mid-Michigan Recovery Services, Inc. including the following license locations (clients must initial any applicable service locations):

Lansing Main Office
913 W Holmes Rd., Suite 200
Lansing, MI 48910-4606_____

Holden House
3300 S Pennsylvania Ave.
Lansing, MI 48910_____

Glass House
419 N Martin Luther King Blvd.
Lansing, MI 48915_____

Transition House
813-817 N. MLK Jr Blvd
Lansing, MI 48915_____

Name or Designee/Agency: _____

Title/Relationship: _____

Address: _____ Phone: _____

Fax: _____ Email: _____

to verbally and/or in writing communicate with and disclose to one another the following information:

(CLIENT MUST INITIAL)

____ Results of assessment/intake	____ Discharge summary/prognosis
____ Recommendations	____ Continuing Care Plan
____ Progress	____ Health History & Physical
____ Attendance Status	____ Medication Assisted Treatment Care
____ Personal Needs: _____	____ Other: _____

The purpose and need for such disclosure is to determine and/or facilitate continuity of care.

I understand that my alcohol and/or other drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and other Drug Abuse Patient Records, 42 C.F.R. Part 2, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164; and the Mental Health Code, Section 330.1748 of Public Act 258. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may redisclose the information and it may no longer be protected by the HIPAA privacy law. The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, noted above, however will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from redisclosure. I also understand I may revoke this authorization at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows:

sixty days from the date that I am discharged from treatment or _____

(date, event or condition upon which this consent expires)

I understand that authorizing the disclosure of this health information is voluntary and that I can refuse to sign this authorization; however, my request to release information will not be fulfilled. I understand I may inspect or copy the information to be used or disclosed. I understand that the covered entity seeking this authorization is not conditioning treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization.

I understand that I am entitled to receive a copy of this authorization after it is signed.

Signature of Participant

____/____/____
Date

Staff Signature (credentials or position)

____/____/____
Date

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or other drug abuse patient.

**MID-MICHIGAN RECOVERY SERVICES, INC.
RECIPROCAL AUTHORIZATION & CONSENT FOR RELEASE OF
CONFIDENTIAL MEDICAL INFORMATION**

I, _____, authorize Mid-Michigan Recovery Services, Inc.

And:

(CHECK ONE< CLIENT MUST INITIAL)

Lansing Main Office 913 W Holmes Rd., Suite 200 Lansing, MI 48910-4606_____	Holden House 3300 S Pennsylvania Ave. Lansing, MI 48910_____	Glass House 419 N Martin Luther King Blvd. Lansing, MI 48915_____	Transition House 813-817 N. MLK Jr Blvd Lansing, MI 48915_____
---	--	---	--

Physician or Medical Facility/Agency: _____

Title/Relationship: _____

Address: _____ Phone: _____

Fax: _____ Email: _____

to verbally and/or in writing communicate with and disclose to one another the following information:

(CLIENT MUST INITIAL)

____ Consultation	____ History & Physical
____ Attendance Status	____ Other: _____

The purpose and need for such disclosure is to determine and/or facilitate continuity of care.

I understand that my alcohol and/or other drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and other Drug Abuse Patient Records, 42 C.F.R. Part 2, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164; and the Mental Health Code, Section 330.1748 of Public Act 258. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may redisclose the information and it may no longer be protected by the HIPAA privacy law. The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, noted above, however will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from redisclosure. I also understand I may revoke this authorization at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows:

sixty days from the date that I am discharged from treatment or _____

(date, event or condition upon which this consent expires)

I understand that authorizing the disclosure of this health information is voluntary and that I can refuse to sign this authorization; however, my request to release information will not be fulfilled. I understand I may inspect or copy the information to be used or disclosed. I understand that the covered entity seeking this authorization is not conditioning treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization.

I understand that I am entitled to receive a copy of this authorization after it is signed.

Signature of Participant

____/____/____
Date

Staff Signature (credentials or position)

____/____/____
Date

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or other drug abuse patient.

MID-MICHIGAN RECOVERY SERVICES, INC.
RECIPROCAL AUTHORIZATION & CONSENT FOR RELEASE OF

CONFIDENTIAL DRUG TESTING INFORMATION

I, _____, authorize Mid-Michigan Recovery Services, Inc. And:

(CHECK ONE, CLIENT MUST INITIAL)

Lansing Main Office 913
W Holmes, Suite 200
Lansing, MI 48910-4606_____

Holden House
3300 S. Pennsylvania 419 N. Martin Luther King Blvd 817 N. Martin Luther King Blvd Lansing, MI
48910_____ Lansing, MI 48915_____ Lansing, MI 48915_____

Glass House
Transitions

Transitions
Lansing, MI 48915_____

Name or Designee/Agency: **ADAM – Alcohol Drug Administrative Monitoring, Inc.**

Address: **3500 South Cedar Street, Suite 112 Lansing, MI 48910**

Fax: **517-267-8831** Phone: **517-267-8830**

Other Drug Testing Facility:

Name or Designee/Agency: _____ Fax: _____

Address: _____ Phone: _____

to verbally and/or in writing communicate with and disclose to one another the following information:

_____ Drug Testing Compliance & Results (CLIENT MUST INITIAL)

The purpose and need for such disclosure is to determine and/or facilitate continuity of care.

I understand that my alcohol and/or other drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and other Drug Abuse Patient Records, 42 C.F.R. Part 2, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164; and the Mental Health Code, Section 330.1748 of Public Act 258. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may redisclose the information and it may no longer be protected by the HIPAA privacy law. The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, noted above, however will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from redisclosure. I also understand I may revoke this authorization at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows:

sixty days from the date that I am discharged from treatment or

(date, event or condition upon which this consent expires)

I understand that authorizing the disclosure of this health information is voluntary and that I can refuse to sign this authorization; however, my request to release information will not be fulfilled. I understand I may inspect or copy the information to be used or disclosed. I understand that the covered entity seeking this authorization is not conditioning treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization. I understand that I am entitled to receive a copy of this authorization after it is signed.

Signature of Participant

_____/_____/_____
Date

Signature (credentials or position) Date

_____/_____/_____
Staff

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or other drug abuse patient.

MID-MICHIGAN RECOVERY SERVICES, INC.

Consent to Treatment

I understand that treatment at Mid-Michigan Recovery Services, Inc. (MMRS, Inc.) is voluntary and that I may discontinue at any time. I have been told the purposes of treatment and the services that may be provided. I acknowledge that no specific results have been promised or implied. I understand that treatment is successfully completed when my counselor and I agree that my treatment goals have been substantially met. A successful discharge will be planned with my counselor in advance and include a continuing care plan. I also understand that I have certain responsibilities, which include, but are not limited to the following:

- Attending all scheduled treatment sessions
- Developing my personal goals and treatment plan in cooperation with staff.
- Working toward achieving the goals and objectives of my treatment plan.
- Clients have the right to at least two or more hours of formalized individual, group or family counseling each week at MMRS, Inc. based on client needs.
- Signing, when appropriate, forms for the release of information to other agencies or individuals.
- Maintaining confidentiality concerning the identity of other clients at MMRS, Inc.
- Paying treatment fees as determined and agreed upon.
- Consent to random drug testing based on specific medical necessity as having clinical or therapeutic benefit.

At times, MMRS, Inc. may need to discharge a client from treatment. Reasons include, but are not limited to the following:

- Consistent failure to comply with the above responsibilities.
- Possession while on MMRS, Inc. premises of alcohol, illegal drugs, drug paraphernalia, or medication not specifically prescribed for you.
- Consistent use at any time of alcohol and/or illegal drugs, or unneeded or abusive use of over-the-counter medication or medication not specifically prescribed for you.
- Attendance at any counseling session while under the influence of alcohol or an illegal or non-prescribed drug.
- When applicable, refusing to cooperate with a random or a for-cause alcohol or other drug screen.
- Committing, or threatening to commit, a personal or property crime against an MMRS, Inc. staff or client, or intentionally damaging MMRS, Inc. property.
- Continued use of language that is disruptive or inappropriate, for example, profanity, or sexual or racist comments.
- Disclosing to someone not in this program the identity of, or information about, another MMRS, Inc. client.
- Consistently missing, rescheduling or being late for appointments.
- Any threatening behavior - physical and/or verbal.

If you are being considered for an unplanned discharge, you will be told the reason, our expectations, and the step(s) if any that you may take to avoid discharge in an individual session with your counselor. Your counselor will also make you aware of the possible consequences and treatment alternatives available to you. If you are unavailable to meet with your counselor you will be provided the information in writing via U.S. Mail. You may or may not be considered for readmission into any of MMRS, Inc.'s treatment programs in the future. You have the right to appeal any discharge in writing to the Assistant Director, who approves all unplanned discharges. Your referral source will be notified of your pending discharge.

Your signature below indicates that you understand all of the above and that you have had the opportunity to ask a staff member any questions concerning the above.

Client Signature: _____

Date: _____

MID-MICHIGAN RECOVERY SERVICES, INC.
DETERMINATION OF FINANCIAL ELIGIBILITY WORKSHEET FOR SUBSTANCE ABUSE SERVICES

PROGRAM NAME _____ DATE COMPLETED _____
 CLIENT NAME _____ CLIENT SSN _____

I. CURRENT GROSS INCOME
 (Use **yearly gross** income figures, rounded to the nearest whole dollar.)

		<u>Weekly</u>		<u>Yearly</u>
Client's Income:	1)	\$ _____		\$ _____
Spouse's Income	2) +	\$ _____		\$ _____
Other Additional Income (Other examples: SSI, Unemployment, Worker's Comp, Child Support)	3) +	\$ _____		\$ _____
SPECIFY OTHER _____				
SUBTOTAL INCOME:	4)	\$ _____		\$ _____
DEDUCT: Annual Child Support Payment	5)	\$ _____		\$ _____
TOTAL INCOME:	6)	\$ _____		\$ _____

II. DEPENDENTS
 Number of Dependents Living in Home (Includes Client) _____

DETERMINED CLIENT ABILITY TO PAY:

Individual & Family (hourly)	\$ _____
Group Session (hourly)	\$ _____
Methadone Dosage	\$ _____
IOP (Daily)	\$ _____
Residential & Detox (Daily)	\$ _____
Intake	\$ _____

Client Signature _____ Date _____
 Staff Signature _____ Date _____
 Program Director Signature _____ Date _____

MID-MICHIGAN RECOVERY SERVICES, INC.

TB Assessment

<u>Yes</u>	<u>No</u>	
___	___	Do you tire easily?
___	___	Have you lost weight recently without trying?
___	___	Have you noticed a loss of appetite?
___	___	Do you sweat a lot at night?
___	___	Have you had a cough for more than three (3) weeks?
___	___	Do you ever cough blood?
___	___	Have you recently had a fever or chills that lasted longer than three (3) days?
___	___	Have you noticed that your glands are swollen?
___	___	Have you had close or casual contact with someone that may have had TB?
___	___	Have you ever had a positive skin test?

If you answered yes to any of the above questions, you should take the first step to find out if you are infected with the TB germ. You can do this by getting a TB skin test at the Ingham County Health Dept.

___Yes ___No Received documentation of a negative skin test at the time of admission.

HIV Risk Assessment

Individuals will be identified at risk for contracting HIV if the answers to any of the following questions are found to be true.

<u>Yes</u>	<u>No</u>	
___	___	Have you engaged in unprotected sexual intercourse (oral, anal or genital) with one or more partners whose HIV status is unknown?
___	___	Have you engaged in sexual activity with individuals who have been identified as HIV positive?
___	___	Have you shared needles or injecting “works” with other individuals?
___	___	Have you experienced other forms of blood-to-blood contact where you have questions about your HIV status, i.e. blood transfusions, hemophilia treatment, dental contact, etc.

I have read the information regarding the nature of TB disease. I understand how TB infection can spread. I have answered the ten health/history questions concerning TB. I have been given information indicating the nature and consequences of HIV infection, the route of HIV transmission, the impact of substance abuse on HIV risk behaviors and the methods for reducing my risk for contracting HIV. I have also been told where I can get additional information and confidential testing.

Client Signature

____/____/____
Date

MID-MICHIGAN RECOVERY SERVICES, INC.

STI Risk Assessment

Sexually Related Infections Risk Assessment

You can answer the following questions to get a sense of their likelihood of having or developing a sexually related infection (STI).

Do you notice scabs, rashes, bumps, or other skin changes on your genitals?	Yes <input type="checkbox"/>	NO <input type="checkbox"/>
Are you experiencing a burning sensation in your genitals or urinary tract?	Yes <input type="checkbox"/>	NO <input type="checkbox"/>
Are you experiencing pain in your pelvis, genitals, or urinary tract?	Yes <input type="checkbox"/>	NO <input type="checkbox"/>
Are you experiencing general symptoms of infection such as fever or chills; aches and pains; or swollen glands?	Yes <input type="checkbox"/>	NO <input type="checkbox"/>
Do you have bleeding after intercourse?	Yes <input type="checkbox"/>	NO <input type="checkbox"/>
Are you under 25 years of age?	Yes <input type="checkbox"/>	NO <input type="checkbox"/>
Have you had a recent (in last six months) change in sexual partner?	Yes <input type="checkbox"/>	NO <input type="checkbox"/>
Have you had more than three sexual partners during the last six months?	Yes <input type="checkbox"/>	NO <input type="checkbox"/>
Does your sexual partner have other sexual partners?	Yes <input type="checkbox"/>	NO <input type="checkbox"/>
Have you had unprotected sex or made inconsistent use inconsistently (not every time)?	Yes <input type="checkbox"/>	NO <input type="checkbox"/>
Do you have unexplained weight loss or night sweats?	Yes <input type="checkbox"/>	NO <input type="checkbox"/>
Do you experience otherwise-unexplained gastrointestinal symptoms, or signs of jaundice (yellow skin and white of eyes, darker-yellow urine and pale feces)?	Yes <input type="checkbox"/>	NO <input type="checkbox"/>
After oral sex, have you developed a sore throat that has persisted?	Yes <input type="checkbox"/>	NO <input type="checkbox"/>

WOMEN ONLY

Are you experiencing vaginal itching?	Yes <input type="checkbox"/>	NO <input type="checkbox"/>
Are you experiencing vaginal discharge?	Yes <input type="checkbox"/>	NO <input type="checkbox"/>
Are you experiencing vaginal odor?	Yes <input type="checkbox"/>	NO <input type="checkbox"/>
Do you have irregular vaginal bleeding?	Yes <input type="checkbox"/>	NO <input type="checkbox"/>
Do you douche?	Yes <input type="checkbox"/>	NO <input type="checkbox"/>

If you check yes to any of these questions you may be at risk and should see your doctor.

Client Signature

Date

MID-MICHIGAN RECOVERY SERVICES, INC.
OUTPATIENT INTAKE PROGRESS NOTE

CLIENT NAME:

CLIENT NUMBER:

DATE:

START TIME:

END TIME:

Behavioral Observations:

General Behavior: Cooperative Passive Withdrawn Mute Dramatic Tearful
 Argumentative Guarded Hostile Restless Bizarre Overly Cooperative Suspicious
Mood: Euthymic Sad Elevated Apathetic Euphoric Anxious Irritable
 Depressed
Affect: Broad Exaggerated Labile Restricted Flat Bland
Comments:

Intervention:

- Completed Biopsychosocial Assessment with Client
- Completed All Appropriate Releases
- Primary Care Physician: (PCP letter sent, etc)
- Diagnostic Criteria met for Substance Use Disorder according to DSM-V
- Diagnostic Criteria not met for Substance Use Disorder according to DSM-V
- Follow-up with referral source: (Discussion of Recommendations)
- Follow-up with client: (Discussion of Recommendations)
- Discussed Drug Screening and Referral Made if Appropriate
- Case Management Needs Discussed
- Referral to Peer Recovery Coach
- Other:

Comments:

Treatment Recommendation(s):

- Reviewed Treatment Options with Client
- Scheduled Client for Treatment: (Start Group Date, Group Orientation Appointment Date)
- Treatment Recommendation Undetermined:
- Referral for Treatment Services Outside of MMRS
- Need To Collect Further Information for Recommendation to be Made
- Contact Referral Source for Further Information
- Referral Source Informed of Recommendations
- Other:

Comments:

Counselor Signature, Credentials

DATE

MID-MICHIGAN RECOVERY SERVICES, INC.
BIOPSYCHOSOCIAL ASSESSMENT

Name: _____ Client #: _____ Date: _____

What brings you to MMRS? _____

Referral for Services: No Yes, who? _____ Release? Yes No

DEMOGRAPHICS:

DOB/Age: _____ Place of Birth: _____

What gender do you identify as? _____ Prefer to self-describe: _____

Are you comfortable with your gender? Y N, explain: _____

Do you identify as transgender? Yes No Prefer not to say

What race do you identify yourself as? _____ What ethnic origin do you identify with? _____

What is your sexual orientation? _____ Prefer to self-describe: _____

Current Relationship Status: _____ If you have previously married, how many times and when? _____

Name of current partner: _____ Age: _____ Length of relationship: _____

I see my current relationship as: N/A Very good Good So-so Bad Very Bad Not sure

Does your current partner use alcohol or other drugs? N/A No Yes, what? _____

Comments: _____

Pregnant? No Yes... **If yes, do you have an OBGYN?** No Yes **Do you use birth control?** No Yes

Referrals: ICHD Women's Center, Planned Parenthood.

Do you have children? No (skip to housing section) Yes... How many? _____ Ages: _____

Client has _____ children in their home, _____ children in foster care, _____ children elsewhere, and _____ adult children.

Comments: _____

Are there any child custody issues? N/A No Yes, workers/agencies? _____

Do the children need counseling services? No Yes N/A

Was/were your child(ren) exposed to alcohol or other drugs during your pregnancy, their infancy, or childhood? N/A No Yes

Do your children use alcohol and/or other drugs? N/A Yes No

Do you want information and/or a referral for assistance with parenting? N/A Yes No

Referrals: Ingham County Great Start, Cristo Rey, Child Abuse Prevention Services, Willow Tree Family Center.

Do you want information and/or referrals for assistance with childcare? N/A Yes No

Referrals: CACS Head Start, Family Growth Center, DHHS.

HOUSING:

Homeless? No Yes, previous address? _____

Current address? _____

County of Residence: _____ Is this where you currently live or mailing address? _____

MID-MICHIGAN RECOVERY SERVICES, INC.
BIOPSYCHOSOCIAL ASSESSMENT

Do you want a referral or other assistance to locate suitable and affordable housing? Yes No
Referrals: Maplewood, Lansing Housing Commission, VOA, City Rescue Mission, Capital Area Community Services, Recovery Coach.

Do you live alone? Yes No **If no, who do you live with?**

Name	Age	Relationship	Uses Substances?

Is your housing currently impacted by divorce or domestic violence? No Yes, explain: _____
 Is your living environment supportive of your recovery? Yes No, explain: _____

Referrals: Eve’s House, MSU Safe Place, National Domestic Violence Hotline (800-799-7233).

FAMILY HISTORY:

Were you raised by your biological parents? Yes No, who raised you? _____

Mother: Living Deceased Unknown **Father:** Living Deceased Unknown

What is your parents’ relationship status with each other? _____

If your parents are no longer together, how old were you when they separated/divorced? _____

Did either of them remarry? No Yes, explain: _____

Do you have siblings? ___ Brothers ___ Step/half brothers ___ Sisters ___ Step/half sisters

Family history of substance use? No Yes, who?: _____

History of CPS involvement? No Yes, explain: _____

Have you ever had foster care involvement?
 No Yes, explain: _____

Has your cultural, religious, or family beliefs affected and/or influenced your decision to use substances at any point in your life? No Yes, when and how? _____

Describe what it was like growing up in your family:

- Parents Strict Lacked Discipline Raised by Other Family Members Raised by Others Happy Childhood
- Unhappy Childhood Strong Religious Convictions Family Problems Affectionate Family
- School Problems Alcohol/Drug Abuse in Family Bullied or Teased

Comments: _____

Will you inform any family members or significant others about your treatment here? Yes No N/A

Will you like to include a family member or support person in your treatment planning sessions? No Yes, release? No Yes

MID-MICHIGAN RECOVERY SERVICES, INC.
BIOPSYCHOSOCIAL ASSESSMENT

How close are you to each of the following?	N/A	VERY CLOSE	SOMEWHAT CLOSE	NOT VERY CLOSE	DON'T SEE/ NOT CLOSE
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friend(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are there any concerns or barriers to your relationships? No Yes, explain: _____

EDUCATION:

Highest level of education you completed: _____

Did you receive special education services while you were in school? No Yes, what services? _____

Are there learning issues we should be aware of? No Yes: what? Reading Writing Concentration Math

Are you currently in school? Yes No, do you plan on returning to school this year? Yes No

Do you feel your use and/or abuse of substances impacted your education? No Yes, explain: _____

Would you like a referral or other assistance to return to school or get a GED? Yes No

Referrals: Lansing Community College, Career Quest, Michigan Rehabilitation Services.

Comments: _____

EMPLOYMENT/FINANCIAL:

Are you currently employed? No Yes: Full-time Part-time Seasonal

If yes, place of employment: _____ Occupation: _____

Days and hours of work if known: _____

If no, date of last employment: _____ Occupation: _____

Employment history in the past: _____

Are you able to work? Yes No, why not? _____

On disability? No Yes, reason: _____

Do you have specific job training or education? No Yes, what? _____

Did/does your use and/or abuse of substances impact your employment?
 No Yes, explain: _____

Do you want information and/or a referral for employment assistance/vocational counseling and/or job development placement? No Yes

Do you have any other source(s) of income (unemployment, disability, others, etc.)? No Yes, explain: _____

Do you have any current financial problems? No Yes, explain: _____

MID-MICHIGAN RECOVERY SERVICES, INC.
BIOPSYCHOSOCIAL ASSESSMENT

Does your use of substances impact your finances? No Yes, explain: _____

Do you want information and/or referral for financial counseling, budgeting, foreclosure, etc.? Yes No
Referrals: DHHS, Lansing Food Bank, Peer Recovery Coach.

Comments: _____

LEGAL:

Total times arrested N/A within the last... 30 days: _____ 6 months: _____ 5 years: _____

Present legal status: _____ Court & Officer? _____

Are you involved in a treatment/sobriety court program? No Yes, where? _____

Do you have any pending charges/cases/warrants? No Yes, what county/court? _____

List your criminal arrest/conviction history beginning with the most recent first:

Date of Offense	Criminal Charge/Conviction	Was AOD Involved?	Sentence and Length?

Have you ever been involved in an accident due to drinking or using drugs? No Yes, what was your BAC? _____

What happened? _____

Comments: _____

Do you want a referral for legal counseling or assistance? Yes No

**Referrals: Legal Aid, Legal Services of South Central Michigan, VOA Ability Law Clinic, St Vincent Catholic Charities
Immigration Law Clinic**

MILITARY SERVICE:

Was anyone close to you in the military? Yes No Do you know anyone in active combat? Yes No

Have you served in the military? No Yes, branch? _____ Highest rank achieved? _____

Honorable discharge? Yes No Dates of Service: _____

Were you ever involved in active combat? Yes No

Did you ever use and/or abuse substances while in the military? Yes No

Did your use and/or abuse of substances impact your involvement with the military? Yes No

Comments: _____

Do you want information and/or a referral to access programs with the Veteran's Administration? Yes No N/A

Referrals: VA Medical Center/Fredrick Reynolds, Lansing VA Clinic (CBOC)

MID-MICHIGAN RECOVERY SERVICES, INC.
BIOPSYCHOSOCIAL ASSESSMENT

SUBSTANCE USE:

Substance	Age of 1st use	Date of Last Use	Route of Admin (oral, smoking, iv, inhalation, other)	Frequency (per wk/mo/yr) Past & Present	Amount used (i.e 2-3 beers, 1g, etc.)	Days used in the last 30 or reason for non-use? i.e jail	Social/ moderate/ problematic?
<i>Alcohol</i>							
<i>Amphetamines (Uppers, Adderall, etc.)</i>							
<i>Methamphetamines (crystal meth, ice)</i>							
<i>Barbiturates (sleepers, yellow jackets)</i>							
<i>Benzodiazepines (Xanax, Ativan, etc.)</i>							
<i>Cocaine/Crack Cocaine (blow, bump)</i>							
<i>Designer /Synthetic Drugs (Ecstasy, K2)</i>							
<i>Hallucinogens (Acid, Mushrooms, Peyote)</i>							
<i>Heroin (Dope, H)</i>							
<i>Methadone/Suboxone</i>							
<i>Other Opiates (Vicodin, Norco, Codeine, "Lean")</i>							
<i>Inhalants (Glue, Whippets, Poppers)</i>							
<i>Marijuana</i>							
<i>Nicotine</i>							
<i>Over the counter drugs (Cold Medicine)</i>							
<i>Steroids</i>							
<i>Others/Comments:</i>							

**MID-MICHIGAN RECOVERY SERVICES, INC.
BIOPSYCHOSOCIAL ASSESSMENT**

Further comments regarding substance used or to what lengths would you go to obtain substances?

Were any of the above listed drugs initially a prescription? No Yes, explain: _____

What is your current drug choice(s)? _____

Have you ever overdosed? No Yes, when, drug, method? _____

Have you experienced withdrawal symptoms? No Yes, what? _____

What problems/symptoms have you experienced while using or as a result of using alcohol and/or other drugs?

- Increased tolerance (need for more of substance to achieve desired effect)
- Spending too much time obtaining/using/recovering
- In the past year, have you ever drank or used more drugs than you meant to? Or have you spent more time drinking than you intended to?
- Have you ever used alcohol/drugs to relieve emotional discomfort i.e. sadness, anger or boredom?
- Experience Cravings (preoccupied thinking or physical sensations about wanting to use)
- Do others complain or express concern about your use?
- Taking or using more than you intended
- Continue to use despite negative effects
- Blackouts
- Relationship problems
- Overdosed
- Job performance/employment problems
- Done things I ordinarily wouldn't do
- Neglected some of your usual responsibilities
- Arrests
- Physical/Medical problems
- Unable to stop or limit or cut down on use
- Financial Problems
- Withdrawal symptoms
- History of serious or life threatening withdrawals
- History of seizures during withdrawal

Have you had any previous substance use treatment? No Yes, complete chart:

Treatment Type	Program/Location	Date of Treatment	Outcome / Successful?
<input type="checkbox"/> Detox <input type="checkbox"/> Residential <input type="checkbox"/> OP <input type="checkbox"/> IOP <input type="checkbox"/> MAT			
<input type="checkbox"/> Detox <input type="checkbox"/> Residential <input type="checkbox"/> OP <input type="checkbox"/> IOP <input type="checkbox"/> MAT			
<input type="checkbox"/> Detox <input type="checkbox"/> Residential <input type="checkbox"/> OP <input type="checkbox"/> IOP <input type="checkbox"/> MAT			
<input type="checkbox"/> Detox <input type="checkbox"/> Residential <input type="checkbox"/> OP <input type="checkbox"/> IOP <input type="checkbox"/> MAT			
<input type="checkbox"/> Detox <input type="checkbox"/> Residential <input type="checkbox"/> OP <input type="checkbox"/> IOP <input type="checkbox"/> MAT			

Comments: _____

Longest period of sobriety? _____ Most recent length of sobriety? _____

What helped you maintain your sobriety? _____

MID-MICHIGAN RECOVERY SERVICES, INC.
BIOPSYCHOSOCIAL ASSESSMENT

MENTAL STATUS:

	Current	Past	Comments
Have you felt depressed, sad, or helpless most days?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you lost interest in things you used to enjoy?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you worried or nervous most days?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you been involved in a traumatic event that caused you to fear your life? (e.g. sexual assault, a physical attack, military combat, robbery, a Moderate car accident, or sexual abuse as a child)	<input type="checkbox"/>	<input type="checkbox"/>	
Do you feel others can read your mind or control your thoughts?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you hear voices or see things that others do not?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you sometimes feel full of energy and on top of the world?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you sleep little and not feel tired?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had Moderate difficulty falling asleep, staying asleep, or sleeping all day lasting a month or more?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you lost a lot of weight without dieting or gained a lot of weight not due to a physical health condition? (more than a 5% change)	<input type="checkbox"/>	<input type="checkbox"/>	
Do your mental health symptoms Moderately affect your daily life most days? (school, work, relationships, self-care)	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have thoughts or plans to hurt yourself or someone else?	<input type="checkbox"/>	<input type="checkbox"/>	

Lethality Assessment			
Danger To:	Past	Current	Explain/Comments:
Self	<input type="checkbox"/> Ideation <input type="checkbox"/> Intent <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Action <input type="checkbox"/> None	<input type="checkbox"/> Ideation <input type="checkbox"/> Intent <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Action <input type="checkbox"/> None	
Others	<input type="checkbox"/> Ideation <input type="checkbox"/> Intent <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Action <input type="checkbox"/> None	<input type="checkbox"/> Ideation <input type="checkbox"/> Intent <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Action <input type="checkbox"/> None	
Property	<input type="checkbox"/> Ideation <input type="checkbox"/> Intent <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Action <input type="checkbox"/> None	<input type="checkbox"/> Ideation <input type="checkbox"/> Intent <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Action <input type="checkbox"/> None	
Did your use of substances trigger your suicidal ideation? <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes, how?			
Have you ever intentionally harmed yourself (burning, cutting, picking, etc.)? <input type="checkbox"/> No <input type="checkbox"/> Yes, explain:			

MID-MICHIGAN RECOVERY SERVICES, INC.
BIOPSYCHOSOCIAL ASSESSMENT

Have you ever been in counseling or therapy? No Yes, where/when? _____

How old were you when you first received MH treatment? _____ Was it helpful? _____

Are you currently receiving mental health treatment? No Yes, where? _____

Were you ever diagnosed with a mental health condition?
 No Yes, what diagnosis, by whom and when was it given? _____

Do you understand the diagnosis? Yes No, explain: _____

Do you have a family history of mental health conditions? No Yes, how did it affect you? _____

Have you ever been hospitalized for emotional or psychological issues?
 No Yes, when, where, for what? _____

Has anyone in your family attempted suicide No Yes, who and your age at attempt? _____

Have you experienced significant loss(es)? No Yes, explain: _____

Have you ever been physically, emotionally, or sexually abused/neglected?
 No Yes Not Sure Explain: _____

Have you ever been the victim of violence? No Yes, explain: _____

Have you even been violent towards someone else? No Yes, explain: _____

Has anyone close to you been a victim of violence? No Yes, explain: _____

Would you like a referral for mental health counseling? Yes No

Referrals: Care Free Medical, Guide to Personal Solutions, Women's Center of Greater Lansing, Community Mental Health, The Listening Ear (517-337-1717), Bridges Crisis Unit (517-346-8460)

PHYSICAL HEALTH:

Do you have a Primary Care Physician? Yes No, Does clt want help obtaining a PCP? Yes No

May we contact your PCP? No Yes, release? No Yes

Name of your current physician or clinic? _____ When was your last visit? _____

Do you have health insurance? No Yes Name of Insurance: _____

How would you rate your current general physical health? Excellent Good Fair Poor

Have you lost/gained weight recently? Gained: Yes No Lost: Yes No

Current Medical Problems:

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Serious/Chronic Infection |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Allergies | <input type="checkbox"/> Dental |

Other: _____

Do you exercise? No Yes, what type? _____

Compared to most people your age, are you... More active Less active Average Unsure

On a scale of 1-10, how would you rate your overall physical health? _____

**MID-MICHIGAN RECOVERY SERVICES, INC.
BIOPSYCHOSOCIAL ASSESSMENT**

On a scale of 1-10, how would you rate your activity level in the last 30 days? _____

Do you smoke cigarettes/electronic cigarettes/chew tobacco? No Yes, how much/often? _____

Have you ever shared needles? Yes No

Have you ever been tested for Hep A, B, C, or HIV? Yes No

Has your use of substance(s) impacted your health? No Yes, how? _____

Have you engaged in any risk-taking behaviors including unprotected sex, using dirty needles, driving at excessive speeds, or driving under the influence? Yes No

Please List any Current Medications:

Medication	Dosage & When Taken	Date Initially Rx & Prescribing DR	Reason Prescribed?	Refills Remaining?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

Have your previous or current medications been effective? Yes No

If no, explain: _____

Have you experienced any side effects when taking your previous or current medications? Yes No

If yes, explain: _____

Do you need assistance with care for your medical needs? Yes No

Referrals: Care Free Medical, Ingham Health Plan, Health Department, Destiny Dental, VOA Sparrow Clinic, DHHS for health insurance.

WOMEN SECTION ONLY:

Is there a history of incest or abuse within your family? No Yes, what age did it begin? _____

Are you using birth control? No Yes, what type? _____

Are you pregnant? No Yes, are you using substances during pregnancy? No Yes, Complications? No Yes, explain: _____

Number of miscarriages/abortions? _____ Number of live births? _____

Do you have an OBGYN? Yes No, do you need assistance finding one? No Yes

Date of last OBGYN appointment if applicable: _____

RECOVERY ENVIRONMENT/SUPPORT:

Do you enjoy sports, recreation games, or hobbies? No Yes, what? _____

How do you spend your leisure time? _____

Are these activities supportive of your recovery? No Yes Have they been affected by your use? No Yes

With whom do you spend your leisure time with? _____

Do these people use/abuse substances? No Yes

If you are currently clean/sober, what is assisting you to abstain from use?	
Do you live with someone who has a substance use and/or mental health problems?	<input type="checkbox"/> No <input type="checkbox"/> Yes

**MID-MICHIGAN RECOVERY SERVICES, INC.
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Are you currently receiving help/support from CMH?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you currently attend AA/NA/CA?	<input type="checkbox"/> No <input type="checkbox"/> Yes, how often?
Do you have a sponsor?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Other forms of support? (Church, friends, family, etc.)	<input type="checkbox"/> No <input type="checkbox"/> Yes, type: family, friend, kids
Do you practice any organized religion and/or spiritual practices?	<input type="checkbox"/> No <input type="checkbox"/> Yes
How much social support do you have? (look at past 30 days)	

Do you want assistance to develop new areas of interest and/or support? No Yes
Referrals: 12 Step Meetings, Celebrate Recovery, Smart Recovery, City Pulse.

GAMBLING:

Have there ever been periods lasting 2 weeks or longer when you spent a lot of time thinking about your gambling experiences or planning out future gambling ventures or bets? No Yes

Have you ever tried to stop, cut down, or control your gambling? No Yes

Have you ever lied to family members, friends, or others about how much you gamble or how much money you lost on gambling? No Yes

If you answer yes to any of these questions, below are the additional questions:

Have there ever been periods lasting 2 weeks or longer when you spent a lot of time thinking about your gambling experiences, planning out future gambling ventures or bets, or thinking about ways of getting money to gamble with? No Yes

Have there ever been periods when you needed to gamble with increasing amounts of money or with larger bets than before in order to get the same feeling of excitement? No Yes

Have you ever felt restless or irritable when trying to stop, cut down, or control your gambling? No Yes

Have you tried and not succeeded in stopping, cutting down, or controlling your gambling three or more times in your life? No Yes

Have you ever gambled to escape from personal problems, or to relieve uncomfortable feelings such as guilt, anxiety, helplessness, or depression? No Yes

Has there ever been a period when, if you lost money gambling one day, you would often return another day to get even? No Yes

Have you lied to family members, friends, or others about how much you gamble, and/or about how much money you lost on gambling, on at least three occasions? No Yes

Has your gambling ever caused serious or repeated problems in your relationships with any of your family members or friends? Or, has your gambling ever caused you problems at work or at school? No Yes

Have you ever needed to ask family members, friends, a lending institution, or anyone else to loan you money or otherwise bail you out of a desperate money situation that was largely caused by your gambling? No Yes

TRANSPORTATION:

Do you have a valid driver's license? No Yes

Do you own a vehicle? No Yes

Do you have reliable transportation? No Yes

Will transportation to substance use services be an issue for you? No Yes, if yes, continue below:

How do you plan to get back and forth to treatment? _____

How do you usually get back and forth to appointments?
/What transportation option have you used in the past? _____

What are the most significant barriers you face to getting back and forth to your appointments? (i.e distance, lack of vehicle, no license, lack of public transportation, difficulty in getting to public transportation) _____

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BIOPSYCHOSOCIAL ASSESSMENT

GENERAL QUESTIONS:

<i>What are your strengths?</i>	<i>What are your needs?</i>
<i>Treatment preferences?</i>	<i>What are your abilities?</i>

Are there any other concerns regarding obsessive or compulsive behaviors (eating, sex, shopping, etc.) No Yes, explain: _____

Referrals: Overeaters Anonymous (505-891-2664), Sex Addiction Anonymous (800-477-8191).

What are you hoping to get out of treatment? _____

What do you think may be barriers to your treatment? (Time, money, transportation, hours, conflicts with employment, childcare, etc.) _____

Do you need any assistive technology including audio books, writing supports, timers, audio devices, etc.? No Yes

Are you related to any past or present MMRS Employees? No Yes, who/relationship to you? _____

Do you know anyone receiving services in this program? No Yes

Does this person know you are aware of their involvement with MMRS? N/A No Yes

Please list any other agencies that you are working with? (Catholic Social Services, RISE, Wellness Inx, FIA, CMH, etc.) _____

Would you like any assistance with case management needs? No Yes

Referrals: Peer Recovery Coach, Case Manager.

DSM DIAGNOSIS:

<input type="checkbox"/> Substance is used in larger amounts or over a longer period of time than intended <input type="checkbox"/> There is a persistent desire or unsuccessful efforts to cut down or control substance use <input type="checkbox"/> A great deal of time is spent in activities necessary to obtain, use, or recover from the substance <input type="checkbox"/> Craving, or a strong desire or urge to use <input type="checkbox"/> Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home <input type="checkbox"/> Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effect of the substance	<input type="checkbox"/> Important social, occupational, or recreational activities are given up or reduced because of substance use <input type="checkbox"/> Recurrent substance use in situations in which it is physically hazardous <input type="checkbox"/> Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance <input type="checkbox"/> Tolerance, as defined by a need for increased amounts to achieve desired effect OR a diminished effect with continued use of the same amount <input type="checkbox"/> Withdrawal, as manifested by either the characteristic of withdrawal syndrome for the substance OR a closely related substance is taken to relieve or avoid withdrawal symptoms
--	---

*Specify current severity: **Mild:** Presence of 2-3 symptoms, **Moderate:** Presence of 4-5 symptoms, or **Moderate:** Presence of 6 or more symptoms.*

*Specify if: **in early remission:** After full criteria for a substance use disorder were previously met, none of the criteria for a substance use disorder have been met for at least 3 months but for less than 12 months (with exception for the "craving" criteria), **in sustained remission:** after full criteria for a substance use disorder were met, none of the criteria have been met at any time during a period of 12 months or longer (with exception for the*

MID-MICHIGAN RECOVERY SERVICES, INC.
BIOPSYCHOSOCIAL ASSESSMENT

“craving” criteria), **in a controlled environment:** this additional specifier is used if the individual is in an environment where access to substances is restricted.

DIAGNOSTIC IMPRESSIONS AS PER THE DSM-5™:

ICD-10	CODE	DESCRIPTION

ASAM PLACEMENT CRITERIA:

DIMENSION		0.5	OMT	1	2.1	2.5	3.1	3.3	3.5	3.7	4.0
I	Acute intoxication and/or withdrawal potential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
II	Biomedical conditions/complications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
III	Emotional/behavioral conditions/complications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IV	Readiness to change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
V	Relapse/continued use potential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VI	Recovery environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of Care Placement:		If Level 1, Specify Group:									

CLINICAL SUMMARY:

MID-MICHIGAN RECOVERY SERVICES, INC.
BIOPSYCHOSOCIAL ASSESSMENT

[Empty rectangular box for assessment content]

Intake Counselor Signature

Date

Supervisor Signature

Date

T F

Fill in the square like this:
Not like this:

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If a statement tends to be TRUE for you, fill in the square of the T column like this:
If a statement tends to be FALSE for you, fill in the square of the F column like this:
Please provide one answer for each question.
There are no right or wrong answers; just answer the way you feel.

- | | |
|---|---|
| <p>T F</p> <p>1. <input type="checkbox"/> <input type="checkbox"/> People know they can count on me for solutions.</p> <p>2. <input type="checkbox"/> <input type="checkbox"/> Most people make some mistakes in their lives.</p> <p>3. <input type="checkbox"/> <input type="checkbox"/> I usually "go along" and do what others are doing.</p> <p>4. <input type="checkbox"/> <input type="checkbox"/> I have never been in trouble with the police.</p> <p>5. <input type="checkbox"/> <input type="checkbox"/> I was always well behaved in school.</p> <p>6. <input type="checkbox"/> <input type="checkbox"/> I like doing things on the spur of the moment.</p> <p>7. <input type="checkbox"/> <input type="checkbox"/> I have not lived the way I should.</p> <p>8. <input type="checkbox"/> <input type="checkbox"/> I can be friendly with people who do many wrong things.</p> <p>9. <input type="checkbox"/> <input type="checkbox"/> I do not like to sit and daydream.</p> <p>10. <input type="checkbox"/> <input type="checkbox"/> No one has ever criticized or punished me.</p> <p>11. <input type="checkbox"/> <input type="checkbox"/> Sometimes I have a hard time sitting still.</p> <p>12. <input type="checkbox"/> <input type="checkbox"/> People would be better off if they took my advice.</p> <p>13. <input type="checkbox"/> <input type="checkbox"/> At times I feel worn out for no special reason.</p> <p>14. <input type="checkbox"/> <input type="checkbox"/> I am a restless person.</p> <p>15. <input type="checkbox"/> <input type="checkbox"/> It is better not to talk about personal problems.</p> <p>16. <input type="checkbox"/> <input type="checkbox"/> I have had days, weeks or months when I couldn't get much done because I just wasn't up to it.</p> <p>17. <input type="checkbox"/> <input type="checkbox"/> I am very respectful of authority.</p> <p>18. <input type="checkbox"/> <input type="checkbox"/> I come up with good strategies.</p> <p>19. <input type="checkbox"/> <input type="checkbox"/> I have been tempted to leave home.</p> <p>20. <input type="checkbox"/> <input type="checkbox"/> I often feel that strangers look at me with disapproval.</p> <p>21. <input type="checkbox"/> <input type="checkbox"/> Other people would fall apart if they had to deal with what I handle.</p> <p>22. <input type="checkbox"/> <input type="checkbox"/> I have avoided people I did not want to speak to.</p> <p>23. <input type="checkbox"/> <input type="checkbox"/> Some crooks are so clever that I hope they get away with what they have done.</p> <p>24. <input type="checkbox"/> <input type="checkbox"/> My school teachers had some problems with me.</p> <p>25. <input type="checkbox"/> <input type="checkbox"/> I have never done anything dangerous just for fun.</p> <p>26. <input type="checkbox"/> <input type="checkbox"/> I need to have something to do so I don't get bored.</p> <p>27. <input type="checkbox"/> <input type="checkbox"/> I have sometimes drunk too much.</p> <p>28. <input type="checkbox"/> <input type="checkbox"/> Much of my life is uninteresting.</p> <p>29. <input type="checkbox"/> <input type="checkbox"/> Sometimes I wish I could control myself better.</p> <p>30. <input type="checkbox"/> <input type="checkbox"/> I believe that people sometimes get confused.</p> <p>31. <input type="checkbox"/> <input type="checkbox"/> Sometimes I am no good for anything at all.</p> <p>32. <input type="checkbox"/> <input type="checkbox"/> I break more laws than many people.</p> <p>33. <input type="checkbox"/> <input type="checkbox"/> If some friends and I were in trouble together, I would rather take the whole blame than tell on them.</p> <p>34. <input type="checkbox"/> <input type="checkbox"/> Crying does not help.</p> <p>35. <input type="checkbox"/> <input type="checkbox"/> I think there is something wrong with my memory.</p> <p>36. <input type="checkbox"/> <input type="checkbox"/> I have sometimes been tempted to hit people.</p> <p>37. <input type="checkbox"/> <input type="checkbox"/> Most people would lie to get what they want.</p> <p>38. <input type="checkbox"/> <input type="checkbox"/> I always feel sure of myself.</p> | <p>T F</p> <p>39. <input type="checkbox"/> <input type="checkbox"/> I have never broken a major law.</p> <p>40. <input type="checkbox"/> <input type="checkbox"/> There have been times when I have done things I couldn't remember later.</p> <p>41. <input type="checkbox"/> <input type="checkbox"/> I think carefully about all my actions.</p> <p>42. <input type="checkbox"/> <input type="checkbox"/> I have used too much alcohol or "pot," or used too often.</p> <p>43. <input type="checkbox"/> <input type="checkbox"/> Nearly everyone enjoys being picked on and made fun of.</p> <p>44. <input type="checkbox"/> <input type="checkbox"/> I like to obey the law.</p> <p>45. <input type="checkbox"/> <input type="checkbox"/> I frequently make lists of things to do.</p> <p>46. <input type="checkbox"/> <input type="checkbox"/> I think I know some pretty undesirable types.</p> <p>47. <input type="checkbox"/> <input type="checkbox"/> Most people will laugh at a joke now and then.</p> <p>48. <input type="checkbox"/> <input type="checkbox"/> I have rarely been punished.</p> <p>49. <input type="checkbox"/> <input type="checkbox"/> I use tobacco regularly.</p> <p>50. <input type="checkbox"/> <input type="checkbox"/> At times I have been so full of energy that I felt I didn't need sleep for days at a time.</p> <p>51. <input type="checkbox"/> <input type="checkbox"/> I have sometimes sat around when I should have been working.</p> <p>52. <input type="checkbox"/> <input type="checkbox"/> I am often resentful.</p> <p>53. <input type="checkbox"/> <input type="checkbox"/> I take all my responsibilities seriously.</p> <p>54. <input type="checkbox"/> <input type="checkbox"/> I do most of my drinking or drug use away from home.</p> <p>55. <input type="checkbox"/> <input type="checkbox"/> I have had a drink first thing in the morning to steady my nerves or to get rid of a hangover.</p> <p>56. <input type="checkbox"/> <input type="checkbox"/> While I was a teenager, I began drinking or using other drugs regularly.</p> <p>57. <input type="checkbox"/> <input type="checkbox"/> One of my parents was/is a heavy drinker or drug user.</p> <p>58. <input type="checkbox"/> <input type="checkbox"/> When I drink or use drugs I tend to get into trouble.</p> <p>59. <input type="checkbox"/> <input type="checkbox"/> My drinking or other drug use causes problems between me and my family.</p> <p>60. <input type="checkbox"/> <input type="checkbox"/> New activities can be a strain if I can't drink or use when I want.</p> <p>61. <input type="checkbox"/> <input type="checkbox"/> I frequently use non-prescription antacids or digestion medicine.</p> <p>62. <input type="checkbox"/> <input type="checkbox"/> I have never felt sad over anything.</p> <p>63. <input type="checkbox"/> <input type="checkbox"/> I have neglected obligations to family or work because of my drinking or using drugs.</p> <p>64. <input type="checkbox"/> <input type="checkbox"/> I am usually happy.</p> <p>65. <input type="checkbox"/> <input type="checkbox"/> I'm good at figuring out the plot in a spy drama or murder mystery long before the end.</p> <p>66. <input type="checkbox"/> <input type="checkbox"/> I have wished I could cut down my drinking or drug use.</p> <p>67. <input type="checkbox"/> <input type="checkbox"/> I am a binge drinker/drug user.</p> <p>68. <input type="checkbox"/> <input type="checkbox"/> I often use energy drinks or other over-the-counter products to get me through my day.</p> <p>69. <input type="checkbox"/> <input type="checkbox"/> I'm reluctant to tell my doctors about all the medications I'm using.</p> <p>70. <input type="checkbox"/> <input type="checkbox"/> My doctors have not prescribed me enough medication to get the relief I need.</p> <p>71. <input type="checkbox"/> <input type="checkbox"/> I know that my drinking/using is making my problems worse.</p> <p>72. <input type="checkbox"/> <input type="checkbox"/> I have built up a tolerance to the alcohol, drugs, or medications I've been using.</p> <p>73. <input type="checkbox"/> <input type="checkbox"/> Over time I have noticed I drink or use more than I used to.</p> <p>74. <input type="checkbox"/> <input type="checkbox"/> I have worried about my parent(s)' drinking or drug use.</p> |
|---|---|

Name/ID _____ Date _____ Gender _____ Age _____

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For each item below, circle the number which reflects how often you have experienced the situation described **DURING THE TIME FRAME** the administrator has checked below:

your entire life the past six months the past twelve months the six months before _____ the six months since _____

FVA

Never Once or Twice Several Times Repeatedly

"Drinks" and "drinking" refer to any type of alcohol - beer, wine, hard liquor, etc.

1. Had drinks (beer, wine, liquor) with lunch? 0 1 2 3
2. Taken a drink or drinks to help you talk about your feelings or ideas? 0 1 2 3
3. Taken a drink or drinks to relieve a tired feeling or give you energy to keep going? 0 1 2 3
4. Had more to drink than you intended to? 0 1 2 3
5. Experienced physical problems after drinking (e.g., nausea, seeing/hearing problems, dizziness, etc.)? 0 1 2 3
6. Gotten into trouble on the job, in school, or with the law because of your drinking? 0 1 2 3
7. Became depressed after having sobered up? 0 1 2 3
8. Argued with your family or friends because of your drinking? 0 1 2 3
9. Had the effects of drinking recur after not drinking for a while (e.g., flashbacks, hallucinations, etc.)? 0 1 2 3
10. Had problems in relationships because of your drinking (e.g., loss of friends, separation, divorce, etc.)? 0 1 2 3
11. Became nervous or had the shakes after having sobered up? 0 1 2 3
12. Tried to commit suicide while drunk? 0 1 2 3
13. Found myself craving a drink or a particular drug? 0 1 2 3

Highest Grade Completed: 1-4 5-8 9 10 11 12/GED
 Some College 2 Year College 4 Year College Graduate Degree

Employment Status: Full-time Part-time Not Employed Student
 Homemaker Disabled Retired

Ethnic Origin: American Indian or Alaska Native Asian
 Black or African American Canadian Native Hispanic
 Native Hawaiian or Pacific Islander White Multiracial Other

Marital Status: Married Unmarried Couple Single Divorced
 Widowed Separated

Number of People in Household: _____
Weekly Family Net Income: Prefer not to answer \$0 Less than \$200 \$200-300
 \$301-400 \$401-500 \$501-600 \$601-700
 \$701-800 \$801-900 Over \$900 Not Sure

FVOD

Never Once or Twice Several Times Repeatedly

The word "misuse" means taking medications in larger amounts than prescribed, longer than prescribed, or using medications not prescribed for you. "Drugs" include things like pot, cocaine, meth, heroin, etc.

1. Misused medications or took drugs to improve your thinking and feelings? 0 1 2 3
2. Misused medications or took drugs to help you feel better about a problem? 0 1 2 3
3. Misused medications or took drugs to become more aware of your senses (e.g., sight, hearing, touch, etc.)? 0 1 2 3
4. Misused medications or took drugs to improve your enjoyment of sex? 0 1 2 3
5. Misused medications or took drugs to help forget that you feel helpless and unworthy? 0 1 2 3
6. Misused medications or took drugs to forget school, work or family pressures? 0 1 2 3
7. Gotten into trouble at home, work, or with the police because of medications or drug-related activities? 0 1 2 3
8. Gotten really stoned or wiped out on drugs (more than just high)? 0 1 2 3
9. Tried to get a hold of some prescription drug (e.g., tranquilizers, pain killers, pills to calm nerves, sleep aids, etc.)? 0 1 2 3
10. Spent your spare time in drug-related activities (e.g., talking about drugs, buying, selling, taking, etc.)? 0 1 2 3
11. Used drugs or medications and alcohol at the same time? 0 1 2 3
12. Kept taking medications or drugs in order to avoid pain or withdrawal? 0 1 2 3
13. Felt your misuse of medications, alcohol, or drugs has kept you from getting what you want out of life? 0 1 2 3
14. Took a higher dose or different medications than your doctor prescribed in order to get the relief you need? 0 1 2 3
15. Used prescription drugs that were not prescribed for you? 0 1 2 3
16. Your doctor denied your request for medications you needed? 0 1 2 3
17. Been accepted into a treatment program because of misuse of medications, alcohol, or drugs? 0 1 2 3
18. Engaged in activity that could have been physically dangerous after (or while) drinking or using drugs or medications? 0 1 2 3



Global Appraisal of Individual Needs - Initial (GAIN-I)

Version [GVER]: 5.7.6

Site ID [XSITE]:.....	Local Site Name [XSITEa]:
Staff ID [XSID]:	Staff Initials [XSIN]:
Part. ID [XPID]:	Last Name [XPNAM]: _____
Tx Pr. ID [XTPID]:	First Name: _____ M.I.: _____
(Optional) Social Security Number [XSSN]: - -	
(Optional) Other/State ID [XPIDA]: - -	
Observation [XOBS]: 0	v. _____
Edit Staff ID [XEDSID]:	Edit Date [XEDDT]: / / 20
Data Entry Staff ID [XDESID]:	Key Date [XDEDT]: / / 20
Rekey Staff ID [XRKSID]:	Rekey Date [XRKDT]: / / 20

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This is a standardized bio-psycho-social assessment designed to help clinicians gather information for diagnosis, placement, and treatment planning. As with any self-report, the GAIN is limited by the veracity of the individual respondent's answers; it should be collected by someone certified in GAIN administration, combined with other information and interpreted by clinical or other qualified personnel prior to taking any specific actions.

The information on this form must be handled in the strictest confidence and will not be released to unauthorized personnel. In accordance with the provisions of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, unauthorized disclosure can result in fines for each violation. All staff with access to the specific answers on this form must understand this restriction and agree to resist sharing specific answers without prior written consent.

The current version of this instrument was developed by Dr. Michael Dennis and others at Chestnut Health Systems. Its development was supported by grants and contracts from the Center for Substance Abuse Treatment, Interventions Foundation, National Institute on Alcohol Abuse and Alcoholism, and National Institute on Drug Abuse. It also incorporates several scales and questions based on the National Family Violence Survey, National Household Survey on Drug Abuse and work by the American Psychiatric Association and the American Society of Addiction Medicine, as well as input from many individuals fully acknowledged in the manual and on the website referred to below.

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For Staff Use Only

A1. Administrative Information

A1a. Time:|_|_| : |_|_| HH:MM..... A1b. |_|_| (AM/PM)

A1c. Today's Date [XOBSDT]: |_|_| / |_|_| / 20 |_|_| (MM/DD/YYYY)

A1d. Reference Date if Different [XRFDt]: |_|_| / |_|_| / 20 |_|_| (MM/DD/YYYY)

Introduction

Purpose: This assessment is designed to help us track how you are doing before, during and after treatment or counseling. The information we collect will only be used for your treatment and to help us evaluate our own services.

Format: This initial assessment has questions about what you have done, what services you are using and what you currently want from the program, either directly or through referral. You will be able to say you do not know or refuse to answer any question that you do NOT want to answer.

Length: Depending on how much has been going on in your life, it will take about 1-2 hours to complete. You will be able to take a break if you need to.

Privacy: As with everything you do in treatment, your answers are private and your confidentiality is protected under the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Confidentiality: All research and clinical staff with access to your answers understand this restriction and have agreed to resist sharing your specific answers without your prior written consent. This includes giving information to family members, other individuals, other treatment agencies, social work agencies, criminal justice agencies and other agencies. (READ ONLY IF APPLICABLE: We have also obtained a certificate of confidentiality to prevent us from being forced to give any information to the court.) There are, however, two exceptions. First, we are mandated to report child abuse or if you are presently a danger to yourself or others. Second, officials from the federal government have the right to audit us to check to make sure we have protected your safety and accurately reported what we have done.

Any questions?

A2. Check for Cognitive Impairment

Because we are going to ask you a lot of questions about when and how often things have happened, we need to start by getting a sense of how well your memory is working right now.

ERROR SCORES

CIS	A2a.	What year is it now? (Select 4 for any error).....	0	4
	A2b.	What month is it now? (Select 3 for any error).....	0	3
	Please repeat this phrase after me: John Brown, 42 Mark Street, Detroit. (No score - used for A2f)			
	A2c.	About what time is it? (Select 3 for any error).....	0	3
	A2d.	Please count backwards from 20 to 1. [20, 19, 18, 17, 16, 15, 14, 13, 12, 11, 10, 9, 8, 7, 6, 5, 4, 3, 2, 1] (Select 2 for one error, 4 for 2 or more errors).....	0	2 4
	A2e.	Please say the days of the week in reverse order. [Sat, Fri, Thu, Wed, Tue, Mon, Sun] (Select 2 for one error, 4 for 2 or more errors).....	0	2 4
	A2f.	Please repeat the phrase I asked you to repeat before [John/ Brown/ 42/ Mark Street/ Detroit] (Select 2 for each subsection of /text/ missed).....	0	2 4 6 8 10
	A2g.	(Add up scores from a through f and record):		<input type="text"/>
	(If total is greater than 10, the individual is experiencing some degree of cognitive impairment. You can attempt again later if intoxication is suspected, or proceed and take into account when making the interpretation. If you do this section over, record the original score in A2h before revising.)			
	A2h.	(Original score):.....		<input type="text"/>

Several questions will ask you about things that have happened during the **past 12 months** or **past 90 days**. To help you remember these time periods, please look at the calendar. First, let's find today's date and circle it.

Next, count back 13 weeks to about 90 days ago and circle that date. Do you recall anything that was going on about (DATE 90 DAYS AGO)?

(PROBE FOR SPECIFIC EVENT. **IF UNABLE TO RECALL:** Do you remember any birthdays, holidays, sporting or other special events that happened around (DATE 90 DAYS AGO)? Did anything change in terms of where you were living, who you were with, whether you were in treatment, work, school or jail? Where were you living then? Were you in treatment, working, in school, or involved with the law then?)

A3a1. Record anchor for 90 days: v. _____

When we talk about things happening to you during the past 90 days, we are talking about things that have happened since about (NAME 90-DAY ANCHOR) .

Now, let's go back to a year ago and circle that date. Do you recall anything that was going on about (DATE 12 MONTHS AGO)?

(PROBE FOR SPECIFIC EVENT. **IF UNABLE TO RECALL:** Do you remember any birthdays, holidays, sporting or other special events that happened around (DATE 12 MONTHS AGO)? Did anything change in terms of where you were living, who you were with, whether you were in treatment, work, school or jail? Where were you living then? Were you in treatment, working, in school, or involved with the law then?)

A3a2. Record anchor for 12 months: v. _____

When we talk about things happening to you during the past 12 months, we are talking about things that have happened since about (NAME 12-MONTH ANCHOR) .

Please answer the next questions using yes or no.

	<u>Yes</u>	<u>No</u>
A3b1. Do you have any problems reading English in something like a newspaper or magazine?	1	0
A3b2. Do you have any problems writing English in something like a job application or resume?	1	0
A3b3. Do you have any problems understanding what you read in English?.....	1	0
A3b4. Do you have any problems talking about your feelings or emotions in English?	1	0
A3b5. Are you better able to read, write, understand or talk about your emotions using a different language (besides English)? (Please describe).....	1	0
v. _____		
A3c. [Document your initial administration decision]		
Done orally because of literacy or client choice.....	0	[READ ORAL INST]
Staff chose in advance to administer	1	[READ ORAL INST]
Self-administered.....	2	[READ SA INST]
Other (Please describe).....	99	[READ SA INST]

v. _____

Additional Instructions for Oral Administration

Please keep this calendar handy and use it as we go through the interview to help you remember when different things happened.

As we go through the questionnaire, I will read the questions and record your answers. It is important that you try to answer each question if you can and are willing to. We know that you will not always know the exact answer, but we would like you to give us your best guess if you can. You can also tell us if you simply do not know or if you do not want to or refuse to answer any questions. I also have some cards here that we will use to help answer some of the questions.

Do you have any questions before we begin?

Optional Additional Instructions for Self-administration

There are four types of questions in this assessment: (1) questions that ask you to answer in your **own words**; (2) questions that ask you to **select one** answer in a list of answers; (3) questions that ask you to select all that are **MENTIONED**; and (4) questions that ask you **how many** days or times something happened. Answers in **your own words** do not need to be long, but try to write neatly so that we can read it. For questions that ask you to **select one**, please pick the one that fits best. Questions where you select all the responses mentioned should have a yes or no selected for each row. Questions that ask you **how many days or times** something happened should always be answered with a number. If the answer is no, none, never or 0, please print 0 in the open box.

Where we are giving you instructions, they will appear in **(bold and parentheses like this)**. After you answer some questions, there may be several more below it that do not apply to you. When this happens there will be a note between **[SQUARE BRACKETS WITH BOLD CAPITAL LETTERS LIKE THIS]**. It will tell you to go to the next question that does apply to you. **Never** skip farther than the next question number. Can you show me how this works in the example below?

Example

	<u>Yes</u>	<u>No</u>	
S6. Have you ever attended Alcoholics Anonymous (AA), Cocaine Anonymous (CA), Narcotics Anonymous (NA), Social Recovery (SR), or another self-help group for your alcohol or other drug use?	1	0	[IF NO, GO TO S6b]
S6a. During the past 90 days , on how many days have you attended one or more self-help group meetings (such as AA, NA, CA, or Social Recovery) for your alcohol or other drug use?	_ _		[IF 0, GO TO S6b]
	Days		

There will also be several boxes marked "For Staff Use Only." You can skip any questions in them unless the staff marks them and asks you to do them.

If you are not sure about an answer, please try to give us your best guess. If you change your mind, please cross through the old answer and select the new answer. If you simply do not know, write "DK" to the right of the question. You may want to decline or refuse to answer any question simply by writing "RF" next to any question you do not want to answer. It is important that you either answer the question or write "DK" or "RF." Otherwise, we will think you just missed the answer by mistake and will ask you about it again. If you do not understand a question or word and want to go over it with a staff person, put a "?" to the right side. If you need a break, write the time you stopped working on the survey on the page you have reached. After your break, write the time you started up again on that same page.

You will notice some abbreviations in the left column. These are to help staff when reading this instrument.

Do you have any questions?

A4. Presenting Concerns

A4a. In a few words, can you tell me why you are here today? (What is your main reason for coming to treatment?) (Do not ask "Any others")

v1. _____

(Clarify and code)

- Drug availability (difficulties obtaining drugs or "good" drugs)..... 1
- Financial (can't afford to stay on drugs, lost an income source) 2
- General personal motive ("habit out of control," "tired," "want to change," "improve lifestyle," "save self") 3
- Health reasons (too ill to continue; drugs or related diseases are hurting or threatening own health, unborn baby, to live) 4
- Pressure from family (parent, spouse, partner)..... 5
- Parenting issues (get or keep custody or become better parent)..... 6
- Pressure from criminal justice system (court mandate, probation officer, parole officer, attorney, etc.)..... 7
- Pressure from Department of Child and Family Services (DCFS) 8
- Pressure from school teacher, minister, coach, etc..... 9
- Desire for services (want housing or other benefit) 10
- School or job (to get, keep or improve situation)..... 11
- Other (**Please describe in A4a**) 99

A4b. What is the name of the person who referred you to treatment?

v. _____

A4c. What is this person's relationship to you?

v. _____

A4d. Referral Code (from below).....

Individuals		Agencies	
1 Self	10 Judge	21 Alcohol/Drug abuse program	41 State alcohol/drug abuse program
2 Mother	11 Teacher	22 Behavioral health provider	42 State mental health program
3 Father	12 Supervisor at work	23 Other health care provider	43 State DCFS or welfare program
4 Brother	13 Social Worker	24 Outreach, Advocacy or Prevention program	44 State health department
5 Sister	14 Lawyer	25 School	49 Other State Agency
6 Grandparent	15 Probation Officer	26 Employer	50 Out of State CJ program
7 Aunt	16 Parole Officer	27 Social Service Agency	59 Other out of State agency
8 Uncle	17 Public Aid Worker	28 Criminal Justice Agency	99 Other (please describe in A4c)
9 Other family	18 Priest/Minister	30 TASC or diversion program	
	19 Other individual	39 Other Agency	

B. Background and Treatment Arrangements

B1. What is your gender?

- Male 1
 Female 2
 Transgender (Male to Female) 4
 Transgender (Female to Male) 5
 Other (**Please describe**)..... 99

v. _____

B2. What is your date of birth? / /
Month Day Year

B2a. How old are you today? **[IF 18 OR OVER, GO TO B3a]**
Age

B2b. Who currently has **legal custody** of you? (Would you say...)

v. _____

(Clarify and code)

- Parents living together 1
 Parents who are separated but share custody 2
 One parent (even if living with stepparent) 3
 Other family members 4
 Legally emancipated minor living on your own 5
 Runaway/on own (without legal emancipation) 6
 County/State (foster home or protective services) 7
 Juvenile or correctional institution 8
 Other (**Please describe in B2bv**) 99

Please answer the next questions using the number of days.

B2c. **During the past 90 days**, on how many **days** were you in foster care?
(Use 0 for none)
Days

B2d. **During the past 90 days**, on how many **days** were you in any other kind
 of group home or child care institution? **(Use 0 for none)**.....
Days

Please answer the next questions using yes or no.

PAI	B2.	During the past 12 months , have you done any of the following things with your (biological, foster, adopted or step) parents?	<u>Yes</u>	<u>No</u>
	e.	Spent 30 minutes or more playing or doing fun things with them	1	0
	f.	Gone with them to an organized activity or event.....	1	0
	g.	Had them read to you, or talked to them about a book, magazine or newspaper	1	0
	h.	Gotten help from them with your homework (reading, writing or math).....	1	0
	j.	Had them meet with a teacher, social worker, lawyer, court official or police officer about you.....	1	0

B3a. Which races, ethnicities, nationalities or tribes best describe you? (Any others?)
(Please record and select all that apply)

v1. _____

Please select at least one race.

		MENTIONED	
		<u>Yes</u>	<u>No</u>
1.	Alaskan Native (Please record tribe in B3av1)	1	0
2.	Asian.....	1	0
3.	African American/Black.....	1	0
4.	Caucasian/White.....	1	0
5.	Hispanic, Latino or Chicano.....	1	0
	a. Puerto Rican.....	1	0
	b. Mexican.....	1	0
	c. Cuban.....	1	0
	e. Dominican.....	1	0
	f. Other Central American.....	1	0
	g. Other South American.....	1	0
	z. Other (Please describe in B3av1)	1	0
6.	Native American (Please record tribe in B3av1)	1	0
7.	Native Hawaiian.....	1	0
8.	Pacific Islander.....	1	0
99.	Some other group (Please describe in B3av1)	1	0

<i>For Staff Use Only (Optional)</i>
<i>Please enter any additional local race, ethnicity or tribal codes that are needed:</i>
B3b1. CODE: _ _ _ _ _ v. _____
B3b2. CODE: _ _ _ _ _ v. _____
B3b3. CODE: _ _ _ _ _ v. _____

Please answer the next questions using yes or no.

TxPI		<u>Yes</u>	<u>No</u>	
B4.	Are you currently under pressure to come to or stay in treatment from...			
a.	an employer, school or training program?.....	1	0	
b.	your lawyer?	1	0	
c.	a court, parole or probation officer, or other part of the criminal justice system?.....	1	0	
d.	a housing or other community agency?.....	1	0	
e.	your church or close friend?	1	0	
f.	your spouse, partner or family?	1	0	
g.	Department of Children and Family Services?.....	1	0	
h.	any other source (Please describe)?	1	0	
	v. _____			
B4j.	Have you been required or mandated to go to treatment?	1	0	[IF NO, GO TO B5]
	By whom?			
	v. _____			
B5.	Are your medical expenses covered by any type of insurance, court or health program?	1	0	[IF NO, GO TO B6]
B5a.	What is the name of your insurance company or provider?			
	v. _____			
B5b.	Is your insurance publicly funded, privately funded, or mixed?			
	Public (Medicare, Medicaid, publicly funded, VA, CHAMPUS, correctional authority)	1		
	Private (HMO, BCBS, from employer, employee assistance program)	2		
	Mixed (both public and private, public purchase of HMO)	3		

<i>For Staff Use Only</i>
B5c. Detailed Insurance Code: _ _ _ _ _ _ _ _

B6. How long (or how much longer) do you think you are going to need to be in treatment?

(Clarify and code)

- Do not need any (more) treatment 0
- 1 to 2 days 1
- 3 to 7 days 2
- 1 to 4 weeks 3
- 1 to 3 months 4
- 4 to 12 months 5
- More than 12 months 6

B7. How do you **plan** to get to this treatment program in the **next** 90 days?

(Clarify and code)

- Do not plan to be in treatment 0
- Will be living there 1
- Walking there 2
- Driving there 3
- Getting a ride from a family member or friend 4
- Taxi 5
- Bus, subway or other public transportation 6
- Other (**Please describe**) 99

v. _____

B7a. How many **minutes** does it take you to get here from home?.....
Minutes

Please answer the next questions using yes or no.

Yes No

B8. Have you **ever** had a driver's license? 1 0 [IF NO, GO TO B9a]

B8_1. Is your license currently...

(Select one)

- valid? 1
- expired? 2
- suspended? 3
- revoked? 4
- under an alias or forged? 5

B8a. What is your driver's license number?

B8b. What state (or country) is it from? or v. _____
State Country

Please answer the next questions using yes or no.

B9a.	Do you currently want (more) help with the following situations in order to come into and stay in treatment?	<u>Yes</u>	<u>No</u>
1.	Making transportation arrangements	1	0
2.	Making child care arrangements.....	1	0
3.	Scheduling around work, school or family responsibilities	1	0
4.	Paying for treatment	1	0
5.	Language, religious, ethnic or cultural issues.....	1	0
6.	Clothing	1	0
7.	Food.....	1	0
B9a99.	Are there any other issues we need to address for you to be able to come to treatment? (Please describe)	1	0

v. _____

(If you are doing this on your own, please tell the staff person that you have finished the first section.)

<i>For Staff Use Only</i>	
AGUR	B10. Urgency Rating [BUR]: NO <input type="checkbox"/> _0 ALREADY <input type="checkbox"/> _1 GT 3 MO <input type="checkbox"/> _2 0-3 MO <input type="checkbox"/> _3 NOW <input type="checkbox"/> _4
AGDM	B11. DM Rating [BDM]: NONE <input type="checkbox"/> _0 SOME <input type="checkbox"/> _1 MISUNDER <input type="checkbox"/> _2 DENIAL <input type="checkbox"/> _3 MISREP <input type="checkbox"/> _4

S. Substance Use (Alcohol, Marijuana and Other Drugs)

The next questions are about your use of alcohol and other drugs. Alcohol includes beer, wine, whiskey, gin, scotch, tequila, rum or mixed drinks. "Other drugs" include a) marijuana, b) other street drugs like crack, heroin, PCP, or poppers, c) inhalants like glue or gasoline and d) any **non-medical** use of prescription-type drugs. Please do not include any prescription drugs you use or used under the direction of a doctor.

S1. Between alcohol, marijuana, cocaine, heroin and any other drugs...

a. which do you like to use the most?

v. _____

For Staff Use

1. | | | | |

b. for which ones do you most need treatment?

v1. _____

v2. _____

v3. _____

For Staff Use

1. | | | | |

2. | | | | |

3. | | | | |

<i>Detailed Drug Codes</i>			
<p>0 None/no others</p> <p>1 Alcohol</p> <p>1A Beer</p> <p>1B Wine</p> <p>1C Hard alcohol (e.g., gin, rum, scotch, tequila, whiskey, or mixed drinks)</p> <p>2 Amphetamines</p> <p>2A Methamphetamine (Desoxyn, methedrine)</p> <p>2B Methylphenidate (Adderall, Concerta, Ritalin)</p> <p>2C Ecstasy/MDMA (methylenedioxy- methamphetamine)</p> <p>2Z Other amphetamines (Benzedrine, Biphetamine, Dexedrine)</p> <p>3 Cannabis</p> <p>3A Marijuana</p> <p>3B Hashish</p> <p>3C Blunts (marijuana-filled cigar)</p> <p>3D Marijuana with other drugs</p> <p>3Z Other cannabis</p> <p>4 Cocaine</p> <p>4A Inhaled cocaine</p> <p>4B Injected cocaine</p> <p>4C Crack</p> <p>4D Freebase</p> <p>4Z Other cocaine</p> <p>5 Hallucinogens</p> <p>5A LSD (lysergic acid diethylamide)</p> <p>5B Mushrooms</p> <p>5C Mescaline</p> <p>5D Peyote</p> <p>5E Psilocybin</p> <p>5F Ketamine (Ketalar, special K)</p> <p>5Z Other hallucinogens</p>	<p>6 Inhalants</p> <p>6A Correction fluids</p> <p>6B Gasoline</p> <p>6C Glue</p> <p>6D Lighters</p> <p>6E Spray paint</p> <p>6F Paint thinner</p> <p>6Z Other inhalants</p> <p>7 Opioids</p> <p>7A Heroin</p> <p>7B Speedball (heroin and cocaine)</p> <p>7C Karachi (heroin and barbiturates)</p> <p>7D Heroin with other drugs</p> <p>7E Street methadone</p> <p>7F Morphine</p> <p>7G Opium</p> <p>7H Codeine</p> <p>7J Tylenol w/codeine</p> <p>7K Hydrocodone (Lorcet, Lortab, Vicodin)</p> <p>7M Oxycodone (OxyContin, Percocet, Percodan)</p> <p>7N Hydrocodeine or Nicodine</p> <p>7Y Other opiates or opioids (Demerol, Dilaudid, hydromorphone, meperidine, pentazocine, Talwin)</p> <p>7Z Other analgesics (Darvocet, Darvon, propoxyphene)</p> <p>8 PCP (angel dust, phencyclidine)</p>	<p>9 Sedative, Hypnotic, or Anxiolytic</p> <p>9A Methaqualone (Parest, Quaaludes, Sopor)</p> <p>9B GHB/GBL</p> <p>9C Diazepam (DPAM, ProPAM, Valium)</p> <p>9D Meprobamate (Deprol, Equanil, Miltown)</p> <p>9E Flunitrazepam (Rohypnol)</p> <p>9G Other benzodiazepine tranquilizers (alprazolam, Ativan, Benzotran, bromazepam, chlordiazepoxide, clonazepam, clorazepate, Dalmane, Dormonox, estazolam, Euhypnos flurazepam, halazepam, Halcion, Hypam, Insoma, ketazolam, Klonopin, Lexotan, Librium lorazepam, loprazolam, Mogadon, Nitrados, nitrazepam, Normison, Novapam, oxazepam, Rivotril, Serax, Serapax, Serenid, Sompam, temazepam, Tranxene, trazepam, triazolam, Tricam, tuazepam, Xanax)</p>	<p>9H Other barbiturates (Alurate, amobarbital, Amytal, aprobarbital, butabarbital, butalbital Butisol, Fiorinal, Fioricet, Lotusate, Luminal, Mebaral, mephobarbital, Nembutal, pentobarbital, phenobarbital, secobarbital, Seconal, Tuinal, talbutal)</p> <p>9Z Other Sed./Hyp./Anx. (doriden, ethchlorvynol, glutethemide, Placidyl)</p> <p>99 Other</p> <p>99A Amyl nitrate</p> <p>99B Cough syrup (Coricidin, DXM, Robitussin, triple C's)</p> <p>99C Nitrous oxide</p> <p>99D NyQuil</p> <p>99E Poppers</p> <p>99F Ephedrine/pseudoephedrine</p> <p>99G Steroids</p> <p>99Z Other</p> <p>100 Tobacco</p>

SFS

S2. The next questions are about the last time, if ever, you used alcohol or other drugs. Using Card A and answering whether it was within the past two days, 3 to 7 days ago, 1 to 4 weeks ago, 1 to 3 months ago, 4 to 12 months ago, more than 12 months ago, or never...	1-2 days	3-7 days	1-4 weeks	1-3 months	4-12 months	1+ years	Never
When was the last time, if ever, you used...							
a. any kind of alcohol (beer, gin, rum, scotch, tequila, whiskey, wine or mixed drinks)? [IF 0, GO TO S2c]	6	5	4	3	2	1	0
b. alcohol until you were drunk (or had 5 or more drinks)?	6	5	4	3	2	1	0
c. marijuana, hashish, blunts or other forms of THC (herb, reefer, weed)?	6	5	4	3	2	1	0
d. crack, smoked rock or freebase cocaine?	6	5	4	3	2	1	0
e. other forms of cocaine?	6	5	4	3	2	1	0
f. inhalants or huffed (such as correction fluids, gasoline, glue, lighters, spray paints, or paint thinner)?	6	5	4	3	2	1	0
g. heroin or heroin mixed with other drugs?	6	5	4	3	2	1	0
h. nonprescription or street methadone?	6	5	4	3	2	1	0
j. painkillers, opiates, or other analgesics (such as codeine, Darvocet, Darvon, Demerol, Dilaudid, Karachi, OxyContin, Oxys, Percocet, Propoxyphene, morphine, opium, Talwin or Tylenol with codeine)?	6	5	4	3	2	1	0
k. PCP or angel dust (phencyclidine)?	6	5	4	3	2	1	0
m. acid, LSD, ketamine, special K, mushrooms, or other hallucinogens (such as mescaline, peyote, psilocybin, or shrooms)?	6	5	4	3	2	1	0
n. anti-anxiety drugs or tranquilizers (such as Ativan, Deprol, Equanil, Diazepam, Klonopin, Meprobamate, Librium, Miltown, Serax, Valium or Xanax)?	6	5	4	3	2	1	0
pa. methamphetamine, crystal, ice, glass, or other forms of methedrine (such as Desoxyn)?	6	5	4	3	2	1	0
pb. speed, uppers, amphetamines, ecstasy, MDMA or other stimulants (such as Biphphetamine, Benzedrine, Dexedrine or Ritalin)?	6	5	4	3	2	1	0
q. downers, sleeping pills, barbiturates or other sedatives (such as Dalmane, Donnatal, Doriden, Flurazepam, GHB, Halcion, liquid ecstasy, methaqualone, Placidyl, Quaalude, Secobarbital, Seconal, Rohypnol or Tuinal)?	6	5	4	3	2	1	0
r. any other drug that has not been mentioned (such as amyl nitrate, cough syrup, nitrous oxide, NyQuil, poppers or Robitussin)? (Please describe)	6	5	4	3	2	1	0
v. _____							

[IF NO USE IN THE PAST 90 DAYS, GO TO S2s TO CONFIRM]

SFS/
BAC

S2. Substance Use Frequency Grid (Read from left to right for those substances used in the past 90 days.) (If this is a self-administered assessment, please ask for staff assistance in completing the following questions.)	1. During the past 90 days, on how many days have you...	2. What was the most (drinks/joints/etc.) you had in one day?	3. Over how many hours did you do this?	4. With how many other people (if any) were you sharing?
a. used any kind of alcohol?		drinks		
b. gotten drunk or had 5 or more drinks?		X	X	X
c. used marijuana, hashish, blunts or THC?		joints		
d. used crack, smoked rock or freebase?		rocks		
e. used other forms of cocaine?		quarters		
f. used inhalants or huffed?		huffs		
g. used heroin (alone or mixed)?		dimes		
h. used nonprescription or street methadone?		X	X	X
j. used painkillers, opiates, or other analgesics?		5v. What did you use?		
k. used PCP or angel dust (phencyclidine)?		X	X	X
m. used acid, LSD, ketamine, special K, mushrooms, or other hallucinogens?		5v. What did you use?		
n. used anti-anxiety drugs or tranquilizers?		5v. What did you use?		
pa. used methamphetamine, crystal, ice, glass, or other forms of methedrine?		X		
pb. used speed, uppers, amphetamines, ecstasy, MDMA or other stimulants?		5v. What did you use?		
q. used downers, sleeping pills, barbiturates or other sedatives?		5v. What did you use?		
r. used any other drug?		5v. What did you use?		

For 5v: Use codes from S1 or spell out

Common Conversions and Norms (0 to 90th percentile of users)

a. standard drink units=1 beer=1 glass wine=1 mixed drink=1 shot; 40 ounces beer=4 drinks; Fifth=up to 26 drinks; (1-20 norm)

c. ounce=25-30 joints; dime=4-5 joints; nickel=2-3 joints; 1 blunt=2-6 joints; 1 gram=1-2 joints; 1 bowl=1 joint; 10 1-hit pipes=1 joint; (1-20 norm)

d. 8 ball=32 rocks; teen=16 rocks; gram=10 rocks; dime=1 rock; nickel=1 hit=1/2 rock (Round to nearest whole number); (1-20 norm)

e. gram=4 quarter grams; (5-10 lines=1 quarter gram); (1-10 norm)

f. (1-10 norm)

g. gram=10 dime bags; (1-10 norm)

Detailed Insurance Date and Quantity of Last Use Grid (If this is a self-administered assessment, please ask for staff assistance in completing the following information.)		
S2. Continued (Read from left to right for those substances used in the past 90 days.)	5. On what date did you last use... (mm/dd/yyyy)	6. About how much did you use? (Record specific substance [e.g., LSD], amount and unit [e.g., drinks, joints, bags, grams])
a. any kind of alcohol?	_ _ / _ _ /20 _ _	v. _____
X	X	X
c. marijuana, hashish, blunts or THC?	_ _ / _ _ /20 _ _	v. _____
d. crack, smoked rock or freebase?	_ _ / _ _ /20 _ _	v. _____
e. other forms of cocaine?	_ _ / _ _ /20 _ _	v. _____
f. inhalants or huffed?	_ _ / _ _ /20 _ _	v. _____
g. heroin (alone or mixed)?	_ _ / _ _ /20 _ _	v. _____
h. nonprescription or street methadone?	_ _ / _ _ /20 _ _	v. _____
j. painkillers, opiates, or other analgesics?	_ _ / _ _ /20 _ _	v. _____
k. PCP or angel dust (phencyclidine)?	_ _ / _ _ /20 _ _	v. _____
m. acid, LSD, ketamine, special K, mushrooms, or other hallucinogens?	_ _ / _ _ /20 _ _	v. _____
n. anti-anxiety drugs or tranquilizers?	_ _ / _ _ /20 _ _	v. _____
pa. methamphetamine, crystal, ice, glass, or other forms of methedrine?	_ _ / _ _ /20 _ _	v. _____
pb. speed, uppers, amphetamines, ecstasy, MDMA or other stimulants?	_ _ / _ _ /20 _ _	v. _____
q. downers, sleeping pills, barbiturates or other sedatives?	_ _ / _ _ /20 _ _	v. _____
r. any other drug?	_ _ / _ _ /20 _ _	v. _____

NOTE: Not necessary to convert to standard units

The next questions are about your use of alcohol, marijuana, cocaine, heroin and other drugs.

Please answer the next questions using the number of days.

- SFS S2s. **During the past 90 days... (Remember, write in 0 for none)**
- 1a. on how many **days** did you go **without using any** alcohol, marijuana or other drugs? [IF 90, GO TO S2x]
Days
2. on how many **days** did you get drunk **at all** or were you high for most of the day?
Days
3. on how many **days** did alcohol or other drug use problems keep you from meeting your responsibilities at work, school or home?
Days
4. what is the **most days** you have gone **in a row** without using alcohol, marijuana or other drugs?
Days

Please answer the next questions using yes or no.

- S2t. **During the past 90 days, did you use alcohol or other drugs...**
- | | <u>Yes</u> | <u>No</u> |
|--|------------|-----------|
| 1. at home? | 1 | 0 |
| 2. at someone else's home? | 1 | 0 |
| 3. at a party or a bar? | 1 | 0 |
| 4. at work? | 1 | 0 |
| 5. at school? | 1 | 0 |
| 6. at a dealer's place or shooting gallery? | 1 | 0 |
| 7. outdoors? | 1 | 0 |
| 8. in a car? | 1 | 0 |
| 99. somewhere else? (Please describe) | 1 | 0 |
| v. _____ | | |

S2u.	During the past 90 days, did you use alcohol or other drugs...	<u>Yes</u>	<u>No</u>
1.	alone?.....	1	0
2.	with your spouse or sexual partner?	1	0
3.	with family?.....	1	0
4.	with friends?	1	0
5.	with a club or gang?	1	0
6.	with coworkers?.....	1	0
7.	with classmates?	1	0
8.	with someone you regularly drink or use other drugs with (a running partner)?	1	0
9.	with a drug dealer or pusher?	1	0
10.	with a stranger?.....	1	0
99.	with someone else? (Please describe)	1	0

v. _____

S2v.	During the past 90 days, have you taken alcohol or other drugs by...	<u>Yes</u>	<u>No</u>
1.	drinking, eating or taking pills (orally)?.....	1	0
2.	smoking?.....	1	0
3.	inhaling, huffing, sniffing, or snorting?.....	1	0
4.	injecting into skin or muscle (intramuscular)?	1	0
5.	injecting into a blood vein or artery (intravenous)?	1	0
99.	any other way? (Please describe)	1	0

v. _____

S2w.	During the past 90 days, did you use alcohol or other drugs while or within an hour prior to...	<u>Yes</u>	<u>No</u>
1.	playing sports or recreating (e.g., skiing, biking, swimming, skateboarding, roller-blading, etc.)?	1	0
2.	taking care of children?	1	0
3.	being in training or school?	1	0
4.	being at a paid job or work?	1	0
5.	driving a vehicle (car, motorcycle, snowmobile, jet ski, boat, etc.)? ..	1	0
6.	using knives, guns, potentially dangerous equipment, or heavy machinery (such as a lawn mower, saw, stove, backhoe, front-end loader, apple picker, etc.)?.....	1	0

Please answer the next question using the number of days.

SFS	S2x. During the past 90 days, on how many days have you been in a jail, hospital or other place where you could not use alcohol, marijuana or other drugs? (Use 0 for none)	<input type="text"/> <input type="text"/>	[IF 0-12, GO TO S3a]
		Days	

Pre-Controlled Environment Use

(If this is a self-administered assessment, please ask for staff assistance in completing the following information.)

To help you remember the time period for the next set of questions, let's get out the calendar like we did earlier and mark out the last 90 days when you spent fewer than 13 days in a jail, hospital or other place where you could not use alcohol, marijuana or other drugs. Do you recall anything that was going on about (DATE 90 DAYS BEFORE PARTICIPANT ENTERED CONTROLLED ENVIRONMENT)?

(PROBE FOR SPECIFIC EVENT AS BEFORE)

Record anchor: v. _____

When we talk about things happening to you during "the past 90 days," we are talking about things that have happened since about (PRE-CONTROLLED ENVIRONMENT ANCHOR)

Please answer the next questions using the number of days. (Use 0 for none)

- | S2x. | In those 90 days in the community... | Days | |
|------|--|------|--------------------|
| 1. | on how many days did you go without using any alcohol, marijuana or other drugs? | _ _ | [IF 90, GO TO S3a] |
| 2. | on how many days did you get drunk at all or were you high for most of the day? | _ _ | |
| 3. | on how many days did alcohol or other drug use problems keep you from meeting your responsibilities at work, school or home? | _ _ | |
| 4. | what is the most days you have gone in a row without using alcohol, marijuana or other drugs?..... | _ _ | |

[IF NO LIFETIME SUBSTANCE USE IN S2a-r, SKIP THE RESPECTIVE ROW IN S2ya-r]

- | S2y. | In those 90 days in the community, on how many days did you use... | Days |
|------|---|------|
| a. | any kind of alcohol?..... | _ _ |
| b. | alcohol until you were drunk (or had 5+ drinks in one sitting)?..... | _ _ |
| c. | any kind of marijuana, hashish, blunts or other forms of THC?..... | _ _ |
| d. | any kind of crack, smoked rock or freebase cocaine?..... | _ _ |
| e. | any other forms of cocaine? | _ _ |
| f. | inhalants or huffed?..... | _ _ |
| g. | heroin or heroin mixed with other drugs? | _ _ |
| h. | nonprescription or street methadone? | _ _ |
| j. | any painkillers, opioids or other analgesics? | _ _ |
| k. | PCP or angel dust? | _ _ |
| m. | acid, LSD, ketamine, special K, mushrooms, or other hallucinogens?..... | _ _ |
| n. | anti-anxiety drugs or tranquilizers? | _ _ |
| pa. | methamphetamine, crystal, ice, glass, or other forms of methedrine?..... | _ _ |
| pb. | speed, uppers, amphetamines, ecstasy, MDMA or other stimulants? | _ _ |
| q. | downers, sleeping pills, barbiturates or other sedatives? | _ _ |
| r. | any other kind of drug? (Please describe) | _ _ |

v. _____

Now we're going to go back to the original 90-day and 12-month timeframes for the rest of the interview.

Please answer the next questions using yes or no.

	<u>Yes</u>	<u>No</u>
S3a. Have you ever had shaky hands, delirium tremens (d.t.'s), convulsions or seizures when you tried to stop, cut down or control your use of alcohol or other drugs?	1	0

[IF NO PAST-WEEK USE, CODE NO FOR S3b]

S3b. During the past week did you stop, try to stop, cut down or try to limit your use of alcohol or other drugs?	1	0	[IF NO, GO TO S4]
--	---	---	-------------------

CWS	S3c.	When you did this, did you have any of the following withdrawal symptoms or problems? Withdrawal symptoms are a group of physical or emotional symptoms that happen when a person who regularly uses alcohol or other drugs stops using them, tries to stop using them, or cuts down on their use during the past week.	<u>Yes</u>	<u>No</u>
		1. Move and talk much slower than usual	1	0
		2. Yawn more than usual	1	0
		3. Feel tired	1	0
		4. Have bad dreams that seemed real	1	0
		5. Have trouble sleeping, including sleeping too much or not being able to sleep	1	0
		6. Feel sad, tense or angry	1	0
		7. Feel really nervous	1	0
		8. Fidget, pace, wring your hands or have trouble sitting still	1	0
		9. Have shaky hands	1	0
		10. Have convulsions or seizures	1	0
		11. Feel hungrier than usual	1	0
		12. Throw up or feel like throwing up	1	0
		13. Have diarrhea.....	1	0
		14. Have muscle aches.....	1	0
		15. Have a runny nose or eyes watering more than usual	1	0
		16. Sweat more than usual, have your heart race or get goose bumps	1	0
		17. Have a fever.....	1	0
		18. See, feel or hear things that are not real	1	0
		19. Forget a lot of things or have problems remembering.....	1	0
		19a. Experience irritability, anger, or aggression.....	1	0
		19b. Feel depressed or have depressed mood.....	1	0
		99. Some other withdrawal-related problem (Please describe).....	1	0

v. _____

[IF NONE REPORTED IN S3c1-99, GO TO S4]

S3c20. Have any of these withdrawal problems kept you from doing social, family, job or other activities? Yes No
 1 0

S3c21. Have you used the same or another drug to stop or avoid having any of these withdrawal problems? 1 0

The next questions are about **treatment** for alcohol or other drug use. Do not count any treatment that you received today or that was **only** for physical health or psychological problems.

S4. Before today, have you **ever** had a breathalyzer or urine test to check for your alcohol or other drug use? Yes No
 1 0 [IF NO, GO TO S5]

Please answer the next questions using the number of times or days.

S4a. **During the past 90 days**, how many **times** have you been given a breathalyzer or urine test to check for your alcohol or other drug use? (Do not count any today)
 Times

S5. **How many times in your life** have you been admitted to a detoxification program for your alcohol or other drug use? [IF 0, ENTER 0 IN S5a]
 Times

S5a. **During the past 90 days**, on how many **days** have you been in a detoxification program to help you through withdrawal?
 Days

NOTE: Detoxification programs are places with professional help and often medication to help you through severe withdrawal; typically these are part of or affiliated with a larger agency or hospital.

S5b. **How many times in your life** have you been treated in an **emergency room** for your alcohol or other drug use problems? [IF 0, GO TO S6]
 Times

S5c. **During the past 90 days** how many times did you go to an **emergency room** for your alcohol or other drug use problems?
 Times

S6. Have you **ever** attended Alcoholics Anonymous (AA), Cocaine Anonymous (CA), Narcotics Anonymous (NA), Social Recovery (SR), or another self-help group for your alcohol or other drug use? Yes No
 1 0 [IF NO, GO TO S6b]

NOTE: Self-help groups are groups of consumers that meet together to provide social support, mutual aid and guidance; while typically part of a large association, they are generally NOT run by professionals.

S6a. **During the past 90 days**, on how many **days** have you attended one or more self-help group meetings (such as AA, NA, CA, or Social Recovery) for your alcohol or other drug use? [IF 0, GO TO S6b]
 Days

Please answer the next question using yes or no. If something does not apply, please answer no.

S6a. In the past 90 days, have you...	<u>Yes</u>	<u>No</u>	
1. spoken up (shared) during a self-help meeting?	1	0	
2. had a sponsor?	1	0	[IF NO, GO TO S6a4]
3. talked to your sponsor at a meeting?	1	0	
4. talked to your sponsor or other members outside of a meeting?	1	0	
5. asked for help from your sponsor or another member?	1	0	
6. read the Twelve Steps and Twelve Traditions or other recovery-related readings?	1	0	
7. actively worked the 12 steps?	1	0	
8. prayed or meditated for help from your Higher Power?	1	0	
9. felt that other people in the meeting understood you and your problems?	1	0	
9a. felt that you understood other people in the meeting and their problems?	1	0	
10. gotten advice or ideas about how to handle your problems better from a meeting or meeting members?	1	0	[IF NO, GO TO S6a11]
10a. agreed with the advice you were given?	1	0	
11. considered yourself a member of a home group (what is the specific name of the group)?	1	0	
v. _____			
12. helped someone else from a meeting?	1	0	
13. sponsored someone else?	1	0	
14. performed a service like setting up for meetings, serving as meeting chairperson, treasurer, or literature person?	1	0	
14a. participated in conferences, dances, picnics, or other social activities sponsored by a self-help group?	1	0	
15. had a spiritual awakening through meeting, working the steps, or reading 12 step related literature?	1	0	
16. considered participation in self-help meetings an important part of your life?	1	0	

S6a17. Do you consider yourself to be a "regular attendee or member" of any specific 12 step fellowships, faith-based, secular or other recovery groups? (Which groups?) (Any other groups?)

MENTIONED

	<u>Yes</u>	<u>No</u>	
a. Alcoholics Anonymous (AA).....	1	0	
b. Cocaine Anonymous (CA)	1	0	
c. Dual Diagnosis Anonymous (DDA)	1	0	
d. LifeRing Secular Recovery	1	0	
e. Narcotics Anonymous (NA).....	1	0	
f. Secular Organization for Sobriety (SOS)	1	0	
g. Social Recovery (SR)	1	0	
h. Women for Sobriety (WFS)	1	0	
j. Adult Children of Alcoholics (ACOA)	1	0	
w. Other 12 step recovery group (Please describe).....	1	0	
v. _____			
x. Other faith-based recovery group (Please describe)	1	0	
v. _____			
y. Other secular recovery group (Please describe).....	1	0	
v. _____			
z. Other recovery group (Please describe)	1	0	
v. _____			
S6b. Have you ever stayed overnight in a recovery home or sanctuary?	1	0	[IF NO, GO TO S7]
S6c. During the past 90 days , on how many nights have you stayed in a recovery home or sanctuary?			_ _ Nights

NOTE: Recovery homes and sanctuaries are groups of consumers or a cooperative that rent a home or apartment to provide a safe, inexpensive environment that is alcohol and other drug free; while typically part of a large association, they often do not have professional staff working around the clock.

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(IF AN INTAKE INTERVIEW: DO NOT COUNT THE CURRENT TREATMENT EPISODE WHEN ANSWERING THE NEXT QUESTIONS.)

Please answer the next question using the number of episodes.

S7. How many **times in your life** have you been **admitted** to treatment or counseling for your use of alcohol or any other drugs?..... [IF 0, GO TO S8]
Episodes

Detailed Treatment History Grid							
(If this is a self-administered assessment, please ask for staff assistance in completing the following information.)							
Next we need to fill out this form for all of the times you have been in outpatient, intensive outpatient, residential or other forms of formal substance abuse treatment, from the first to the most recent treatment episode. If you changed levels of care or were readmitted to treatment, please count each episode separately. Please do not include any detoxification, self-help or recovery programs (which were just reported). What was the first (next) treatment program you went to? (Attach prior grids if available and update)							
S7_	b. What is the name of the treatment program?	b1. Program Code	c. What type of treatment was this? (Use codes from next page)	d. On about what date did you start? (mm/dd/yyyy)	d1. Are you still in treatment? (If yes, skip e & g) Y N	e. On about what date did you leave? (mm/dd/yyyy)	g. About how many days were you there?
1.					1 0		
2.					1 0		
3.					1 0		
4.					1 0		
5.					1 0		
6.					1 0		
7.					1 0		
8.					1 0		
9.					1 0		
10.					1 0		
11.					1 0		
12.					1 0		
13.					1 0		
14.					1 0		
15.					1 0		
99.	For staff use only. Record row number of the index treatment episode that current GAIN-I interview is related to						

<i>Summary of Treatment History and Directions and Codes</i>													
<ul style="list-style-type: none"> • Please do not list detox, self-help groups, recovery homes, or sanctuaries. • Start with the earliest admission at the top and continue down to the most recent. • If the participant is still in treatment, leave the discharge date blank. • If you re-interview a participant, please attach and update the previous grid. • If still in treatment, enter 1 or "Yes" in d1 and skip items e and g, else put "No." • If you have the admission and discharge date (start and end date), skip question g (how long). • If you are missing the admission date or discharge date, ask how long and note the answer in days. 													
<p>Common Local Program Codes (b1) and Names (b) (Insert text or consult study-specific appendix)</p>	<p>General Level of Care Codes (c)</p> <table style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 50px;">0</td><td>Not assigned yet</td></tr> <tr><td>10</td><td>Outpatient (OP)</td></tr> <tr><td>15</td><td>Methadone Maintenance</td></tr> <tr><td>20</td><td>Intensive Outpatient (OR)</td></tr> <tr><td>30</td><td>Inpatient/Residential/Halfway house (ST/LT/HH)</td></tr> <tr><td>99</td><td>Other</td></tr> </table> <p>Date Guidelines (d/e) Use the following rules if the participant is unsure of the exact date:</p> <p>Day Use the 5th for the beginning of the month, 15th for the middle of the month, and 25th for the end of the month.</p> <p>Month Use March for early in the year, July for middle of the year, and October for later in the year, but try to make it so the number of weeks is about right.</p> <p>Year Make best approximation based on age or other information.</p> <p>If the participant is still in treatment, leave the discharge date blank (so that it can be filled in later).</p>	0	Not assigned yet	10	Outpatient (OP)	15	Methadone Maintenance	20	Intensive Outpatient (OR)	30	Inpatient/Residential/Halfway house (ST/LT/HH)	99	Other
0	Not assigned yet												
10	Outpatient (OP)												
15	Methadone Maintenance												
20	Intensive Outpatient (OR)												
30	Inpatient/Residential/Halfway house (ST/LT/HH)												
99	Other												

Please answer the next questions using the number of episodes.

(If available, use treatment history grid to help)

- S7a. How many of these times were you...
- 2. admitted for at least one night to a residential, inpatient, or hospital program for your alcohol or other drug use problems?
Episodes
 - 3. admitted to an intensive outpatient or day program for your alcohol or other drug use problems?
Episodes
 - 4. admitted to a regular (1-8 hours per week) outpatient program for your alcohol or other drug use problems?
Episodes
 - 5. given medication like **methadone or Antabuse** to help with withdrawal or cravings?.....
Episodes
 - 99. in any **other** kind of treatment program or working with some other kind of case manager about your alcohol or other drug use problems (**Please describe**)?
Episodes
- v. _____

S7b. What substances did you receive treatment or counseling for? (Any others?)

MENTIONED

	<u>Yes</u>	<u>No</u>
1. Use of any kind of alcohol.....	1	0
2. Use of any kind of marijuana or hashish	1	0
3. Use of any kind of crack, freebase or other forms of cocaine	1	0
4. Use of any kind of heroin or other opioid	1	0
99. Use of any other kind of drug. (Please use codes from S1 or describe)	1	0

v. _____

S7c. Are you currently taking medication for alcohol or other drug problems? (**Please describe**).....
1 0 [IF NO, GO TO S7d]

v. _____

S7c1. Are you currently taking methadone? (**Code if reported in S7cv**) 1 0

(IF AN INTAKE INTERVIEW: DO NOT COUNT THE CURRENT TREATMENT EPISODE WHEN ANSWERING THE NEXT QUESTIONS.)

Using **Card A...**

S7d. When was the **last** time you received treatment, counseling, medication, case management or aftercare for your use of alcohol or **any other drug**?

(Select one)

- Within the past two days 6
- 3 to 7 days ago 5
- 1 to 4 weeks ago 4
- 1 to 3 months ago..... 3
- 4 to 12 months ago..... 2 [GO TO S8]
- More than 12 months ago 1 [GO TO S8]
- Never 0 [GO TO S8]

Please answer the next questions using the number of times, nights, or days.

(If no lifetime service use in S7a, skip the respective row in S7e.)

SATI S7e. **During the past 90 days**, how many...

- 2. **nights** were you in a halfway house, **residential**, inpatient, or hospital program for your alcohol or other drug use problems?
Nights
- 3. **days** were you in an **intensive outpatient** or day program for your alcohol or other drug use problems?.....
Days
- 4. **times** did you go to a regular (1-8 hours per week) **outpatient** program for your alcohol or other drug use problems?
Times
- 5. **days** did you take medication like **methadone or Antabuse** to help with withdrawal or cravings?
Days
- 99. **days** did you go to any **other** kind of treatment program or work with some other kind of case manager for your alcohol or other drug use problems? (**Please describe**)
Days

v. _____

Yes No

S7f. Are you currently being treated **regularly** for alcohol or other drug problems? (**Where do you go?**) 1 0 [IF NO, GO TO S7g1]

v. _____

TxRS S7g. How long have you been treated **regularly**?..... + + +
Years Months Weeks Days

The next questions are about all of the kinds of substance abuse treatment you have received in the past 90 days.

Please answer the next questions using yes or no.

TxRS	S7g.	As part of the alcohol and other drug abuse treatment, counseling, case management or aftercare you received in the past 90 days, did anyone...	<u>Yes</u>	<u>No</u>
		(If not applicable, select No)		
	1.	work with you at your home?	1	0
	2.	call you on the phone between appointments?	1	0
	3.	ask you what you thought were the benefits of being drug-free?.....	1	0
	4.	teach or review relapse prevention procedures with you?.....	1	0
	5.	ask you to talk about the fun things you could do without alcohol or other drugs?	1	0
	6.	talk about different ways to solve problems?	1	0
	7.	meet with family members of yours more than one time?	1	0
	8.	work with members of your family on communication?	1	0
	9.	talk with you about your friends?	1	0
	10.	require you to take urine tests?	1	0
	11.	talk with you about probation?	1	0
	12.	talk with your probation officer?	1	0
	13.	talk with a counselor, teacher, or other adult at school?.....	1	0
	14.	hook you up with other services?	1	0
	15.	hook your family up with services?.....	1	0
	16.	encourage you to attend appointments?.....	1	0
	17.	ask if you went to appointments?	1	0
	18.	provide you with transportation to appointments?	1	0
	19.	help you figure out agency procedures or to understand your rights?	1	0
	99.	Other than the treatment you've told us about or the services just mentioned, were there other services you received? (Please describe)	1	0

v. _____

(If more than one type of treatment in S7e, include all in answering the next questions.)

The next questions are about how you feel about the staff in the programs where you have received treatment or case management in the past 90 days.

Please answer the next questions using yes or no.

TxSS	S7jj.	Are you satisfied that the staff in (this program/these programs)...	<u>Yes</u>	<u>No</u>	
	1.	did a good job?	1	0	
	2.	were fair with clients or patients?	1	0	
	3.	explained the rules of the program?	1	0	
	4.	had the time to see you?	1	0	
	5.	respected clients or patients?	1	0	
	6.	(staff) and you agreed on what your problems were?	1	0	
	7.	explained what your treatment was supposed to accomplish?	1	0	
	8.	asked for your opinions about your problems and how to solve them?	1	0	
	9.	(staff) and you agreed on what to do about your alcohol and other drug use?	1	0	
	10.	helped you do something about your alcohol and other drug use?	1	0	
	11.	(staff) and you agreed on what to do about your other problems?	1	0	
	12.	helped you do something about your other problems?	1	0	
	13.	were sensitive to your cultural background?	1	0	
	14.	gave you enough help for now?	1	0	
			<u>Yes</u>	<u>No</u>	
	S7k.	In the past 90 days, did you attend one or more group treatment sessions?	1	0	[IF NO, GO TO S7m]

Please answer the next questions about **group treatment** using yes or no.

GES	S7kk.	Thinking about the group treatment you attended in the past 90 days...	<u>Yes</u>	<u>No</u>	
	1.	Did you like the other group members?	1	0	
	2.	Did you get to talk about your own problems?	1	0	
	3.	Did you like having the group rules?	1	0	
	4.	Did the other group members dislike you?	1	0	
	5.	Did a group member threaten to harm you?	1	0	
	6.	Did a group member offer you alcohol or other drugs?	1	0	
	7.	Did other group members not follow the rules?	1	0	
	8.	Did the counselor do a good job of running the group?	1	0	
	9.	Did the counselor do a good job of explaining the main subjects of the session?	1	0	
	10.	Did the counselor like other people in the group better than you?	1	0	

Please answer the next questions about **family nights** using yes or no.

			<u>Yes</u>	<u>No</u>	
	S7m.	In the past 90 days, did you attend one or more family nights?	1	0	[IF NO, GO TO S8]

FNEI	S7m.	Thinking about the family nights you attended in the past 90 days...	<u>Yes</u>	<u>No</u>
	1.	Did you like the other family members?	1	0
	2.	Did you get to talk about your family's problems?.....	1	0
	3.	Did you like having the group rules?.....	1	0
	4.	Did the other group members dislike you or your family?.....	1	0
	5.	Did a group member threaten to harm you or your family?.....	1	0
	6.	Did a group member offer you alcohol or other drugs?	1	0
	7.	Did other group members not follow the rules?	1	0
	8.	Did the counselor do a good job of running the group?	1	0
	9.	Did the counselor do a good job of explaining the main subjects of the session?	1	0
	10.	Did the counselor like other people in the group better than you or your family?.....	1	0

The next questions are about your current treatment and use.

Please answer the next questions using yes or no. If any questions do not apply to you at this time, please answer "no."

TRI	S8.	Do you currently feel that...	<u>Yes</u>	<u>No</u>	
	a.	being in a treatment program is too demanding?	1	0	
	b.	you have too many other responsibilities now to be in a treatment program?	1	0	
	c.	it will be hard for you to resist alcohol or other drugs where you currently live, work or go to school?	1	0	
	d.	your old friends may try to get you to drink or use drugs again?	1	0	
TMI	S8.	Do you currently feel that...	<u>Yes</u>	<u>No</u>	
	e.	there is a lot of pressure for you to be in alcohol or other drug treatment?	1	0	
	f.	you can get the help you need in an alcohol or other drug treatment program?	1	0	
	g.	you need to be in treatment for at least a month?	1	0	
	h.	you will probably need to come back to treatment again one or more times during your lifetime?	1	0	
	j.	you need support from friends and relatives to deal with your alcohol or other drug use?	1	0	
SES	S8.	Do you currently think you...	<u>Yes</u>	<u>No</u>	
	k.	spend a lot of time thinking about alcohol or other drugs?	1	0	
	m.	could avoid using alcohol or other drugs at home ?	1	0	
	n.	could avoid using alcohol or other drugs at work or school ?	1	0	
	p.	could avoid using alcohol or other drugs with your friends ?	1	0	
	q.	could avoid using alcohol or other drugs when people around you were using them ?	1	0	
POS	S8.	Do you currently think...	<u>Yes</u>	<u>No</u>	
	r.	you have any problems related to alcohol or other drug use, including those things we just talked about?	1	0	[IF NO, GO TO S9ab1]
	s.	you have a good understanding of how alcohol and other drug use is related to your problems?	1	0	
	t.	your problems can and will go away?	1	0	
	u.	you know the course most of your problems will follow?	1	0	
	v.	your problems are out of control?	1	0	
	w.	your problems can be solved?	1	0	

Below are some reasons that some people give for wanting to quit using alcohol or other drugs (including marijuana, cocaine, heroin, and other drugs you mentioned).

Please answer the next questions using yes or no. Please use "no" for any that do not apply to you.

RFQ/ PMS	S9ab. You want to quit using alcohol and other drugs at this time...	<u>Yes</u>	<u>No</u>
	1. so that you will be able to think more clearly.....	1	0
	2. because you will like yourself better if you quit.	1	0
	3. because your memory will improve.	1	0
	4. so that you can get more things done during the day.	1	0
	5. because you want to have more energy.	1	0
	6. because you are concerned that using alcohol or other drugs will shorten your life.....	1	0
	7. so that your hair and clothes won't smell.....	1	0
	8. so that you can feel in control of your life.....	1	0
	9. because you have noticed that alcohol or other drug use is hurting your health.	1	0
	10. so that you won't burn holes in clothes or furniture.	1	0
	11. because you are concerned that you will have health problems if you don't quit.	1	0
	12. because alcohol or other drug use does not fit with your image.	1	0
	13. to prove to yourself that you're not addicted.	1	0
	14. because alcohol or other drug use is becoming less cool or socially acceptable.	1	0
	15. because you won't have to leave social functions or other people's houses to drink, smoke or use.....	1	0
	16. because you have known other people with health problems that were caused by alcohol or other drug use.....	1	0
	17. to show yourself that you can quit if you really want to.	1	0
	18. because you want to save the money that you spend on alcohol or other drug use.	1	0
	19. for spiritual or religious reasons.	1	0
	20. because you want to do better in life.	1	0

RFQ/ IMS	S9ac. You want to quit using alcohol and other drugs at this time...	<u>Yes</u> <u>No</u>
	1. so that you can get a lot of praise from people you are close to.....	1 0
	2. because people you are close to will be upset with you if you don't quit.....	1 0
	3. because you don't want to embarrass your family.....	1 0
	4. because your parents, girlfriend, boyfriend or other person you are close to will stop nagging you if you quit.	1 0
	5. because someone has told you to quit or else.....	1 0
	6. because you will receive a special gift if you quit.....	1 0
	7. because there is an alcohol or other drug testing policy in detention, probation, parole or school.	1 0
	8. because of legal problems related to your alcohol or other drug use.	1 0
	9. because you want to get a job.....	1 0
	10. to keep a job.....	1 0
	11. because (you are/ your partner is) pregnant.....	1 0
	12. because you have children.....	1 0
	13. to get your children back.	1 0

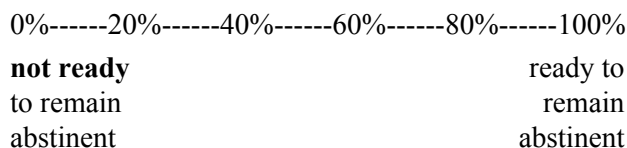
S9ad. What is your main or most important reason for wanting to quit now?
(Do not ask "Any others")

v1. _____

	<u>Yes</u> <u>No</u>
S9b. Have you quit yet?	1 0 [IF NO, GO TO S9b2]

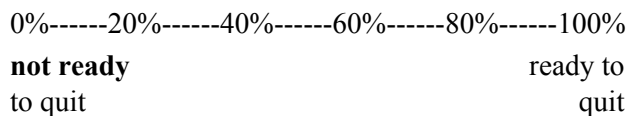
Using **Card F** and answering anywhere from 0% for "not ready at all" to 100% for "entirely ready"...

S9b1. How ready are you **right now** to remain abstinent from (not use) alcohol, marijuana, cocaine, heroin and other drugs? [GO TO S9c]



Using **Card F** and answering anywhere from 0% for "not ready at all" to 100% for "entirely ready"...

S9b2. How ready are you **right now** to stop using alcohol, marijuana, cocaine, heroin and other drugs?



Next we want to go over a list of common problems related to alcohol or other drug use. After each of the following questions, we would like you to tell us the **last** time you had this problem.

Using **Card Q** and responding "in the past month," "2 to 3 months ago," "4 to 12 months ago," "1 or more years ago," or "never"...

		Past Month	2 to 3 Months Ago	4 to 12 Months Ago	1+ Years Ago	Never
S9c. When was the last time that...						

SPS/O	c.	you tried to hide that you were using alcohol or other drugs?	4	3	2	1	0
	d.	your parents, family, partner, co-workers, classmates or friends complained about your alcohol or other drug use?	4	3	2	1	0
	e.	you used alcohol or other drugs weekly or more often?	4	3	2	1	0
	f.	your alcohol or other drug use caused you to feel depressed, nervous, suspicious, uninterested in things, reduced your sexual desire or caused other psychological problems?	4	3	2	1	0
	g.	your alcohol or other drug use caused you to have numbness, tingling, shakes, blackouts, hepatitis, TB, sexually transmitted disease, or any other health problems?	4	3	2	1	0

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Using Card Q...

		Past Month	2 to 3 Months Ago	4 to 12 Months Ago	1+ Years Ago	Never
S9c. When was the last time that...						
SPS/A	h. you kept using alcohol or other drugs even though you knew it was keeping you from meeting your responsibilities at work, school, or home?	4	3	2	1	0
	j. you repeatedly used alcohol or other drugs when it made the situation unsafe or dangerous for you, such as when you were driving a car, using a machine, or when you might have been forced into sex or hurt?	4	3	2	1	0
	k. your alcohol or other drug use caused you to have repeated problems with the law?.....	4	3	2	1	0
	m. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	4	3	2	1	0
SPS/D	n. you needed more alcohol or other drugs to get the same high or found that the same amount did not get you as high as it used to?.....	4	3	2	1	0
	p. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?.....	4	3	2	1	0
	q. you used alcohol or other drugs in larger amounts, more often or for a longer time than you meant to?	4	3	2	1	0
	r. you were unable to cut down on or stop using alcohol or other drugs?	4	3	2	1	0
	s. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or feeling the effects of alcohol or other drugs (high, sick)?	4	3	2	1	0
	t. your use of alcohol or other drugs caused you to give up, reduce or have problems at important activities at work, school, home or social events?	4	3	2	1	0
	u. you kept using alcohol or other drugs even after you knew it was causing or adding to medical, psychological or emotional problems you were having?.....	4	3	2	1	0
	ua. you had such strong urges to use alcohol or other drugs you could not think of anything else?	4	3	2	1	0
	v. How old were you when you first got drunk or used any drugs?	□□		Age		

(FOR EACH "NEVER" RESPONSE IN S9ch-ua, SKIP THE CORRESPONDING ROW ON THE S9 GRID)

*NOTE: **Withdrawal Problems** are a group of physical or emotional symptoms that happen when a person who regularly uses alcohol or other drugs stops using them, tries to stop using them, or cuts down on their use.*

S9c. Detailed Substance Use Disorder Worksheet (If this is a self-administered assessment, please ask for staff assistance in completing the following information.)	For Staff Use Only									
	1	2	3	4	5	6	7	8	9	99
For each of the problems endorsed in S9ch-ua, ask: <ul style="list-style-type: none"> • Can you tell me which substance...(Read from below)? • About when did that happen? (Using Card Q) • Have you ever had this problem with any other substance(s)? • Repeat for each problem endorsed until no more are reported. Record time code (4=past month, 3=2-3 months ago, 2=4-12 months ago, 1=1+ years ago, 0 or blank means never).	Alcohol	Amphetamine	Cannabis	Cocaine	Hallucinogen	Inhalant	Opioid	PCP	Sed./Hyp./Anx.	Other
h. repeatedly caused you not to meet your responsibilities?										
j. you repeatedly used in unsafe situations?										
k. caused you to have repeated problems with the law?										
m. did you keep using even though it was leading to fights or getting you into trouble with other people?										
n. you have needed more of to get high?										
p. you have had withdrawal problems from?										
q. you have used more of or longer than you meant to?										
r. you have been unable to cut down on or stop using?										
s. you spent a lot of time getting or using?										
t. caused you to give up activities or caused problems?										
u. you kept using despite medical or psychological problems?										
ua. you had such strong urges to use you could not think of anything else?										
Clinical Significance (for each drug with 1+ criteria ask...)										
v. At what age did you first use...(for alcohol, read "At what age did you first get drunk")?										
w. How do you usually take... (1-oral, 2-smoking, 3-inhalation, 4-intramuscular, 5-intravenous, 6-NA, 7-other)?										

See manual for scoring Polysubstance Dependence.

For consistency, at least one timeframe reported for each line of the S9 grid has to match the timeframe reported for the corresponding item in S9ch-ua. No timeframe for a line on this grid can be earlier than the timeframe reported for the corresponding item in S9ch-ua.

Using **Card E** and answering "right away," "in the next 3 months," "more than three months from now," "getting the help I need already" or "do not need any help"...

S10. How **soon** if at all do you need (more) help with your **current** alcohol or other drug situation? (Would you say...)

(Select one)

- Right away 4
- In the next 3 months 3
- More than 3 months from now 2
- Getting the help I need already 1 [GO TO S11]
- Do not need any help 0 [GO TO S11]

Please answer the next questions using yes or no.

- | S10a. Do you currently want (more) help with issues related to... | <u>Yes</u> | <u>No</u> |
|--|------------|-----------|
| 1. your alcohol or other drug use? | 1 | 0 |
| 2. your family's alcohol or other drug use? | 1 | 0 |
| 3. your situation at home, work or school?..... | 1 | 0 |
| 4. AA, NA, CA, or other self-help and support groups? | 1 | 0 |
| 5. detoxification? | 1 | 0 |
| 6. getting treatment? | 1 | 0 |
| 7. getting methadone (Methadose), Antabuse, or other medication (disulfiram, LAAM) for alcohol or other drug withdrawal or cravings? | 1 | 0 |
| 99. anything else related to your alcohol or other drug use? (Please describe)..... | 1 | 0 |
| v. _____ | | |

<i>For Staff Use Only</i>	
AGUR	S11. Urgency Rating [SUR]: NO <input type="checkbox"/> _0 ALREADY <input type="checkbox"/> _1 GT 3 MO <input type="checkbox"/> _2 0-3 MO <input type="checkbox"/> _3 NOW <input type="checkbox"/> _4
AGDM	S12. DM Rating [SDM]: NONE <input type="checkbox"/> _0 SOME <input type="checkbox"/> _1 MISUNDER <input type="checkbox"/> _2 DENIAL <input type="checkbox"/> _3 MISREP <input type="checkbox"/> _4

P. Physical Health

The next questions are about your health and how you have been feeling physically.

BAC P1. About how **tall** are you in feet and inches?
Feet Inches

P2. About how much do you **weigh** without shoes?.....
Pounds

HDS P3. **During the past 12 months** would you say your health in general was...
(Select one)

Excellent	0	
Very good	1	
Good	2	
Fair.....	3	
Poor.....	4	

Please answer the next questions using yes or no.

P3. **During the past 12 months** has your health **limited** your ability to do... Yes No

a. vigorous activities like running, lifting heavy objects or active sports?	1	0	
b. moderate activities like moving a table, carrying groceries or light sports?	1	0	[IF NO, GO TO P3d]
c. light activities like bending, lifting or stooping?	1	0	

P3. **During the past 12 months** have you... Yes No

d. lost or gained 10 or more pounds when you were not trying to?	1	0	
e. had a lot of physical pain or discomfort ?	1	0	
f. been worried about your health or behaviors?	1	0	
g. had health problems that kept you from meeting your responsibilities at work, school or home?	1	0	
h. had lung or breathing problems?	1	0	
j. had pain when you urinated?	1	0	
k. coughed up or urinated blood?	1	0	

The next questions are about any physical limitations you may have. Please include problems that have been corrected by things such as wearing prescription glasses or contacts, a hearing aid, artificial limbs, or other mobility aids.

	<u>Yes</u>	<u>No</u>	
P4. Do you have any physical problems with your vision, hearing, limbs or any other problems communicating or getting around? (Any other issues?).....	1	0	[IF NO, GO TO P5_1]

P4. What problems do you have? (Any other issues?)

v. _____

MENTIONED

	<u>Yes</u>	<u>No</u>	
3. Deaf	1	0	
4. Limited hearing or other hearing problems	1	0	
5. Legally blind.....	1	0	
6. Limited vision or other vision problems	1	0	
7. Lost limbs	1	0	
8. Other difficulties moving hands, feet or body	1	0	
99. Other physical impairments (Please describe in P4v)	1	0	
P5_1. Have you ever (been/gotten someone) pregnant?	1	0	[IF NO, GO TO P6a]

P5a1. About when did (your/the) **last** pregnancy begin?

(Clarify and code)

During the past 90 days	1
4 to 6 months ago.....	2
7 to 9 months ago.....	3
10 to 12 months ago.....	4
More than a year ago	5

P5b1. What happened (or is happening) during that pregnancy?

(Clarify and code)

Carried the baby to term–live birth.....	1	[GO TO P5c1]
Miscarriage	2	[GO TO P6a]
Abortion.....	3	[GO TO P6a]
Uncertain	4	[GO TO P6a]
Currently pregnant.....	5	[GO TO P6a]
Other (Please describe).....	6	[GO TO P6a]

v. _____

P5c1. How much did the baby **weigh** at birth?.....|_|_| | |_|_|
Pounds Ounces

P5d. What was the baby's date of birth?

_ _	/	_ _	/	_ _ _ _
Month		Day		Year

Using **Card B...**

	Past Month	2-12 months	1+ years	Never
P6. When was the last time, if ever, you were told by a doctor or nurse that you have...				
a. Hepatitis , yellow jaundice, or cirrhosis of the liver?.....	3	2	1	0
b. Tuberculosis or TB?.....	3	2	1	0
c. the Human Immunodeficiency Virus, HIV or AIDS? (In Illinois, record answer to P6c in separate secure record)	3	2	1	0
d. other sexually transmitted diseases or infections , such as syphilis, gonorrhea, or chlamydia?.....	3	2	1	0
e1. been tested for these or other infectious diseases or illnesses?.....	3	2	1	0
e2. other infectious diseases or illnesses? (Please describe).....	3	2	1	0
v. _____				

[IF NONE REPORTED IN P6a-e2, GO TO P7a]

Please answer the next questions using yes or no.

P6f. Are you currently receiving treatment for any of these diseases?	<u>Yes</u>	<u>No</u>
	1	0
P7. Have you ever had the following childhood illnesses?	<u>Yes</u>	<u>No</u>
a. Rubella.....	1	0
b. Chicken pox.....	1	0
c. Mumps.....	1	0
d. Rheumatic fever.....	1	0
e. Measles	1	0
f. Whooping cough	1	0
g. Polio.....	1	0
h. Other childhood illness (Please describe)	1	0
v. _____		

<i>Useful Definitions</i>
<u>Rubella</u> or German measles is a viral infection marked by fever and skin rash
<u>Chicken pox</u> is a viral infection marked by multiple small, blister-like swellings
<u>Mumps</u> is a viral infection marked by swollen salivary glands
<u>Rheumatic fever</u> is an inflammatory disease marked by joint pain and inflammation of areas of the heart
<u>Measles</u> is a viral infection marked by a skin rash
<u>Whooping cough</u> is a bacterial infection marked by severe coughing fits
<u>Polio</u> is a viral infection of the nervous system that can cause flu-like symptoms and, in rare cases, paralysis

P7j. Did you have all the vaccinations required to attend school? Yes No
 1 0

P8. When was your **last** tetanus shot?

(Clarify and code)

- During the past year..... 5
- 1 to 2 years ago..... 4
- 3 to 7 years ago..... 3
- 8 to 10 years ago..... 2
- More than 10 years ago 1
- Never 0

The next questions are about any health or medical problems including those we have talked about as well as other common problems such as colds, the flu, asthma, allergies, your period, and other physical problems you may have been treated for.

Using **Card A...**

HPS P9. When was the **last** time, if ever, that you were bothered by any health or medical problems or that they kept you from meeting your responsibilities at work, school or home?

(Select one)

- Within the past two days 6
- 3 to 7 days ago 5
- 1 to 4 weeks ago 4
- 1 to 3 months ago..... 3
- 4 to 12 months ago..... 2 [GO TO P10]
- More than 12 months ago 1 [GO TO P10]
- Never 0 [GO TO P10]

Please answer the next questions using the number of days.

P9a. **During the past 90 days**, on how many **days** were you bothered by **any** health or medical problems?
 Days

P9b. **During the past 90 days**, on how many **days** have medical problems kept you from meeting your responsibilities at work, school or home?.....
 Days

P9c. What is the problem you have been having?

v1. _____

Please answer the next questions using yes or no.

	<u>Yes</u>	<u>No</u>
P10. Do you need any medical attention in order to attend treatment? (Please describe).....	1	0

v1. _____

Please answer the next questions using yes or no.

PHPI	P10. Have you ever been treated or told by a health professional that you have...	<u>Yes</u>	<u>No</u>
	a. allergies to specific medicines, foods, pollen or other things? (Please describe)	1	0
	v. _____		
	b. major or untreated dental problems (such as gum disease or teeth that need to be removed)?.....	1	0
	c. physical injuries or unhealed wounds (such as a broken bone, knife or gun wound, or a cut/bruise that would not go away)?	1	0
	d. convulsions, migraines, or nervous system problems (such as epilepsy, seizures, strokes or blackouts)?	1	0
	e. heart, blood, or circulatory problems (such as high or low blood pressure, endocarditis, irregular heart beats, angina, heart attacks, blood diseases, abnormal bleeding or bruising)?.....	1	0
	f. asthma, shortness of breath, hoarseness, coughing up blood or phlegm, or other respiratory problems (such as bronchitis, pneumonia, emphysema, or wheezing)?.....	1	0
	g. tumors, cancer, or unusual lumps under your skin (lung, blood, leukemia, breast, testicle, colon, neoplasms, skin, or Kaposi's sarcoma)?.....	1	0
	h. diabetes, thyroid or other problems with how your body controls itself (low or high blood sugar, control of growth, weight, fluids, early or late body development, gland or hormone problems)?	1	0
	j. vitamin deficiencies, fluid buildup, anemia, or problems with how your body stores things.....	1	0
	k. stomach or digestive system problems (such as ulcers or colitis, nausea, vomiting, persistent diarrhea or constipation, or heartburn)?	1	0
	m. sexual or fertility problems (such as pain during intercourse, coming too soon or being unable to, impotence or the inability to have children)?	1	0
	n. [IF MALE, GO TO P10p] female problems (such as a yeast infection, problems with your menstrual period, bad cramps, pain urinating, unusual discharge, urinary tract or vaginal infections, cysts or breast cancer)?.....	1	0
	p. [IF FEMALE, GO TO P10q] male problems (such as jock itch, pain urinating, abnormal discharge, urinary tract infections, cancer of the testicles, prostate problems or cancer)?.....	1	0
	q. bone, muscle, or foot problems (such as arthritis, bunions, bursitis, chronic back pain, paralysis, permanent stiffness, scoliosis, or swelling)?	1	0
	r. skin problems (such as skin ulcers or cancer, rashes, lesions or other skin infections)?	1	0
	s. any other major medical problems or conditions other than those just mentioned? (Please describe)	1	0
	v. _____		

[IF MALE, SELECT 0 IN P10u1 AND GO TO P11]

Using **Card A...**

HPI P10u1. When did you **start** your last menstrual period?

(Select one)

- Within the past two days 6
 3 to 7 days ago 5
 1 to 4 weeks ago 4
 1 to 3 months ago..... 3
 4 to 12 months ago..... 2
 More than 12 months ago 1
 Never 0 **[GO TO P11]**

P10u2. How old were you when you had your first period?
 Age

The next questions are about treatment for injuries or physical health problems (including pregnancy and giving birth). Do not count counseling or treatment that was only for alcohol or other drug use or psychological problems here. **(Record 0 for none)**

Please answer the next questions using the number of times.

P11. How many **times in your life** have you...

- a. been treated in an emergency room for health problems?
 Times
- b. been admitted for at least one night to a hospital for health problems?
 Times
- c. received any outpatient surgical procedures for health problems?.....
 Times

Please answer the next question using yes or no.

- d. Are you currently taking medication for allergies or health problems? **(Please describe)** Yes No
 1 0

v. _____

Using **Card A...**

P11e. When was the **last** time you saw a doctor or nurse about a health problem or took prescribed medication for one?

(Select one)

- Within the past two days 6
- 3 to 7 days ago 5
- 1 to 4 weeks ago 4
- 1 to 3 months ago..... 3
- 4 to 12 months ago..... 2 [GO TO P12]
- More than 12 months ago 1 [GO TO P12]
- Never 0 [GO TO P12]

Please answer the next questions using the number of times, nights or days.

[IF NO LIFETIME SERVICE IN P11a-c, SKIP THE RESPECTIVE ROW BELOW]

P11. **During the past 90 days**, how many...

PHTI

- f. **times** have you had to go to the **emergency room** for a health problem?
Times
- g. **nights** total did you spend in the **hospital** for a health problem?
Nights
- h. **times** did you have an outpatient **surgical procedure** for a health problem?
Times
- j. **times** did you see a doctor or nurse in an **office or outpatient clinic** for a health problem?.....
Times
- j1. **days** did you take prescribed **medication** for a health problem?.....
Days

Yes No

P11k. Are you currently being treated for a health problem? (**Where do you go?**).....

1 0 [IF NO, GO TO P12]

v. _____

TxRS

P11m. How long have you been treated **regularly**?..... + + +
Years Months Weeks Days

The next questions are about blood relatives. This includes your children, brothers, sisters, parents, aunts, uncles and grandparents. **(Please write "DK" if you don't know.)**

Please answer the next questions using yes or no.

P12.	Have any of your blood relatives ever had...	<u>Yes</u>	<u>No</u>
a.	problems with alcohol use?	1	0
b.	problems with drug use?	1	0
c.	heart or blood problems?	1	0
d.	diabetes, thyroid or other problems with how your body controls itself (low or high blood sugar, control of growth, weight, fluids, early or late body development, gland or hormone problems)?	1	0
e.	emotional, mental or psychological problems?	1	0
f.	other problems that caused them to be sick or in treatment a lot (such as cancer or other serious illnesses)? (Please describe)	1	0
v.	_____		

P12g. Are you adopted? 1 0

Using **Card E**...

AGHS P13. How **soon**, if at all, do you need (more) help with your **current** physical health?
(Would you say...)

	(Select one)
Right away	4
In the next 3 months	3
More than 3 months from now	2
Getting the help I need already	1 [GO TO P14]
Do not need any help	0 [GO TO P14]

Please answer the next questions using yes or no.

P13a.	Do you currently want (more) help with...	<u>Yes</u>	<u>No</u>
1.	getting dental treatment?	1	0
2.	pregnancy, postpartum or family planning?	1	0
3.	testing, counseling or education on hepatitis, TB, HIV or STDs?	1	0
4.	help with sexual or fertility problems?	1	0
5.	getting health care treatment?	1	0
6.	coping with your current medical problems?	1	0
7.	paying for health care treatment?	1	0
8.	physical handicap or physical therapy?	1	0
99.	anything else related to your health situation? (Please describe)	1	0
v.	_____		

For Staff Use Only

AGUR

P14. Urgency Rating [PUR]: NO _0 ALREADY _1 GT 3 MO _2 0-3 MO _3 NOW _4

AGDM

P15. DM Rating [PDM]: NONE _0 SOME _1 MISUNDER _2 DENIAL _3 MISREP _4

R. Risk Behaviors and Disease Prevention

Next, we would like to ask a few personal questions about behaviors that may have affected your risk of getting or spreading infectious diseases. Please remember that all of your answers are strictly confidential.

The first questions are about the use of a needle to inject you with drugs or medication. Do **not** include shots given by a doctor or nurse, but do include if you were injected by someone besides a doctor or nurse or if you injected prescribed medication.

Using **Card A...**

- NFS R1. When was the **last** time, if ever, that you used **a needle to inject drugs or medication**? Please include medication prescribed by a doctor.
- (Select one)
- | | | |
|--------------------------------|---|------------|
| Within the past two days | 6 | |
| 3 to 7 days ago | 5 | |
| 1 to 4 weeks ago | 4 | |
| 1 to 3 months ago..... | 3 | |
| 4 to 12 months ago..... | 2 | |
| More than 12 months ago | 1 | [GO TO R2] |
| Never | 0 | [GO TO R2] |

Please answer the next questions using yes or no.

- | | NFS | R1. During the past 12 months, did you... | <u>Yes</u> | <u>No</u> |
|--|-----|---|------------|-----------|
| | a. | use a needle to shoot up drugs? | 1 | 0 |
| | b. | reuse a needle that you had used before? | 1 | 0 |
| | c. | reuse a needle without cleaning it with bleach or boiling water first ? | 1 | 0 |
| | d. | use a needle that you knew or suspected someone else had used before? | 1 | 0 |
| | e. | use someone else's rinse water, cooker or cotton after they did?.... | 1 | 0 |
| | f. | ever skip cleaning your needle with bleach or boiling water after you were done?..... | 1 | 0 |
| | g. | let someone else use a needle after you used it?..... | 1 | 0 |
| | h. | let someone else use the rinse water, cooker or cotton after you did? | 1 | 0 |
| | j. | allow someone else to inject you with drugs? | 1 | 0 |

[IF 4 TO 12 MONTHS REPORTED IN R1, GO TO R2]

Please answer the next questions using the number of days or number of people.

NFS R1k. **During the past 90 days**, on how many **days** did you use a needle to inject any kind of drug or medication?
Days

R1m. **During the past 90 days**, with how many **people** have you shared needles or works? **[IF 0, GO TO R2]**
People

R1n. **During the past 90 days**, on how many **days** did you share needles with other people?.....
Days

The next questions are about having sex. When we refer to sex it includes vaginal, oral and anal sex with anyone. (Vaginal sex is when a man puts his penis into a woman's vagina. Oral sex is when one person puts his or her mouth onto the other person's penis or vagina. Anal sex is when a man puts his penis into another person's anus or butt.)

Using **Card A...**

R2. When was the **last** time, if ever, that you **had any kind of vaginal, oral or anal sex** with another person?

(Select one)

- | | |
|--------------------------------|---------------|
| Within the past two days | 6 |
| 3 to 7 days ago | 5 |
| 1 to 4 weeks ago | 4 |
| 1 to 3 months ago..... | 3 |
| 4 to 12 months ago..... | 2 |
| More than 12 months ago | 1 [GO TO R3a] |
| Never | 0 [GO TO R3a] |

Please answer the next questions using yes or no.

SxRS	R2.	During the past 12 months, did you...	Yes	No
	a.	have sex while you or your partner was high on alcohol or other drugs?	1	0
	b.	have sex with someone who was an injection drug user?	1	0
	c.	have sex involving anal intercourse (penis to butt)?	1	0
	d.	have sex with a man who might have had sex with other men?	1	0
	e.	trade sex to get drugs, gifts or money?.....	1	0
	f.	use drugs, gifts or money to purchase or get sex?.....	1	0
	fl.	have sex with someone who you thought might have HIV or AIDS?	1	0
	g.	have two or more different sex partners (not necessarily at the same time)?.....	1	0
	h.	have sex with a male partner?	1	0
	j.	have sex with a female partner?	1	0
	k.	have sex without using any kind of condom, dental dam or other barrier to protect you and your partner from diseases or pregnancy?	1	0
	m.	have a lot of pain during sex or after having had sex?.....	1	0
	n.	use alcohol or other drugs to make sex last longer or hurt less?	1	0

[IF 4 TO 12 MONTHS AGO REPORTED IN R2, GO TO R3a]

[IF NO PAST-YEAR MALE PARTNERS, SKIP R2p]

[IF NO PAST-YEAR FEMALE PARTNERS, SKIP R2q]

Please answer the next questions using the number of partners or times.

R2. **During the past 90 days...**

p. how many sex partners did you have who were male?

Partners

q. how many sex partners did you have who were female?

Partners

SPR r. how many times did you have any kind of vaginal, oral, or anal sex
with another person?..... **[IF 0, GO TO R3a]**
Times

[IF NO PAST-YEAR BEHAVIOR REPORTED FOR R2a-b, R2d-e, OR R2f1, SKIP THE CORRESPONDING ITEMS]

R2. **During the past 90 days** when you had sex, how many times...

s. did you have sex with **any kind of condom, dental dam or other barrier** to protect you and your partner from diseases or pregnancy?.....

Times

t. did you have sex while you or your partner were **high on alcohol or other drugs?**.....

Times

u. did you have sex with someone who was an **injection drug user?**...

Times

v. did you have sex with a man who might have had **sex with other men?**

Times

w. did you **trade sex** for drugs, gifts or money?.....

Times

x. did you have sex with someone who you thought might have **HIV or AIDS?**

Times

R3a. What forms of contraception do you or your partner try to use, if at all, to avoid pregnancy or sexually transmitted diseases? (Any other methods?)

MENTIONED

	<u>Yes</u>	<u>No</u>
1. Do not regularly use contraceptives	1	0
2. Following (your/your partner's) period or cycle.....	1	0
3. Pulling out before (you/your partner) comes.....	1	0
4. A douche, foam or suppository	1	0
5. A birth control pill	1	0
6. An intrauterine device (IUD).....	1	0
7. A condom or other barrier	1	0
8. Not having intercourse	1	0
9. Sterile, tubes tied, vasectomy or infertile	1	0
99. Something else (Please describe)	1	0

v. _____

Using **Card A...**

R4. When was the **last** time you smoked or used any kind of tobacco? Please include cigarettes, cigars, chewing tobacco and pipes.

(Select one)

- | | |
|--------------------------------|---------------|
| Within the past two days | 6 |
| 3 to 7 days ago | 5 |
| 1 to 4 weeks ago | 4 |
| 1 to 3 months ago..... | 3 |
| 4 to 12 months ago..... | 2 [GO TO R4c] |
| More than 12 months ago | 1 [GO TO R4c] |
| Never | 0 [GO TO R5] |

Please answer the next questions using the number of days or times.

R4a. **During the past 90 days**, on how many **days** have you smoked or used any kind of tobacco? [IF 0, GO TO R4c]
Days

R4b. On those days, **how many times per day** did you usually smoke or use any kind of tobacco? (**NOTE:** A pack of cigarettes would be about 20 times.)
Times

R4c. How old were you when you first smoked or used any kind of tobacco? ...
Age

Next we want to go over a list of common problems related to tobacco use. After each of the next questions, we would like you to tell us the **last** time you had this problem.

Using **Card Q...**

TDS

	Past Month	2 to 3 Months Ago	4 to 12 Months Ago	1+ Years Ago	Never
R4cc. When was the last time that...					
h. your tobacco use repeatedly caused you not to meet your responsibilities at work, school, or home?	4	3	2	1	0
j. you repeatedly used tobacco in unsafe situations?	4	3	2	1	0
m. you kept using tobacco even though it was leading to fights or getting you into trouble with other people?	4	3	2	1	0
n. you needed more tobacco to get the same effect?	4	3	2	1	0
p. you had headaches or other withdrawal symptoms when you tried to stop or cut down on your tobacco use?	4	3	2	1	0
q. you used more tobacco or used it longer than you meant to?	4	3	2	1	0
r. you were unable to cut down on or stop using tobacco?	4	3	2	1	0
s. you spent a lot of time using or getting tobacco?	4	3	2	1	0
t. your use of tobacco caused you to give up activities or caused problems?	4	3	2	1	0
u. you kept using tobacco despite medical or psychological problems?	4	3	2	1	0
ua. you had such strong urges to use tobacco that you could not think of anything else?	4	3	2	1	0

Please answer the next questions using the number of days.

R5. **During the past 90 days**, on how many **days** have you...

- a. gone without eating or thrown up much of what you did eat?
Days
- b. exercised for at least 20 minutes per day?
Days

Please answer the next questions using the number of times.

- R6. **During the past 90 days**, how many **times** have you attended classes or sessions on the following topics?
- a. Diet or nutrition
Times
 - b. Exercise
Times
 - c. Relaxation
Times
 - d. HIV/AIDS prevention or education
Times
 - e. Testing or counseling for HIV/AIDS or other health services
Times
 - f. How to stop smoking
Times
 - g. Other health education or prevention classes (**Please describe**)
Times
 - v. _____

Using **Card E...**

AGHS R7. How **soon**, if at all, do you need (more) help with changing your pattern of dieting, exercise, needle use, sexual activity, smoking, or other health risks?

(Select one)

- Right away 4
- In the next 3 months 3
- More than 3 months from now 2
- Getting the help I need already 1 [GO TO R8]
- Do not need any help 0 [GO TO R8]

Please answer the next questions using yes or no.

- | | | | |
|------|---|------------|-----------|
| R7a. | Do you currently want (more) help with... | <u>Yes</u> | <u>No</u> |
| 1. | changing your pattern of needle use? | 1 | 0 |
| 2. | changing your pattern of sexual behavior? | 1 | 0 |
| 3. | getting information about health or prevention? | 1 | 0 |
| 4. | diet, exercise or relaxation programs? | 1 | 0 |
| 5. | quitting or cutting back on your smoking? | 1 | 0 |
| 99. | anything else related to your risk behaviors? (Please describe)..... | 1 | 0 |

v. _____

<i>For Staff Use Only</i>	
AGUR	R8. Urgency Rating [RUR]: NO <input type="checkbox"/> 0 ALREADY <input type="checkbox"/> 1 GT 3 MO <input type="checkbox"/> 2 0-3 MO <input type="checkbox"/> 3 NOW <input type="checkbox"/> 4
AGDM	R9. DM Rating [RDM]: NONE <input type="checkbox"/> 0 SOME <input type="checkbox"/> 1 MISUNDER <input type="checkbox"/> 2 DENIAL <input type="checkbox"/> 3 MISREP <input type="checkbox"/> 4

M. Mental and Emotional Health

The next questions are about common nerve, mental or psychological problems that many people have. These problems are considered **significant** when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities or when they make you feel like you cannot go on.

Please answer the next questions using yes or no.

IMDS/ M1a. GMDS/ SSI	During the past 12 months , have you had significant problems with...	<u>Yes</u>	<u>No</u>
	1. headaches, faintness, dizziness, tingling, numbness, sweating, or hot or cold spells?	1	0
	2. sleep trouble, such as bad dreams, sleeping restlessly or falling asleep during the day?	1	0
	3. having dry mouth, loose bowel movements, constipation, trouble controlling your bladder, or related itching?	1	0
	4. pain or heavy feeling in your heart, chest, lower back, arms, legs or other muscles?	1	0

IMDS/ M1b. GMDS/ DSS	During the past 12 months , have you had significant problems with...	<u>Yes</u>	<u>No</u>
	1. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	1	0
	3. remembering, concentrating, making decisions, or having your mind go blank?	1	0
	4. feeling very shy, self-conscious or uneasy about what people thought or were saying about you?	1	0
	5. thoughts that other people did not understand you or appreciate your situation?	1	0
	6. feeling easily annoyed, irritated, or having trouble controlling your temper?	1	0
	7. feeling tired, having no energy, or feeling like you could not get things done?	1	0
	8. losing interest or pleasure in work, school, friends, sex or other things you cared about?	1	0
	9. losing or gaining 10 or more pounds when you were not trying to? ..	1	0
	10. moving and talking much slower than usual?	1	0
	11. feeling worthless or that the bad things that have happened in your life are your fault?	1	0

IMDS/ M1c. **During the past 12 months**, have you...

GMDS/
HSTS

	<u>Yes</u>	<u>No</u>	
1. thought about killing or hurting someone else?.....	1	0	
2. thought about ending your life or committing suicide?.....	1	0	[IF 0, GO TO M1d]
3. had a plan to commit suicide?	1	0	
4. gotten a gun, pills or other things to carry out your plan?.....	1	0	
5. attempted to commit suicide?	1	0	

M1c6. **During the past week** have you thought about ending your life or committing suicide?.....

1 0

IMDS/ M1d. **During the past 12 months**, have you had **significant** problems with...

GMDS/
AFSS

	<u>Yes</u>	<u>No</u>
1. feeling very anxious, nervous, tense, scared, panicked or like something bad was going to happen?	1	0
2. having to repeat an action over and over, or having thoughts that kept running over in your mind?	1	0
3. trembling, having your heart race, or feeling so restless that you could not sit still?.....	1	0
4. getting into a lot of arguments and feeling the urge to shout, throw things, beat, injure or harm someone?.....	1	0
5. feeling very afraid of open spaces, leaving your home, having to travel or being in a crowd?	1	0
6. avoiding snakes, the dark, being alone, elevators or other things because they frightened you?	1	0
7. thoughts that other people were taking advantage of you, not giving you enough credit, or causing you problems?	1	0
8. thoughts that someone was watching you, following you or out to get you?	1	0
9. seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?	1	0
10. thoughts that you should be punished for thinking about sex or other things too much?	1	0
11. having a lot of tension or muscle aches because you were worried? ..	1	0
12. being unable or finding it difficult to control your worries?	1	0

The next questions are about all the different kinds of nerve, mental or psychological problems just mentioned.

Using **Card A...**

- EPS M1e. When was the **last** time, if ever, your life was **significantly** disturbed by nerve, mental or psychological problems or that you felt you could not go on, **including** those things we just talked about?

(Select one)

- Within the past two days 6
 3 to 7 days ago 5
 1 to 4 weeks ago 4
 1 to 3 months ago..... 3
 4 to 12 months ago..... 2 [GO TO M1j]
 More than 12 months ago 1 [GO TO M1j]
 Never 0 [GO TO M2]

Please answer the next questions using the number of days.

- M1f. **During the past 90 days**, on how many **days** were you bothered by any nerve, mental, or psychological problems?
 Days

- M1g. **During the past 90 days**, on how many **days** did these problems keep you from meeting your responsibilities at work, school or home, or make you feel like you could not go on?.....
 Days

The next questions are about whether and how these problems have interacted with your drug and alcohol use.

Please answer the next questions using yes or no.

- | M1j. | Do these psychological problems... | <u>Yes</u> | <u>No</u> |
|------|--|------------|-----------|
| 1. | go away when you use alcohol or other drugs?..... | 1 | 0 |
| 2. | get worse when or after you have been using alcohol or other drugs? | 1 | 0 |
| 3. | happen only when or after you have been using alcohol or other drugs? | 1 | 0 |
| 4. | happen even when you have not been using alcohol or other drugs? | 1 | 0 |

- M1k. How **old** were you when you **first** started having these kinds of psychological problems?
 Age

The next set of questions is about any upsetting **memories** or **feelings** that keep bothering you from times when **you** or **someone close to you** was in danger of being hurt, was actually hurt, or died. This includes memories related to emotional, physical or sexual abuse; neglect; serious illness; accidents or disasters; violence in your community; war; or other traumatic events. These may be things you experienced yourself or that you witnessed.

Using **Card A...**

- EPS M2. When was the **last** time, if ever, your life was disturbed by **memories** or **feelings** of something you did, something you saw, something that happened to you, or something you heard about happening to someone else?
- (Select one)**
- | | |
|--------------------------------|--------------|
| Within the past two days | 6 |
| 3 to 7 days ago | 5 |
| 1 to 4 weeks ago | 4 |
| 1 to 3 months ago..... | 3 |
| 4 to 12 months ago..... | 2 |
| More than 12 months ago | 1 [GO TO M3] |
| Never | 0 [GO TO M3] |

Please answer the next questions using yes or no.

- | IMDS/
TSS | M2. During the past 12 months , have the following situations happened to you? | <u>Yes</u> | <u>No</u> |
|--------------|---|------------|-----------|
| a. | When something reminded you of the past, you became very distressed and upset | 1 | 0 |
| b. | You had nightmares about things in your past that really happened.. | 1 | 0 |
| c. | When you thought of things you had done, you wished you were dead..... | 1 | 0 |
| d. | It seemed as if you had no feelings..... | 1 | 0 |
| e. | Your dreams at night were so real that you awoke in a cold sweat and forced yourself to stay awake | 1 | 0 |
| f. | You felt like you could not go on | 1 | 0 |
| g. | You were frightened by your urges | 1 | 0 |
| h. | You used alcohol or other drugs to help yourself sleep or forget about things that happened in the past..... | 1 | 0 |
| j. | You lost your cool and exploded over minor, everyday things..... | 1 | 0 |
| k. | You were afraid to go to sleep at night..... | 1 | 0 |
| m. | You had a hard time expressing your feelings, even to the people you cared about..... | 1 | 0 |
| n. | You felt guilty about things that happened because you felt like you should have done something to prevent them | 1 | 0 |

[IF NONE REPORTED IN M2a-n, GO TO M2q]

	<u>Yes</u>	<u>No</u>
M2p. Have you ever had any of the problems just mentioned for three or more months?	1	0

[IF 4 TO 12 MONTHS AGO REPORTED IN M2, GO TO M3]

Please answer the next question using the number of days.

EPS	M2q. During the past 90 days , on how many days have you been disturbed by memories of things from the past that you did, saw or had happen to you?.....	_ _
		Days

Using **Card A...**

EPS	M3. When was the last time, if ever, you had any problems paying attention, controlling your behavior, or broke rules you were supposed to follow?	
		(Select one)
	Within the past two days	6
	3 to 7 days ago	5
	1 to 4 weeks ago	4
	1 to 3 months ago.....	3
	4 to 12 months ago.....	2
	More than 12 months ago	1 [GO TO M4]
	Never	0 [GO TO M4]

Please answer the next questions using yes or no.

BCS/ IDS	M3a. During the past 12 months , have you done the following things two or more times ?	<u>Yes</u>	<u>No</u>
	1. Made mistakes because you were not paying attention.....	1	0
	2. Had a hard time paying attention at school, work or home.....	1	0
	3. Had a hard time listening to instructions at school, work or home. ...	1	0
	4. Not followed instructions or not finished your assignments.....	1	0
	5. Had a hard time staying organized or getting everything done.....	1	0
	6. Avoided things that took too much effort, like school work or paperwork.....	1	0
	7. Lost things that you needed for school, work or home.	1	0
	8. Been unable to pay attention when other things were going on.....	1	0
	9. Been forgetful or absentminded.	1	0

BCS/ HIS	10. Fidgeted or had a hard time keeping your hands or feet still when you were supposed to.	1	0
	11. Been unable to stay in a seat or where you were supposed to stay. ...	1	0
	12. Felt restless or the need to run around or climb on things.....	1	0
	13. Gotten in trouble for being too loud when you were playing or relaxing.	1	0
	14. Felt like you were always on the go or driven by a motor.	1	0
	15. Talked too much or had others complain that you talked too much...	1	0
	16. Gave answers before the other person finished asking the question. .	1	0
	17. Had a hard time waiting for your turn.	1	0
	18. Interrupted or butted into other people's conversations or games.	1	0

[IF NONE REPORTED IN M3a1-18, GO TO M3b]

		<u>Yes</u>	<u>No</u>
M3a19.	Have you ever had any of the problems just mentioned for six or more months in your lifetime?	1	0
M3a20.	How old were you when you first started having problems with paying attention or controlling your behavior?	_ _	
			Age

Please answer the next questions using yes or no.

BCS/ CDS	M3b. During the past 12 months , have you done the following things two or more times ?	<u>Yes</u>	<u>No</u>
	1. Been a bully or threatened other people.	1	0
	2. Started physical fights with other people.	1	0
	3. Used a weapon in fights.	1	0
	4. Been physically cruel to other people.....	1	0
	5. Been physically cruel to animals.	1	0
	6. Taken a purse, money or other things from another person by force.	1	0
	7. Forced someone to have sex with you when they did not want to.	1	0
	8. Set fires.	1	0
	9. Broken windows or destroyed property.....	1	0
	10. Taken money or things from a house, building or car.	1	0
	11. Lied or conned to get things you wanted or to avoid having to do something.	1	0
	12. Taken things from a store or written bad checks to buy things.	1	0
	13. Stayed out at night later than your parents or partner wanted.	1	0
	14. Run away from home (partner) for at least one night.....	1	0
	15. Skipped work or school.	1	0
M3b17.	Before you were 18 , did you ever run away for 2 or more days or two or more times?.....	1	0

- | | | | |
|------|---|------------|-----------|
| M3b. | Before you were 13 years old , did you... | <u>Yes</u> | <u>No</u> |
| | 18. often stay out at night later than your parents wanted? | 1 | 0 |
| | 19. skip school or work many times? | 1 | 0 |

[IF NONE REPORTED IN M3b1-19, GO TO M3c]

M3b20. Have you ever had any of the problems just mentioned for six or more months? 1 0

M3b21. How **old** were you when you **first** started having these problems with other people, animals, property or breaking rules?.....
Age

[IF 4 TO 12 MONTHS AGO REPORTED IN M3, GO TO M4]

[NOTE: The next questions include behaviors reported in M3a and M3b.]

Please answer the next question using the number of days.

EPS M3c. **During the past 90 days**, on how many **days** have you had any problems paying attention, controlling your behavior, or broke rules you were supposed to follow?
Days

Please answer the next questions using yes or no.

M4. Do each of the next statements describe you during the past 12 months?		<u>Yes</u>	<u>No</u>	
PCSS/ CPI	a. You could not really trust people.	1	0	
	b. Rather than get mad, you wanted to get even.	1	0	
	c. You daydreamed or tried to space out the world a lot.	1	0	
	d. You did not care to be around other people much.	1	0	
	e. You were not very emotional about other people or things.	1	0	
	f. You were afraid that you were crazy.	1	0	
PCSS/ IPI	g. You often did not pay bills or live up to your commitments.	1	0	
	h. You lied often and easily.	1	0	
	j. You got bored easily or hated routines.	1	0	
	k. You often acted before thinking about the trouble you might get into.	1	0	
	m. You were a very moody person or had your feelings toward others change drastically.	1	0	
	n. You did not like being told by others what you should be doing.	1	0	
	p. You could usually get people to do things your way.	1	0	
	q. Other people think your problems are worse than they really are.	1	0	
PCSS/ WPI	r. You spent a lot of time trying to think through your problems or decide what to do.	1	0	
	s. You got mad at yourself a lot because you did not do a good enough job.	1	0	
	t. You felt like you could not make it through life.	1	0	
	u. You had a hard time deciding what to do.	1	0	
	v. You had a hard time changing the way you did things.	1	0	
	w. You often felt critical of others or picked on them.	1	0	
	x. You were very concerned about your health and other things that happened to you.	1	0	
M4z. During the past 12 months , have you...		<u>Yes</u>	<u>No</u>	
	1. cut, burned or hurt yourself on purpose?	1	0	[IF NO, GO TO M5a]
	2. needed medical treatment after you cut, burned or hurt yourself on purpose?	1	0	
	3. felt like you could not stop yourself from cutting, burning or hurting yourself?	1	0	

Please answer the next question using the number of days.

M4z4. **During the past 90 days**, on how many **days** have you cut, burned or hurt yourself on purpose?
Days

The next questions are about **treatment** for mental, emotional, behavioral or psychological problems. This includes taking medication like Ritalin that a regular doctor may have given you to help you focus or calm down. Do not count treatment that was **only** for substance use or health problems.

M5a. Has a doctor, nurse or counselor **ever** told you that you have a mental, emotional or psychological problem, or told you the name of a particular condition you have or had?..... 1 0 [IF NO, GO TO M5b]

M5a. What did they say? (**Please record and select all that apply**)

v1. _____

MENTIONED

	<u>Yes</u>	<u>No</u>
1. Alcohol or drug use disorders.....	1	0
2. Attention-deficit/hyperactivity disorder	1	0
3. Antisocial personality disorder.....	1	0
4. Anxiety or phobia disorder	1	0
5. Borderline personality	1	0
6. Conduct disorder	1	0
7. Major depression	1	0
8. Other depression, dysthymia, bipolar or mood disorder	1	0
9. Mental retardation, developmental or other communication disorder	1	0
10. Oppositional defiant disorder	1	0
11. Pathological gambling	1	0
12. Post or acute traumatic stress disorder	1	0
13. Somatoform, pain, sleep, eating or body disorder.....	1	0
14. Other cognitive disorder (like delirium, dementia, amnesic)	1	0
15. Other mental breakdown, nerves or stress.....	1	0
16. Other personality disorder (like avoidant, dependent, histrionic, narcissistic, obsessive-compulsive, paranoid, schizoid or schizotypal).....	1	0
17. Other schizophrenia or psychotic disorder	1	0
99. Other (Please describe in M5av1)	1	0

Please answer the next questions using the number of times.

M5. How many **times in your life** have you...

b. been treated in an emergency room for mental, emotional, behavioral or psychological problems?
 Times

c. been admitted for at least one night to a hospital for mental, emotional, behavioral or psychological problems?
 Times

Yes No

M5d. Are you currently taking medication for mental, emotional, behavioral or psychological problems? **(Please describe)**..... 1 0

v. _____

Using **Card A...**

MHTI M5e. When was the **last** time, if ever, you were treated for a mental, emotional, behavioral or psychological problem by a mental health specialist or in an emergency room, hospital or outpatient mental health facility, or with prescribed medication?

(Select one)

Within the past two days 6

3 to 7 days ago 5

1 to 4 weeks ago 4

1 to 3 months ago..... 3

4 to 12 months ago..... 2 [GO TO M6]

More than 12 months ago 1 [GO TO M6]

Never 0 [GO TO M6]

Please answer the next questions using the number of times, nights or days.

[IF NO LIFETIME SERVICE USE IN M5b OR M5c, SKIP THE RESPECTIVE ROW IN M5f AND M5g]

MHTI M5. **During the past 90 days**, how many...

f. **times** have you had to go to the **emergency room** for mental, emotional, behavioral or psychological problems?

Times

g. **nights** total did you spend in the **hospital** for mental, emotional, behavioral or psychological problems?

Nights

h. **times** did you see a mental health doctor in an **office or outpatient clinic** for mental, emotional, behavioral or psychological problems?

Times

h1. **days** did you take prescribed **medication** for mental, emotional, behavioral or psychological problems?

Days

Yes No

M5j. Are you currently being treated for a mental, emotional, behavioral or psychological problem? **(Where do you go?)** 1 0 [IF NO, GO TO M6]

v. _____

M5k. How long have you been treated **regularly**?..... + + +

Years Months Weeks Days

Using **Card E...**

AGHS M6. How **soon**, if at all, do you need (more) help with your **current** mental, emotional, behavioral or psychological problems?

(Select one)

- Right away 4
- In the next 3 months 3
- More than 3 months from now 2
- Getting the help I need already 1 [GO TO M7]
- Do not need any help 0 [GO TO M7]

Please answer the next questions using yes or no.

M6a. Do you currently want (more) help with...	<u>Yes</u>	<u>No</u>
1. how you have been feeling emotionally?	1	0
2. how your mind or body seem to be working?	1	0
3. how you control your mind or behavior?	1	0
4. concerns about suicide?	1	0
5. memories that disturb you?	1	0
6. getting medication to help control yourself?	1	0
99. anything else related to your emotional or mental situation? (Please describe).....	1	0
v. _____		

<i>For Staff Use Only</i>	
AGUR	M7. Urgency Rating [MUR]: NO <input type="checkbox"/> _0 ALREADY <input type="checkbox"/> _1 GT 3 MO <input type="checkbox"/> _2 0-3 MO <input type="checkbox"/> _3 NOW <input type="checkbox"/> _4
AGDM	M8. DM Rating [MDM]: NONE <input type="checkbox"/> _0 SOME <input type="checkbox"/> _1 MISUNDER <input type="checkbox"/> _2 DENIAL <input type="checkbox"/> _3 MISREP <input type="checkbox"/> _4

Please answer the next questions using the number of days.

E1d. **During the past 90 days**, on how many **days** have you been homeless or had to stay with someone else to avoid being homeless?
Days

E2. **During the past 90 days**, on how many **days** have you lived someplace...

a. where **you** paid any rent or mortgage or money to stay there?
Days

b. where any part of the rent was paid for by public housing or a public housing voucher?
Days

c. that would be considered a homeless shelter or emergency housing?
Days

The next two questions are about alcohol and other drug use at home or where you are living.

RERI E2. **During the past 90 days**, on how many **days** did...

d. **other people** use alcohol **where you were living**?
Days

e. **other people** use drugs **where you were living**?
Days

RERI E2f. **During the past 90 days**, on how many **days** did you live someplace where you were not free to come and go as you please - such as jail, an inpatient program, or a hospital?
Days

RERI E3. **During the past 90 days**, on how many **days** have you gotten into trouble at home or with your family for any reason?
Days

Please answer the next questions using yes or no.

E3a1. **During the past 12 months**, have you lived with anyone other than yourself? Yes No
1 0 [IF NO, GO TO E3b1]

E3a. Who have you lived with? (Code or say, "Have you lived with"...) (Anyone else?)

MENTIONED

	<u>Yes</u>	<u>No</u>
2. Spouse, significant companion or other sexual partner	1	0
3. Parents	1	0
3a. Stepparent	1	0
4. Your biological or adopted children age 12 or less	1	0
5. Your biological or adopted children over the age of 12	1	0
6. Your brothers or sisters age 12 or less	1	0
7. Your brothers or sisters over the age of 12	1	0
8. Other relatives	1	0
9. Other children age 12 or less	1	0
10. Other children over the age of 12	1	0
11. Other adult roommates	1	0
12. Foster parents	1	0
13. Institutional staff	1	0
99. Other (Please describe)	1	0

v. _____

Yes No

E3b1. Have you ever been married or lived as married with someone? 1 0 [IF NO, SELECT 8 IN E3b2 AND GO TO E3c]

E3b2. What is your **current** marital status?

(Clarify and code)

Married	1
Remarried	2
Living with someone as married	3
Married but living apart	4
Divorced	5
Legally separated	6
Widowed	7
Never married and not living as married	8

E3c. Do you currently have significant sexual or romantic attractions mostly to...

(Select one)

- the opposite sex?..... 1
- the same sex? 2
- both males and females? 3
- neither males or females? 5
- not sure?..... 6
- or something else? **(Please describe)**..... 99

v. _____

E3d. Which of the following labels best fits how you would describe your sexual orientation identity?

(Select one)

- Non-sexual or asexual 1
- Heterosexual or straight..... 2
- Homosexual, gay or lesbian..... 3
- Bisexual 5
- Questioning or curious..... 6
- Not sure..... 7
- Other **(Please describe)**..... 99

v. _____

E4. How many children, if any, do you have under the age of 21? **[IF 0, GO TO E5]**
Children

E4a. **During the past 12 months**, who has had legal custody of the children (Anyone else during the past 12 months)?

MENTIONED

	<u>Yes</u>	<u>No</u>
1. You	1	0
2. Your spouse or child's other parent	1	0
3. Other relative	1	0
4. Department of Children and Family Services (DCFS) or a court	1	0
5. The children ran away	1	0
6. The children were adopted	1	0
7. The children legally live on their own.....	1	0
99. Some other situation (Please describe)	1	0

v. _____

E4b. Do you still **have or want** legal custody of **any** of your children?..... **[IF NO, GO TO E5]**

Please answer the next questions using the number of children or days.

E4b1. For how many of the children living with you are you the primary caregiver?.....
Children

E4c. **During the past 90 days**, how many children under 21 do you have who have been in foster care?..... [IF 0, GO TO E4e]
Children

E4d. **During the past 90 days**, on how many **days** were they in foster care? (Use the average if more than one child).....
Days

E4e. **During the past 90 days**, how many children under 21 do you have who have been in a group home or child care institution? [IF 0, GO TO E4g]
Children

E4f. **During the past 90 days**, on how many days were they in a group home or child care institution? (Use average if more than one child).....
Days

E4g. **During the past 90 days**, how many children under 21 do you have who have been living with someone else?.....
Children

E4h. What is the **age** of the **youngest** child whom you have custody of (or are trying to get custody of)?.....
Age

Please answer the next questions for all your children under age 21 using yes or no.

CAS	E4.	During the past 12 months , have you done any of the following things with these children?	<u>Yes</u>	<u>No</u>
	j.	Spent 30 minutes or more playing with them.....	1	0
	k.	Taken them to an organized activity or event.....	1	0
	m.	Read a book to them	1	0
	n.	Worked with them on homework or taught them to read, write, or do math	1	0
	p.	Met with a teacher, social worker, lawyer, court official or police officer about them.....	1	0

CFS	E4q.	During the past 12 months, (has this child/have these children) been doing well in terms of...	<u>Yes</u>	<u>No</u>
	1.	doing schoolwork and learning?.....	1	0
	2.	avoiding alcohol and drugs?	1	0
	3.	avoiding illegal activities?	1	0
	4.	getting along with other people?	1	0
	5.	getting to places on time?	1	0
	6.	health?.....	1	0

For the following questions, please do not count people **just** because they are in the same building (e.g., jail, detention, school), or because you only see them a few times.

Using number of people...

E5. **During the past 12 months**, how many people would you say you have **regularly lived with**, including your parents and family?..... [IF 0, GO TO E6]
People

Using Card C...

LRI/ ERS	E5.	Of the people you have regularly lived with , would you say that none, a few, some, most or all of them...	<u>None</u>	<u>A Few</u>	<u>Some</u>	<u>Most</u>	<u>All</u>
	a.	were employed or in school or training full time ?..	4	3	2	1	0
	b.	were involved in illegal activity?.....	0	1	2	3	4
	c.	weekly got drunk or had 5 or more drinks in a day?	0	1	2	3	4
	d.	used any drugs during the past 90 days ?	0	1	2	3	4
	e.	shout, argue and fight most weeks?.....	0	1	2	3	4
	f.	have ever been in drug or alcohol treatment?.....	4	3	2	1	0
	g.	would describe themselves as being in recovery?...	4	3	2	1	0

Using number of people...

E6. **During the past 12 months**, how many people would you say you spend most of your time with at work, a training program or school? [IF 0, GO TO E7]
People

Using Card C...

VRI/ ERS	E6.	Of the people you have regularly worked or gone to school with , would you say that none, a few, some, most or all of them	<u>None</u>	<u>A Few</u>	<u>Some</u>	<u>Most</u>	<u>All</u>
	a.	were employed or in school or training full time ?..	4	3	2	1	0
	b.	were involved in illegal activity?.....	0	1	2	3	4
	c.	weekly got drunk or had 5 or more drinks in a day?	0	1	2	3	4
	d.	used any drugs during the past 90 days ?	0	1	2	3	4
	e.	shout, argue and fight most weeks?.....	0	1	2	3	4
	f.	have ever been in drug or alcohol treatment?.....	4	3	2	1	0
	g.	would describe themselves as being in recovery?...	4	3	2	1	0

Using number of people...

- E7. **During the past 12 months**, how many people would you say you spend most of your free time with or hang out with? [IF 0, GO TO E8]
 People

Using **Card C...**

SRI/ ERS	E7. Of the people you have regularly socialized with , would you say that none, a few, some, most or all of them...	<u>None</u>	<u>A Few</u>	<u>Some</u>	<u>Most</u>	<u>All</u>
	a. were employed or in school or training full time? ..	4	3	2	1	0
	b. were involved in illegal activity?.....	0	1	2	3	4
	c. weekly got drunk or had 5 or more drinks in a day?	0	1	2	3	4
	d. used any drugs during the past 90 days?	0	1	2	3	4
	e. shout, argue and fight most weeks?.....	0	1	2	3	4
	f. have ever been in drug or alcohol treatment?.....	4	3	2	1	0
	g. would describe themselves as being in recovery?...	4	3	2	1	0

No matter how hard people try, they sometimes have conflicts or disagreements. Next is a list of various ways people try to settle their differences. The first set of questions is about what you may have done.

Using **Card A...**

- RERI E8. When was the **last** time, if ever, that during an argument with someone else **you** swore, cursed, threatened them, threw something, or pushed or hit them in any way?
- (Select one)**
- Within the past two days 6
- 3 to 7 days ago 5
- 1 to 4 weeks ago 4
- 1 to 3 months ago..... 3
- 4 to 12 months ago..... 2
- More than 12 months ago 1 [GO TO E9]
- Never 0 [GO TO E9]

Please answer the next questions using yes or no.

GCTS E8.	During the past 12 months , have you had a disagreement in which you...	<u>Yes</u>	<u>No</u>
	a. discussed it calmly and settled the disagreement?.....	1	0
	b. left the room or area rather than argue?.....	1	0
	c. insulted, swore or cursed at someone?	1	0
	d. threatened to hit or throw something at another person?.....	1	0
	e. actually threw something at someone?	1	0
	f. pushed, grabbed or shoved someone?	1	0
	g. slapped another person?.....	1	0
	h. kicked, bit or hit someone?.....	1	0
	j. hit or tried to hit anyone with something (an object)?.....	1	0
	k. beat up someone?	1	0
	m. threatened anyone with a knife or gun?.....	1	0
	n. actually used a knife or gun on another person?	1	0

[IF 4 TO 12 MONTHS AGO REPORTED IN E8, GO TO E9]

Please answer the next question using the number of days.

RERI E8p.	During the past 90 days , on how many days did you have an argument with someone else in which you swore, cursed, threatened them, threw something, or pushed or hit them in any way?	_ _
		Days

The next questions are about things that other people may have done to **you**.

Please answer the next questions using yes or no.

GVS E9.	Has anyone ever ...	<u>Yes</u>	<u>No</u>
	a. attacked you with a gun, knife, stick, bottle or other weapon?	1	0
	b. hurt you by striking or beating you to the point that you had bruises, cuts, or broken bones or otherwise physically abused you? .	1	0
	c. pressured or forced you to participate in sexual acts against your will, including your regular sex partner, a family member or friend?	1	0
	d. abused you emotionally ; that is, did or said things to make you feel very bad about yourself or your life?.....	1	0

[IF ALL OF E9a-d ARE NO, GO TO E9n]

E9e.	About how old were you the first time any of these things happened to you?.....	_ _
		Age

E9e18.	[IS E9e UNDER 18?]	<u>Yes</u>	<u>No</u>
		1	0

Please answer the next questions using yes or no.

E9.	Did any of the previous things happen...	<u>Yes</u>	<u>No</u>
f.	several times or over a long period of time?	1	0
g.	with more than one person involved in hurting you?	1	0
h.	where one or more of the people involved was a family member, close family friend, professional or someone else you had trusted? ..	1	0
j.	to the point that you were afraid for your life or afraid that you might be seriously injured?	1	0
k.	and result in oral, vaginal or anal sex?	1	0
m.	and people you told did not believe or help you?	1	0
E9.	Are you currently worried that someone might...	<u>Yes</u>	<u>No</u>
n.	attack you with a gun, knife, stick, bottle or other weapon?	1	0
p.	hurt you by striking or beating , or otherwise physically abuse you?	1	0
q.	pressure or force you to participate in sexual acts against your will?	1	0
r.	abuse you emotionally ?	1	0

[IF E9a-d AND E9f-r ARE ALL NO, GO TO E9t]

		<u>Yes</u>	<u>No</u>
E9s.	Have you gotten the help you need to deal with these problems?	1	0

Using **Card A...**

RERI	E9t.	When was the last time, if ever, you were attacked with a weapon, beaten, sexually abused, or emotionally abused?	
			(Select one)
		Within the past two days	6
		3 to 7 days ago	5
		1 to 4 weeks ago	4
		1 to 3 months ago	3
		4 to 12 months ago	2 [GO TO E10]
		More than 12 months ago	1 [GO TO E10]
		Never	0 [GO TO E10]

Please answer the next question using the number of days.

RERI	E9u.	During the past 90 days , on how many days were you attacked with a weapon, beaten, sexually abused or emotionally abused?	<input type="text"/> <input type="text"/> <input type="text"/>
			Days

Please answer the next questions using yes or no.

PSSI	E10.	During the past 12 months , have you been under stress for any of the following reasons related to your family, friends, classmates or coworkers?	<u>Yes</u>	<u>No</u>
			1	0
		1. Birth or adoption of a new family member.	1	0
		2. Health problem of a family member or close friend.	1	0
		3. Major change in relationships (marriage, divorce, separations).....	1	0
		4. Death of a family member or close friend.	1	0
		5. Fights with boss, teacher, coworkers or classmates.	1	0
		99. Other changes or problems in family or primary support groups. (Please describe)	1	0
		v. _____		

OSSI	E11.	During the past 12 months , have you been under stress because of the following other kinds of demands on you?	<u>Yes</u>	<u>No</u>
			1	0
		1. Major change in housing or bad housing.	1	0
		2. New job, position or school.	1	0
		3. Hard work or school schedule.	1	0
		4. Problems with transportation.	1	0
		5. Discrimination in community, work, school or transportation.	1	0
		6. Threat of losing current housing, job, school or transportation.	1	0
		7. Interruption or loss of housing, job, school or transportation.	1	0
		8. Something you saw or that happened to someone close to you. (Please describe)	1	0
		v. _____		
		99. Other environmental demands on you. (Please describe)	1	0
		v. _____		

Please answer the next questions using yes or no.

SSEI	E12a. During the past 12 months , which of the following areas do you consider to be your strengths?	<u>Yes</u>	<u>No</u>
	1. Doing well at school or training.	1	0
	2. Doing well at work.	1	0
	3. Doing well with your family.	1	0
	4. Doing well with your close friends.	1	0
	5. Doing well at sports, exercise or other physical activity.	1	0
	6. Doing well at music, dancing, acting or other performing arts.	1	0
	7. Drawing, painting, design or other art activities.	1	0
	8. Listening, caring, and communicating with others.	1	0
	9. Problem solving and figuring things out.	1	0
	10. Working or playing with computers.	1	0

E12b. What do you consider your most important **strengths** as a person?

v1. _____

Please answer the next questions using yes or no.

GSSI	E12c. During the past 12 months , did you have the following kinds of social support ?	<u>Yes</u>	<u>No</u>
	1. A professional counselor or other health provider to talk to.	1	0
	2. Friends or colleagues from other companies or schools you could talk to without worry about things getting back to others at work or school	1	0
	3. People at work or school you could talk to about day-to-day things.	1	0
	4. People at work or school who could help you get your assignments done.	1	0
	5. Family members or close partners you could talk to and rely on.	1	0
	6. Friends you could just hang out with and not talk about work or family issues.	1	0
	7. A legal hobby or activity that you enjoyed and did for yourself.	1	0
	8. someone you felt like you could talk to about needs and emotions. ...	1	0
	9. Someone you felt could help you figure out how to cope with any problems you were having or might have.	1	0

E12d. Which people, agencies or things do you consider your most important sources of social support?

v1. _____

E13a. Do you consider yourself a **member** of a religious group? (If so, which of the following best describes it?)

(Clarify and code)

No/None.....	0 [GO TO E13d]
Baptist.....	1
Buddhist.....	2
Catholic.....	3
Evangelical.....	4
Hindu.....	5
Jewish.....	6
Lutheran.....	7
Methodist.....	8
Mormon.....	9
Muslim.....	10
Presbyterian.....	11
Other Protestant.....	12
Shinto.....	13
Native American Church.....	14
Traditional Native American.....	15
Christian (non-denominational or not specified).....	16
Some other group (Please describe).....	99

v. _____

E13b. How long have you been a member of your religion? + + +
 Years Months Weeks Days

[Use age in years for whole life]

Please answer the next questions using yes or no.

E13c. Do you... Yes No

1. consider yourself to be a good member of your religion?.....	1	0
2. regularly attend services or ceremonies?.....	1	0

E13d. Do you consider your religious or spiritual beliefs to... Yes No

1. be very strong?	1	0
2. be very important to you?.....	1	0
3. often influence your decisions?	1	0

Yes No

E13e. Is it important for your friends to share your religious or spiritual beliefs? 1 0

Please answer the next questions using the number of days.

- RERI E14. **During the past 90 days**, on how many **days** have you been to a formal activity where...
- a. no one was using alcohol or other drugs?.....
Days
- b. people were using alcohol or other drugs?
Days

Please answer the next questions using yes or no.

- GSI E15a. Are you **satisfied** with Yes No
1. where you are living? 1 0
2. your family relationships? 1 0
3. your sexual or marital relationships?..... 1 0
4. your school and work situations? 1 0
5. how you spend your free time?..... 1 0
6. the extent to which you are coping with or getting help with your problems? 1 0

Using **Card E**...

- AGHS E16. How **soon**, if at all, do you need (more) help with issues related to your **current** environment, living situation or sexual orientation? (Would you say...)
- (Select one)**
- Right away 4
- In the next 3 months 3
- More than 3 months from now 2
- Getting the help I need already 1 **[GO TO E17]**
- Do not need any help 0 **[GO TO E17]**

Please answer the next questions using yes or no.

- E16a. Do you **currently** want (more) help with... Yes No
1. your housing? 1 0
2. parenting or children you are living with or see regularly?..... 1 0
3. people with whom you live, work, go to school or socialize?..... 1 0
4. how you spend your free time and get social support?..... 1 0
5. people you have been avoiding, or arguing or fighting with? 1 0
6. people who have or might attack or abuse you physically, sexually or emotionally? 1 0
7. how you handle arguments? 1 0
8. issues related to sexual orientation, attractions, or gender identity? .. 1 0
99. anything else related to your environment or social situation or coping? (**Please describe**) 1 0

v. _____

For Staff Use Only

AGUR E17. Urgency Rating [EUR]: NO _0 ALREADY _1 GT 3 MO _2 0-3 MO _3 NOW _4

AGDM E18. DM Rating [EDM]: NONE _0 SOME _1 MISUNDER _2 DENIAL _3 MISREP _4

L. Legal (Civil and Criminal)

This section deals with the legal system and behaviors that may get you into trouble or be against the law. Recall that your answers here are strictly confidential and will be used only for your treatment and to help us evaluate our program.

Please answer the next questions using yes or no.

- L1. Are you currently involved in any of the following kinds of **civil proceedings**?
- | | <u>Yes</u> | <u>No</u> |
|---|------------|-----------|
| 1. Traffic court..... | 1 | 0 |
| 2. A child custody case..... | 1 | 0 |
| 3. Divorce proceedings..... | 1 | 0 |
| 4. A lawsuit..... | 1 | 0 |
| 99. Any other civil proceedings (Please describe)..... | 1 | 0 |

v. _____

[SELECT 0 IF NEVER MARRIED AND NO CHILDREN]

- L2. As a result of a divorce or child custody case, do you have **any** settlements or ongoing alimony or child support payments you are supposed to make?

(Clarify and code)

- | | |
|--------------------------|--------------|
| No | 0 [GO TO L3] |
| Only alimony | 1 |
| Only child support | 2 |
| Both | 3 |

- L2a. How much is either the total payment or payment per month?
- \$|_|_|_|_|, |_|_|_|_|
- Total Still Due

\$|_|_|_|_|, |_|_|_|_|

Dollars Per Month

- | | <u>Yes</u> | <u>No</u> |
|--|------------|-----------|
| L2b. Are your payments up to date? | 1 | 0 |

Using **Card A...**

- IAS L3. When was the **last** time you did anything you thought might get you in trouble or be against the law besides using alcohol or other drugs?

(Select one)

- | | |
|--------------------------------|--------------|
| Within the past two days | 6 |
| 3 to 7 days ago | 5 |
| 1 to 4 weeks ago | 4 |
| 1 to 3 months ago..... | 3 |
| 4 to 12 months ago..... | 2 |
| More than 12 months ago | 1 [GO TO L4] |
| Never | 0 [GO TO L4] |

Please answer the next questions using the number of times.

L3a. **During the past 12 months**, how many **times** have you...

- | | | |
|-------------|--|-------------------|
| GCS/
PCS | 1. purposely damaged or destroyed property that did not belong to you? | _ _ _ _
Times |
| | 2. bought, received, possessed or sold any stolen goods? | _ _ _ _
Times |
| | 3. passed bad checks, forged or altered a prescription, or took money from an employer? | _ _ _ _
Times |
| | 4. taken something from a store without paying for it? | _ _ _ _
Times |
| | 5. other than from a store, taken money or property that didn't belong to you? | _ _ _ _
Times |
| | 6. broken into a house or building to steal something or just to look around? | _ _ _ _
Times |
| | 7. taken a car that didn't belong to you? | _ _ _ _
Times |
| GCS/
ICS | 8. used a weapon, force, or strong-arm methods to get money or things from a person? | _ _ _ _
Times |
| | 9. hit someone or gotten into a physical fight? | _ _ _ _
Times |
| | 10. hurt someone badly enough they needed bandages or a doctor? | _ _ _ _
Times |
| | 11. used a knife or gun or some other thing, like a club, to get something from a person | _ _ _ _
Times |
| | 12. made someone have sex with you by force when they did not want to have sex? | _ _ _ _
Times |
| | 13. been involved in the death or murder of another person, including accidents? | _ _ _ _
Times |
| | 14. intentionally set a building, car or other property on fire? | _ _ _ _
Times |
| GCS/
DCS | 15. driven a vehicle while under the influence of alcohol or illegal drugs? | _ _ _ _
Times |
| | 16. sold, distributed or helped to make illegal drugs? | _ _ _ _
Times |
| | 17. traded sex for food, drugs or money? | _ _ _ _
Times |

- L3a. **During the past 12 months**, how many **days** have you...
18. been a member of a gang?
Days
19. gambled illegally?
Days
99. done something else, other than drug use, that would have gotten you into trouble with the police if they had known about it? (**Please describe**).....
Days

v. _____

[IF 4 TO 12 MONTHS AGO REPORTED IN L3, GO TO L4]

Please answer the next questions using the number of days.

- IAS L3d. **During the past 90 days**, on how many **days** were you involved in any activities you thought might get you into trouble or be against the law, besides drug use? **[IF 0, GO TO L4]**
Days
- L3. On how many of these days were you involved in these activities (you thought might get you into trouble or be against the law)...
- e. in order to support yourself financially?.....
Days
- f. in order to obtain alcohol or other drugs?.....
Days
- g. while you were high or drunk?.....
Days

Please answer the next questions using the number of tickets or times.

- L4. **In your lifetime**, about how many tickets have you gotten for minor traffic violations? Do not include any that led to an arrest.
Tickets
- L4a. **In your lifetime**, about how many **times** have you been picked up by the police for status offenses such as running away or truancy?
Times

L5. **In your lifetime, how many times have you been arrested and charged with a crime?** Please include all the times this happened, even if you were then released or the charges were dropped. [IF 0, GO TO L6]
Times

L5a. What were the charges? (Were there any other charges?)
(If more than 5 arrests, ask all as: For which of the following offenses have you ever been arrested and charged with?)

		MENTIONED	
		<u>Yes</u>	<u>No</u>
1.	Vandalism or property destruction	1	0
2.	Receiving, possessing or selling stolen goods.....	1	0
3.	Passing bad checks, forgery, or fraud.....	1	0
4.	Shoplifting	1	0
5.	Larceny or theft	1	0
6.	Burglary or breaking and entering.....	1	0
7.	Motor vehicle theft	1	0
8.	Robbery	1	0
9.	Simple assault or battery	1	0
10.	Aggravated assault or battery	1	0
11.	Forcible rape	1	0
12.	Murder, homicide or non-negligent manslaughter	1	0
13.	Arson	1	0
14.	Driving under the influence	1	0
15.	Drunkenness or other liquor law violation	1	0
16.	Possession, dealing, distribution or sale of drugs.....	1	0
17.	Prostitution, pimping, or commercialized sex	1	0
18.	Probation or parole violations	1	0
19.	Illegal gambling.....	1	0
99.	Status or other offenses (curfew, truancy, graffiti, gang involvement/activity, runaway, domestic violence, disturbing the peace, disorderly conduct, paraphernalia) (Please describe).....	1	0

v. _____

L5ac. How many times were you found guilty and sentenced, including being adjudicated as an adolescent or convicted as an adult?
Times

L5ad. How old were you the first time you were adjudicated or convicted?
Age

L5ae. In your lifetime, how much total time have you spent in detention, jail or prison? + + +
Years Months Weeks Days

Using **Card A...**

L5b. When was the **last** time you were arrested and charged with a crime?

(Select one)

- Within the past two days 6
- 3 to 7 days ago 5
- 1 to 4 weeks ago 4
- 1 to 3 months ago..... 3
- 4 to 12 months ago..... 2 [GO TO L6]
- More than 12 months ago 1 [GO TO L6]
- Never 0 [GO TO L6]

Please answer the next questions using the number of times.

L5c. **During the past 90 days**, how many **times** have you been arrested and charged with breaking a law? (Please do not count minor traffic violations.) [IF 0, GO TO L6]
Times

L5d. What were you arrested for **in the past 90 days**? (How many times? Was there anything else you were arrested for? How many times?)

MENTIONED

Times

- 1. Vandalism or property destruction
- 2. Receiving, possessing or selling stolen goods.....
- 3. Passing bad checks, forgery, or fraud.....
- 4. Shoplifting
- 5. Larceny or theft
- 6. Burglary or breaking and entering.....
- 7. Motor vehicle theft
- 8. Robbery
- 9. Simple assault or battery
- 10. Aggravated assault or battery
- 11. Forcible rape
- 12. Murder, homicide or non-negligent manslaughter
- 13. Arson
- 14. Driving under the influence
- 15. Drunkenness or other liquor law violation
- 16. Possession, dealing, distribution or sale of drugs.....
- 17. Prostitution, pimping, or commercialized sex
- 18. Probation or parole violations
- 19. Illegal gambling.....
- 99. Status or other offenses (curfew, truancy, graffiti, gang involvement/activity, runaway, domestic violence, disturbing the peace, disorderly conduct, paraphernalia) (**Please describe**).....

v. _____

Using **Card A...**

CJSI L6. When was the **last** time you were on or in probation, parole, jail, detention, house arrest or electronic monitoring?

(Select one)

- Within the past two days 6
- 3 to 7 days ago 5
- 1 to 4 weeks ago 4
- 1 to 3 months ago..... 3
- 4 to 12 months ago..... 2 [GO TO L7]
- More than 12 months ago 1 [GO TO L7]
- Never 0 [GO TO L7]

Please answer the next questions using the number of days.

L6. **During the past 90 days**, how many **days** have you been...

- a. on probation?
Days
- b. on parole?
Days
- c1. in juvenile detention?
Days
- c2. in jail or prison?
Days
- d. on house arrest?
Days
- e. on electronic monitoring?
Days

L6g. How many of these **days** did you get into trouble with your probation officer or parole officer?

Days

Yes No

L6h. Are you **currently** in jail, prison or detention? 1 0 [IF NO, GO TO L7]

L6j. How much longer do you think you will be there?

[Use 99 years for rest of life] + + +
Years Months Weeks Days

Please answer the next questions using yes or no.

L7.	Are you currently involved with the criminal justice system in any of the following ways?	<u>Yes</u>	<u>No</u>
1.	Awaiting a trial	1	0
2.	Awaiting sentencing	1	0
3.	Out on bail or released on own recognizance (ROR) or word	1	0
4.	On probation	1	0
5.	In jail or prison	1	0
6.	On treatment release, work release, or school release	1	0
7.	On parole	1	0
8.	In detention	1	0
9.	Assigned to a sentencing alternative or treatment program (TASC)..	1	0
10.	Under house arrest	1	0
11.	Under other forms of court supervision.....	1	0
12.	Awaiting charges	1	0
99.	Any other involvement in the criminal justice system (Please describe).....	1	0

v. _____

Please answer the next question using the number of times.

L7a.	During the past 10 years , how many times have you had DUI offenses that led to convictions including those reduced to reckless driving, court ordered supervision, or your license being suspended? (Record 0 if no prior arrests)	_ _ _
		Times

Please answer the next questions using yes or no.

		<u>Yes</u>	<u>No</u>	
L8.	Are there currently any outstanding warrants for your arrest?	1	0	[IF NO, GO TO L9a]
L8a.	Are you working with a lawyer or someone else to resolve these warrants?.....	1	0	
L9a.	Do you have any outstanding fines or restitution you must pay as a result of a criminal, traffic, civil or administrative court ruling?	1	0	[IF NO, GO TO L10]
L9b.	Are your payments up to date?	1	0	
L9c.	What is the total still due?	\$ _ _ _ , _ _ _		Total Dollars Still Due
L9d.	How much are you supposed to pay per month?	\$ _ _ _ , _ _ _		Dollars Per Month

Using **Card E...**

AGHS L10. How **soon**, if at all, do you need (more) help with your **current** legal situation?
(Would you say...?)

(Select one)

- Right away 4
- In the next 3 months 3
- More than 3 months from now 2
- Getting the help I need already 1 [GO TO L11]
- Do not need any help 0 [GO TO L11]

Please answer the next questions using yes or no.

- | L10a. Do you currently want (more) help with | <u>Yes</u> | <u>No</u> |
|--|------------|-----------|
| 1. civil justice proceedings?..... | 1 | 0 |
| 2. being involved in illegal activities?..... | 1 | 0 |
| 3. criminal justice proceedings? | 1 | 0 |
| 4. making arrangements with a probation officer, parole officer, or
other officer of the court? | 1 | 0 |
| 5. child custody case? | 1 | 0 |
| 99. anything else related to your legal situation? (Please describe)..... | 1 | 0 |

v. _____

<i>For Staff Use Only</i>	
AGUR	L11. Urgency Rating [LUR]: NO <input type="checkbox"/> ₀ ALREADY <input type="checkbox"/> ₁ GT 3 MO <input type="checkbox"/> ₂ 0-3 MO <input type="checkbox"/> ₃ NOW <input type="checkbox"/> ₄
AGDM	L12. DM Rating [LDM]: NONE <input type="checkbox"/> ₀ SOME <input type="checkbox"/> ₁ MISUNDER <input type="checkbox"/> ₂ DENIAL <input type="checkbox"/> ₃ MISREP <input type="checkbox"/> ₄

V. Vocational (School, Work, Financial)

These next questions are about school, work and money.

V1. What is the **last** grade or year that you **completed in school**?
(NOTE: Use 12 for high school, 16 for a BA/BS, and 17 for graduate school or more than 4 years of college)
 Grade

Yes No

V1a. Have you **ever** received any special education classes or services or gone to any alternative school programs? 1 0 **[IF NO, GO TO V1b]**

V1a. What kind of services or program did you go to?
 v1. _____

V1b. During your **last** year in school, what was your **average** grade?
(Clarify and code)

- As..... 4
- Bs..... 3
- Cs..... 2
- Ds..... 1
- Fs..... 0
- Mixed/Other **(Please describe)** 99

v. _____

V2. What kinds of diplomas, degrees, work-related certificates or licenses have you received? (Any others?)

MENTIONED

Yes No

- 1. High school diploma..... 1 0
- 2. Passed GED (general equivalency diploma) 1 0
- 3. Adult Basic Education (ABE) certificate 1 0
- 4. Junior college or associate's degree 1 0
- 5. Bachelor's degree..... 1 0
- 6. Advanced college degree (master's or doctorate) 1 0
- 7. Vocational or trade certificate 1 0
- 8. Trade license apprenticeship 1 0
- 9. Commercial driver's license 1 0
- 99. Other degrees or licenses **(Please describe)** 1 0

v. _____

Using **Card A...**

TAS V3. When was the **last** time you were in any kind of school or training program?

(Select one)

Within the past two days	6
3 to 7 days ago	5
1 to 4 weeks ago	4
1 to 3 months ago.....	3
4 to 12 months ago.....	2
More than 12 months ago	1 [GO TO V4]
Never	0 [GO TO V4]

Please answer the next questions using yes or no.

TPS V3. **During the past 12 months**, have you...

	<u>Yes</u>	<u>No</u>
a. gotten bad grades or had your grades drop at school or training?	1	0
b. come in late or left early from school or training?	1	0
c. gotten sick at school or training?	1	0
d. gotten hurt or injured at school or training?	1	0
e. gotten into a fight or trouble at school or training?	1	0
f. been absent 5 or more days from school or training for any reason? ..	1	0
h. skipped or cut school or training just because you didn't want to be there?	1	0
j. been suspended or expelled from school or training?	1	0

[IF 4 TO 12 MONTHS AGO REPORTED IN V3, GO TO V4]

5 days per week in 90 days is equal to 64 days. Vacation days, holidays or other days when you were not required to be in school do not count for days in school or training or for days missed.

Please answer the next questions using the number of days or times.

TAS V3. **During the past 90 days**, how many...

k. days did you go to any kind of school or training?	_ _	
		Days
m. days did you go to school or training full time?	_ _	
		Days
n. days did you miss school or training?	_ _	
		Days
p. days did you get in trouble at school or training for any reason?	_ _	
		Days
q. days were you suspended from school or training for any reason? ...	_ _	
		Days
r. times did you get expelled from school or training?	_ _	
		Times

V3s. Where (do/did) you go to school?

v. _____

[IF UNDER 17, SELECT 0 AND GO TO V5]

V4. Have you **ever** been in the armed forces of the United States or another country?

(Select one)

- No, never served in any armed forces 0 **[GO TO V5]**
- Yes, served in the United States armed forces 1
- Yes, served in the armed forces or military of another country (**Which country?**)..... 99

v. _____

Please answer the next question using yes or no.

Yes No

V4a. Were you **ever** in a combat zone? 1 0

V4b. What was your **highest** rank in the military?

v. _____

V4c. What is your military status or type of discharge?

(Clarify and code)

- On active duty in the armed forces 1
- In a reserves component 2
- Retired, honorably or regularly discharged from either reserves or active duty..... 3
- Discharged because of alcohol, drug, mental, physical or other problems (**Please describe**) 4

v. _____

V5. **During the past 90 days**, how many **times** have you applied for a job? ...
Times

V5a. Including time in the military, which of the following **best describes** your level of work experience? (**Read all**)

(Select one)

- Five or more years with the same type of job or employer 1
- Five or more years with several different types of jobs or employers .. 2
- Two to five years of job experience 3
- Less than two years of job experience..... 4
- No job experience 5 **[GO TO V6]**

V5b. What was the last type of job you had?

v1. _____

V5b. Select the option that best describes the type of job reported in V5b

(Select one)

Professional and Technical (accountant, architect, doctor, engineer, entertainer, judge, lawyer, registered nurse, scientist, social worker, teacher, writer)	1
Manager and Administrator (government official, office manager, sales manager, school administrator, small-business owner)	2
Sales (cashier, insurance agent, real estate broker, sales clerk, sales representative, telemarketing, or other sales person)	3
Clerical or Office Worker (bank teller, bookkeeper, secretary, typist, postal clerk or carrier, ticket agent)	4
Craft and Kindred (auto detailer, baker, carpenter, electrician, bricklayer, mechanic, machinist, music lessons, tool and die maker, telephone installer)	5
Operative (assembler, checker, gas station attendant, meat cutter, packer, laundry or dry-cleaning operative, miner operative, welder, garage worker)	6
Transportation Equipment Operative (bus driver, cab driver or chauffeur, truck driver, delivery person)	7
Non-farm Laborer (construction worker, dishwasher, forklift operator, freight handler, gardener at a nursery, high-level maintenance/fix things, newspaper route/paper delivery, paper handler, sanitation worker, stocker at a store)	8
Private Household Worker (babysitter, butler, cook, maid)	9
Service Worker (bagger at store, barber, beautician, bussing tables at restaurant, camp counselor, cook, customer service at store, dietary aide, fast food cashier, janitor, lawn mowing, lifeguard, maintenance-raking/cleanup, practical nurse, restaurant host/hostess, skate guard/rental, usher at theater/show, waiter/waitress)..	10
Farm and Farm Manager	11
Farm Laborer (foreman, picker)	12
Military Service	13
Other (Please describe in V5b)	99

Using **Card A...**

EmAS V6. When was the **last** time you worked at a civilian job or were self-employed?

(Select one)

- Within the past two days 6
- 3 to 7 days ago 5
- 1 to 4 weeks ago 4
- 1 to 3 months ago..... 3
- 4 to 12 months ago..... 2
- More than 12 months ago 1 [GO TO V7]
- Never 0 [GO TO V7]

Please answer the next questions using yes or no.

EmPS V6. During the past 12 months , have you...	<u>Yes</u>	<u>No</u>
a. done badly at work or done worse at work?	1	0
b. come in late or left early from your work?	1	0
c. gotten sick at work?	1	0
d. gotten hurt or injured at work?	1	0
e. gotten into a fight or trouble at work?	1	0
f. been absent 5 or more days from work for any reason?	1	0
h. skipped or cut your work just because you didn't want to be there? ..	1	0
j. been fired, laid off, or told not to come in to work?	1	0

[IF 4 TO 12 MONTHS AGO REPORTED IN V6, GO TO V7]

5 days per week in 90 days is equal to 64 working days. Vacation days, holidays or other days when you were not required to be at work do not count for days at work or for days missed.

Please answer the next questions using the number of days or times.

EmAS V6. During the past 90 days , how many...	
k. days did you work for money at a job or in a business?	□□□
	Days
m. days did you work full time (7 or more hours per day)?.....	□□□
	Days
n. days did you miss work?	□□□
	Days
p. days did you get in trouble at work for any reason?	□□□
	Days
q. days were you suspended from work for any reason?	□□□
	Days
r. times did you get fired from work?.....	□□□
	Times

V6s. Where (do/did) you go to work?

v. _____

Please answer the next questions using yes or no.

FPS	V8. During the past 12 months , have you...	<u>Yes</u>	<u>No</u>
	a. run out of money for food or transportation?	1	0
	b. run out of money for housing?	1	0
	c. spent half or more of your income on housing and utilities?	1	0
	d. not counting a home or car loan, owed people more than what you make in two months?	1	0
	e. not had enough money to pay all your bills on time?	1	0
	f. been 120 days or more behind on a bill?	1	0
	g. spent money that was needed for bills on alcohol, drugs, gambling or some other way on yourself?	1	0
	h. had to borrow money from another family member or close friend for food, rent or utilities?	1	0
	j. had to use a food bank, soup kitchen or emergency shelter?	1	0
	k. argued regularly with other people in your family or household about money?	1	0

[IF 4 TO 12 MONTHS AGO REPORTED IN V8, GO TO V9]

Please answer the next question using the number of days.

FIS	V8m. During the past 90 days , on how many days have you had any money problems, including arguing about money or not having enough for food or housing?.....	<input type="text"/> <input type="text"/>
		Days

The next questions are about gambling. This includes betting on sports, playing the lottery, going to casinos, or betting for money, drugs, sex or other things.

Using **Card A...**

- FIS V9. When was the **last** time, if ever, you gambled for money, drugs, sex or other things?
- (Select one)**
- Within the past two days 6
 - 3 to 7 days ago 5
 - 1 to 4 weeks ago 4
 - 1 to 3 months ago..... 3
 - 4 to 12 months ago..... 2
 - More than 12 months ago 1 [GO TO V10]
 - Never 0 [GO TO V10]

Please answer the next questions using yes or no.

- PGS V9. **During the past 12 months**, have you...
- | | <u>Yes</u> | <u>No</u> |
|--|------------|-----------|
| a. spent a lot of time thinking or talking about your gambling? | 1 | 0 |
| b. needed to gamble more often or in larger amounts to get the same enjoyment or high? | 1 | 0 |
| c. tried to cut back on your gambling? | 1 | 0 |
| d. had a hard time staying still or got mad when you could not gamble?..... | 1 | 0 |
| e. gambled to get away from your problems or to feel better?..... | 1 | 0 |
| f. tried to win back your losses by going back another day? | 1 | 0 |
| g. lied about how much time you spent gambling or about how much you lost?..... | 1 | 0 |
| h. paid for your gambling with bad checks, someone else's money, or with something that didn't belong to you?..... | 1 | 0 |
| j. lost or had problems at home, work, school, or with your friends because of your gambling?..... | 1 | 0 |
| k. borrowed or gotten money from others to pay for your gambling? ... | 1 | 0 |

[IF 4 TO 12 MONTHS AGO REPORTED IN V9, GO TO V10]

Please answer the next question using the number of days.

- FIS V9m. **During the past 90 days**, on how many **days** have you gambled for money, drugs, sex or other things?
- Days

V10. What is **your** primary source of income?

(Clarify and code)

- None..... 0
- Wages or a salary from a legitimate job or business 1
- Social Security or Railroad Retirement payments..... 2
- Supplemental (Disability) Security Income (SSI or SSDI) 3
- Other public assistance or welfare payments from the state or local welfare office such as general assistance 4
- Temporary Assistance for Needy Families (TANF, formerly AFDC).. 5
- Interests, dividends, rent, royalties or inheritance 6
- Income from spouse, family or friends (include child support, allowance or alimony) 7
- Gambling (including a loss) 8
- Hustling, dealing or other illegal activities..... 9
- Unemployment compensation 10
- Some other source (**Please describe**)..... 99

v. _____

Using **Card A...**

V10a. When was the **last** time, if ever, you received Temporary Assistance for Needy Families (TANF, formerly AFDC)?

(Select one)

- Within the past two days 6 [RECORD 1 in V10b]
- 3 to 7 days ago 5 [RECORD 1 in V10b]
- 1 to 4 weeks ago 4
- 1 to 3 months ago..... 3
- 4 to 12 months ago..... 2
- More than 12 months ago 1
- Never 0 [GO TO V11]

Yes No

V10b. Are you still receiving TANF benefits?..... 1 0 [IF YES, GO TO V11]

V10b1. Can you tell me why you stopped receiving benefits?

v. _____

<i>For Staff Use Only: Reason Code</i>			
V10b1. Benefits expired	1	Other change in eligibility	4
Got a job.....	2	Technical violation (missed appointment, paperwork).....	5
Change in custody	3	Other (Please describe in V10b1v)	99

Please answer the next questions using dollars.

V11. **During the past 90 days**, about how much did you receive all together from each of the following sources? **(Read all)**

[VERIFY THAT AMOUNT IS FOR PAST 90 DAYS. IF NONE, RECORD 0]

	90-Day Total
a. Wages or salary from a legitimate job or business.....	\$ _ _ _ _ , _ _ _ _
b. Spouse, family or friends.....	\$ _ _ _ _ , _ _ _ _
c. Alimony and child support.....	\$ _ _ _ _ , _ _ _ _
d. SSI - Supplemental Security Income (that you qualify for because of low income).....	\$ _ _ _ _ , _ _ _ _
e. Disability pay, such as SSDI, unemployment compensation of a work-related injury, or income from a private disability plan.....	\$ _ _ _ _ , _ _ _ _
f. Unemployment compensation because of layoff.....	\$ _ _ _ _ , _ _ _ _
g. Other retirement income, including military and private pensions. ...	\$ _ _ _ _ , _ _ _ _
h. Welfare or public assistance programs such as TANF (Temporary Assistance for Needy Families), food stamps, or housing assistance.	\$ _ _ _ _ , _ _ _ _
j. Department of Veterans Affairs.	\$ _ _ _ _ , _ _ _ _
k. Criminal or possibly illegal activities, including hustling or dealing.	\$ _ _ _ _ , _ _ _ _
m. Any other income not previously mentioned. (Please describe)	\$ _ _ _ _ , _ _ _ _
v. _____	

V11n. So overall, you received about (read amount) from all of these sources during the past 90 days? (Add up & correct)..... \$|_|_|_|_|,|_|_|_|_|

V11p. How much did you spend on alcohol?..... \$|_|_|_|_|,|_|_|_|_|

V11q. How much did you spend on drugs?..... \$|_|_|_|_|,|_|_|_|_|

The next two questions are about your family's household. This may include people with whom you share your income and expenses, such as husband, wife children, parents, relatives or sex partners.

PoPI V11r. How **many** people are there in your family household? |_|_|
People

The next question is about the income of everyone in your household together. We do NOT need an exact number. You can give your answer to the nearest hundreds or thousands of dollars if that is easier.

V11s. **During the past 90 days**, what was the total **family** income of everyone in your household together?..... \$|_|_|_|_|,|_|_|_|_|

Using **Card E...**

AGHS V12. How **soon**, if at all, do you need help with your school, work or financial situation? (Would you say...)

(Select one)

- Right away 4
- In the next 3 months 3
- More than 3 months from now 2
- Getting the help I need already 1 [GO TO V13]
- Do not need any help 0 [GO TO V13]

Please answer the next questions using yes or no.

V12a. Do you currently want (more) help with...	<u>Yes</u>	<u>No</u>
1. going to training or school?	1	0
2. getting a school loan or getting out of default on a school loan?	1	0
3. getting a (better) job?.....	1	0
4. getting or keeping public or private benefits?	1	0
5. managing your financial situation?.....	1	0
6. gambling?	1	0
7. identification (Social Security card)?	1	0
8. childcare while in work or school?.....	1	0
99. anything else related to your school, work or financial situation? (Please describe).....	1	0

v. _____

<i>For Staff Use Only</i>	
AGUR	V13. Urgency Rating [VUR]: NO <input type="checkbox"/> _0 ALREADY <input type="checkbox"/> _1 GT 3 MO <input type="checkbox"/> _2 0-3 MO <input type="checkbox"/> _3 NOW <input type="checkbox"/> _4
AGDM	V14. DM Rating [VDM]: NONE <input type="checkbox"/> _0 SOME <input type="checkbox"/> _1 MISUNDER <input type="checkbox"/> _2 DENIAL <input type="checkbox"/> _3 MISREP <input type="checkbox"/> _4

Z. End

Thank you! That is all of the questions we have for you at this time.

(Please enter the current time in Z1. If you went straight through, we will figure out how many minutes you took. If you took any breaks, please make sure that you record about how many minutes total it took you to do the assessment without including the time for the breaks. If continuing interview on another day, record the time for the first day in Z1d and record the total time in XADMh1a-d.)

Z1. What time is it now? |__|__| : |__|__|
Time (HH:MM)

b. Is it AM or PM |__|__|
AM/PM

c. How many breaks did you take today?..... |__|__|
Breaks

d. Not counting breaks, how long did it take you to finish this? |__|__|__|__|
Minutes

Z2. Are there any other special issues we need to know about to help you (or help you come to treatment)? Do you have any additional comments or questions?

v1. _____

You can now return this form to the person who gave it to you. This person will check it over to make sure everything is filled out and answer any questions you have.

<i>For Staff Use Only (Optional)</i>		
Z3. Once we have answered any of your questions and gone over the assessment with you, we will ask you to sign and date this form below.		
Person	Signature	Date (mm/dd/yyyy)
a. Client/Patient: _____	_____	_____
b. Counselor: _____	_____	_____
c. Clinical Supervisor: _____	_____	_____
d. Medical Staff: _____	_____	_____
e. Other: _____	_____	_____

<i>For Staff Use Only</i>		
XADM.Administration		
Please document the following aspects of how the interview was administered. If there are more detailed comments elsewhere in the document, please be sure to summarize them in the additional comments section in XADMj or at least say where we can find them.		
a1.	How were the questions administered?	<u>Yes</u> <u>No</u>
	a. Self-Administered (SA)	1 0
	b. Orally Administered by staff (ORS)	1 0
	c. Orally Administered by others (ORA)	1 0
	z. Other (OTH) (Please describe)	1 0
	v. _____	
a2.	What was the mode of administration?	<u>Yes</u> <u>No</u>
	a. Done with Pen and Paper (PAP)	1 0
	b. Done on Computer (COMP)	1 0
	c. Done on Telephone (TEL)	1 0
	z. Other (OTH) (Please describe)	1 0
	v. _____	
b.	What was the primary language in which it was conducted (LNG)?	
	English using the English GAIN	1
	Spanish using the English GAIN	2
	Spanish using the Spanish VGNI	3
	Other combinations/languages (Please describe)	99
	v. _____	
c.	Were there any indications that the client might have learning disabilities that would interfere with his or her ability to respond or participate in treatment or, in general, indications of developmental disabilities (IDD) ?	
	No/none (NO)	0
	Minimal (MIN)	1
	Moderate (MOD)	2
	Major (MAJ)	3
d.	Was there any evidence that the person could not place himself or herself in place or time or, in general, any evidence of cognitive impairment or dementia (ECD) ?	
	No/none (NO)	0
	Minimal (MIN)	1
	Moderate (MOD)	2
	Major (MAJ)	3

<i>For Staff Use Only</i>			
e.	Was there any evidence of the following observed participant behaviors? (OPB)	<u>Yes</u>	<u>No</u>
1.	Depressed or withdrawn (DEP)	1	0
2.	Violent or hostile (VIO).....	1	0
3.	Anxious or nervous (ANX).....	1	0
4.	Bored or impatient (BOR)	1	0
5.	Intoxicated or high (INT).....	1	0
6.	In withdrawal (WIT).....	1	0
7.	Distracted (DIS).....	1	0
8.	Cooperative (COP).....	1	0
f.	Did the individual's appearance suggest ...(APP)		
	No problems/none (NO)	0	
	Poor hygiene? (PH).....	1	
	Unkempt appearance? (UNK).....	2	
	Inadequate clothing? (INA)	3	
	Non applicable? (NA).....	4	
g.	What was the participant's location during the assessment? (LOC)		
	Treatment unit (Tx).....	1	
	Specialized intake unit (INT).....	2	
	Correctional setting (COR)	3	
	School (SCH).....	4	
	Employment or work setting (EMP).....	5	
	Home (HOM).....	6	
	Probation or Parole Office (PPO)	7	
	Welfare or Child Protection Agency (WCP)	8	
	Research Office or Setting (RES).....	11	
	Other (OTH) (Please describe)	99	
v.	_____		
g1-5.	Were there any problems providing a quiet, private environment? (PRI)	<u>Yes</u>	<u>No</u>
1.	Noise or other frequent distractions (DIS).....	1	0
2.	Divided attention or frequent interruptions (DIV).....	1	0
3.	Other people present or within earshot (EAR)	1	0
4.	Police, guards, social workers or other officials present (OFF)	1	0
5.	Speaker or telephone call monitoring (MON)	1	0

<i>For Staff Use Only</i>																									
h.	What administration protocol was followed? Partial assessment, not completed to date (PAR) 5 Regular site protocol 6 Regular site protocol supplemented with additional questions..... 7 Other (OTH) (Please describe) 99 v. _____																								
h1.	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;"><u>Yes</u></th> <th style="width: 10%; text-align: center;"><u>No</u></th> </tr> </thead> <tbody> <tr> <td>Was administration done over multiple days? (MUL).....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">0</td> </tr> <tr> <td colspan="3" style="text-align: right;">[IF NO, GO TO XADMj]</td> </tr> <tr> <td>a. What is the final revision date (mm/dd/yyyy)?</td> <td style="text-align: center;"> _ _ /</td> <td style="text-align: center;"> _ _ / 20 _ _ </td> </tr> <tr> <td></td> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day Year</td> </tr> <tr> <td>b. What is the total number of breaks across all sessions and days? (Include "1" for break in between multiple sessions.).....</td> <td colspan="2" style="text-align: center;"> _ _ </td> </tr> <tr> <td>c. What is the total number of minutes spent doing the interview across all sessions and days?</td> <td colspan="2" style="text-align: center;"> _ _ _ </td> </tr> <tr> <td>d. What is the Staff ID [XSID] of the person finishing the interview?.</td> <td colspan="2" style="text-align: center;"> _ _ _ _ _ _ _ </td> </tr> </tbody> </table>		<u>Yes</u>	<u>No</u>	Was administration done over multiple days? (MUL).....	1	0	[IF NO, GO TO XADMj]			a. What is the final revision date (mm/dd/yyyy)?	_ _ /	_ _ / 20 _ _		Month	Day Year	b. What is the total number of breaks across all sessions and days? (Include "1" for break in between multiple sessions.).....	_ _		c. What is the total number of minutes spent doing the interview across all sessions and days?	_ _ _		d. What is the Staff ID [XSID] of the person finishing the interview?.	_ _ _ _ _ _ _	
	<u>Yes</u>	<u>No</u>																							
Was administration done over multiple days? (MUL).....	1	0																							
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d. What is the Staff ID [XSID] of the person finishing the interview?.	_ _ _ _ _ _ _																								
j.	Do you have any additional comments about the administration of the assessment or things that should be considered in interpreting this assessment (AC)? Be sure to document any critical collateral information that you think should be considered during interpretation (or cross-reference where it is documented). v1. _____																								

For Staff Use Only (Collateral Supplemental Information)

Yes No

CY0. Do you want to enter additional collateral information? 1 0 [IF NO, GO TO XDX]

We would like to ask you a few questions about a participant named _____.

- CY1. What is your relationship with the participant?
- Mother 1
 - Father 2
 - Brother 3
 - Sister 4
 - Other relative 5
 - Other legal guardian 6
 - Spouse 7
 - Living as married 8
 - Close friend 9
 - Professional working with participant 10
 - Other (**Please describe**) 99

v. _____

Yes No

CB5. Are the participant's medical expenses covered by any type of insurance, court or health program? 1 0 [IF NO, GO TO CV11r]

CB5a. What is the name of the participant's insurance company or provider?

v. _____

- CB5b. Is the participant's insurance publicly funded, privately funded, or mixed?
- Public (Medicare, Medicaid, publicly funded, VA, CHAMPUS, correctional authority) 1
 - Private (HMO, BCBS, from employer, employee assistance program) 2
 - Mixed (both public and private, public purchase of HMO) 3

For Staff Use Only

CB5c. Detailed Insurance Code: |_|_|_|_|_|_|_|_|

The next two questions are about the participant's family household size and income. This includes people with whom he/she shares his/her income and expenses, such as husband, wife, children, parents, relatives or sexual partners.

CV11r. How **many** people are there in the participant's family household? |_|_|
People

For the next question, we do **not** need an exact number. You can give your answer to the nearest hundreds or thousands of dollars if that is easier.

CV11s. **During the past 90 days**, what was the total **family** income of everyone in his/her household together? \$|_|_|_|_|,|_|_|_|_|

Next we want to go over a list of common problems related to alcohol or other drug use. After each of the following questions, we would like you to tell us the **last** time the participant had this problem.

Using **Card Q** and answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never...

		Past Month	2 to 3 Months Ago	4 to 12 Months Ago	1+ Years Ago	Never
CS9c. When was the last time that...						
SPS/O	c. the participant tried to hide that he/she was using alcohol or other drugs?.....	4	3	2	1	0
	d. the participant's parents, family, partner, co-workers, classmates or friends complained about his/her alcohol or other drug use?.....	4	3	2	1	0
	e. the participant used alcohol or other drugs weekly or more often?	4	3	2	1	0
	f. the participant's alcohol or other drug use caused him/her to feel depressed, nervous, suspicious, uninterested in things, reduced his/her sexual desire or caused other psychological problems?	4	3	2	1	0
	g. the participant's alcohol or other drug use caused him/her to have numbness, tingling, shakes, blackouts, hepatitis, TB, sexually transmitted disease, or any other health problems?	4	3	2	1	0
SPS/A	h. the participant kept using alcohol or other drugs even though he/she knew it was keeping him/her from meeting his/her responsibilities at work, school or home?	4	3	2	1	0
	j. the participant repeatedly used alcohol or other drugs when it made the situation unsafe or dangerous for him/her, such as when he/she was driving a car, using a machine, or when he/she might have been forced into sex or hurt?	4	3	2	1	0
	k. the participant's alcohol or other drug use caused him/her to have repeated problems with the law?.....	4	3	2	1	0
	m. the participant kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting him/her into trouble with other people?.....	4	3	2	1	0

		Past Month	2 to 3 Months Ago	4 to 12 Months Ago	1+ Years Ago	Never
CS9c. When was the last time that...						

SPS/D	n.	the participant needed more alcohol or other drugs to get the same high or found that the same amount did not get him/her as high as it used to?	4	3	2	1	0
	p.	the participant had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or he/she used any alcohol or other drugs to stop being sick or avoid withdrawal problems?	4	3	2	1	0
	q.	the participant used alcohol or other drugs in larger amounts, more often or for a longer time than he/she meant to?.....	4	3	2	1	0
	r.	the participant was unable to cut down on or stop using alcohol or other drugs?	4	3	2	1	0
	s.	the participant spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or feeling the effects of alcohol or other drugs (high, sick)?.....	4	3	2	1	0
	t.	the participant's use of alcohol or other drugs caused him/her to give up, reduce or have problems at important activities at work, school, home or social events?	4	3	2	1	0
	u.	the participant kept using alcohol or other drugs even after he/she knew it was causing or adding to medical, psychological or emotional problems he/she was having?	4	3	2	1	0
	ua.	the participant had such strong urges to use alcohol or other drugs he/she could not think of anything else?.....	4	3	2	1	0
	v.	How old was the participant when he/she first got drunk or used any drugs? ...	_ _				
			Age				

For Staff Use Only (Optional Supplemental Diagnostic Impressions [XDX])

XDX. Do you want to enter additional diagnostic information? Yes No
1 0

[IF NO, GO TO XAS]

1. Additional Diagnosis

<u>Type</u> 1. DSM-IV Axis I	2. DSM-IV Axis II	3. DSM-IV Axis III
4. DSM-IV Axis IV	5. DSM-5/ICD-9	6. DSM-5/ICD10 99. Unknown

Type	Code	Spec.	Condition
a.	<input type="text"/> <input type="text"/> - <input type="text"/>	<input type="text"/>	v. _____
b.	<input type="text"/> <input type="text"/> - <input type="text"/>	<input type="text"/>	v. _____
c.	<input type="text"/> <input type="text"/> - <input type="text"/>	<input type="text"/>	v. _____
d.	<input type="text"/> <input type="text"/> - <input type="text"/>	<input type="text"/>	v. _____
e.	<input type="text"/> <input type="text"/> - <input type="text"/>	<input type="text"/>	v. _____
f.	<input type="text"/> <input type="text"/> - <input type="text"/>	<input type="text"/>	v. _____
g.	<input type="text"/> <input type="text"/> - <input type="text"/>	<input type="text"/>	v. _____
h.	<input type="text"/> <input type="text"/> - <input type="text"/>	<input type="text"/>	v. _____
j.	<input type="text"/> <input type="text"/> - <input type="text"/>	<input type="text"/>	v. _____
k.	<input type="text"/> <input type="text"/> - <input type="text"/>	<input type="text"/>	v. _____
m.	<input type="text"/> <input type="text"/> - <input type="text"/>	<input type="text"/>	v. _____
n.	<input type="text"/> <input type="text"/> - <input type="text"/>	<input type="text"/>	v. _____
p.	<input type="text"/> <input type="text"/> - <input type="text"/>	<input type="text"/>	v. _____

2. Clinical Ratings

(Select here if using CGAF in a/b) Yes-1 No-0

a. GAF Past Year Average <input type="text"/>	b. GAF Past 90 Day Average <input type="text"/>		
c. GARF Past Year Average <input type="text"/>	d. GARF Past 90 Day Average <input type="text"/>		
e. SOFAS Past Year Average <input type="text"/>	f. SOFAS Past 90 Day Average <input type="text"/>		
WHODAS Scale	Rating	Scale	Rating
g. Understanding and communicating <input type="text"/>	h. Getting around <input type="text"/>		
j. Self-care <input type="text"/>	k. Getting along with people <input type="text"/>		
m. Life activities-Household <input type="text"/>	n. Life activities-School/Work <input type="text"/>		
p. Participating in society <input type="text"/>	q. Total <input type="text"/>		

3. Other Clinical Ratings (write in)

Rating Name	Score/Rating
v1. _____	v2. _____
v3. _____	v4. _____
v5. _____	v6. _____

4. Additional Sources of Information Considered (will be reported as part of Methods)

v1. _____
v2. _____
v3. _____

<i>For Staff Use Only (Optional Supplemental ASAM Impressions [XAS])</i>		
	<u>Yes</u>	<u>No</u>
XAS. Do you want to enter additional placement information?	1	0
A1. Substance Use Disorder Diagnostic Severity: Comment: v1. _____		
B1. Acute Intoxication and Withdrawal: Comment: v1. _____		
B2. Biomedical Conditions and Complications: Comment: v1. _____		
B3. Emotional/Behavioral Conditions and Complications: Comment: v1. _____		
B4. Readiness for Change (formerly Treatment Acceptance/Resistance): Comment: v1. _____		
B5. Relapse Potential: Comment: v1. _____		
B6. Recovery Environment: Comment: v1. _____		
C. Level of Care Placement Recommendation: Comment: v1. _____ _____ _____		

MID-MICHIGAN RECOVERY SERVICES, INC.
PRE-SCREEN ASSESSMENT

Name: _____

Date: _____

HOUSING:

Current address: _____

How long have you lived here? _____

List all the people who live with you:

Name	Age	Relationship	Uses Substances?

Is your housing currently impacted by divorce or domestic violence? No Yes

Explain: _____

Is your living environment supportive of your recovery? No Yes

Explain: _____

FAMILY HISTORY:

Were you raised by your biological parents? No Yes, who raised you? _____

Mother: Living Deceased Unknown Father: Living Deceased Unknown

Do you have siblings? ___Brothers ___Step/half brothers ___Sisters ___Step/half sisters

Do you have any concerns with family relationships? No Yes If yes, explain: _____

Family history of substance use? No Yes, who?: _____

Has your cultural, religious, or family beliefs affected and/or influenced your decision to use substances at any point in your life?
No Yes, explain: _____

Would you like to include a family member or support person in your treatment planning sessions? No Yes

SUBSTANCE USE HISTORY:

What is your current drug(s) of choice?

When did you last used alcohol or other drugs?

Have you ever overdosed? No Yes When, Drug, Method? _____

Longest period of sobriety from **all** substances? _____

MID-MICHIGAN RECOVERY SERVICES, INC.
PRE-SCREEN ASSESSMENT

MENTAL HEALTH STATUS

	Current	Past	Comments
Have you felt depressed, sad, or helpless most days?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you lost interest in things you used to enjoy?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you worried or nervous most days?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you been involved in a traumatic event that caused you to fear your life? (e.g. sexual assault, a physical attack, military combat, robbery, a Moderate car accident, or sexual abuse as a child)	<input type="checkbox"/>	<input type="checkbox"/>	
Do you feel others can read your mind or control your thoughts?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you hear voices or see things that others do not?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you sometimes feel full of energy and on top of the world?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you sleep little and not feel tired?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had Moderate difficulty falling asleep, staying asleep, or sleeping all day lasting a month or more?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you lost a lot of weight without dieting or gained a lot of weight not due to a physical health condition? (more than a 5% change)	<input type="checkbox"/>	<input type="checkbox"/>	
Do your mental health symptoms Moderately affect your daily life most days? (school, work, relationships, self-care)	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have thoughts or plans to hurt yourself or someone else?	<input type="checkbox"/>	<input type="checkbox"/>	

Lethality Assessment			
Danger To:	Past	Current	Explain/Comments:
Self	<input type="checkbox"/> Ideation <input type="checkbox"/> Intent <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Action <input type="checkbox"/> None	<input type="checkbox"/> Ideation <input type="checkbox"/> Intent <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Action <input type="checkbox"/> None	
Others	<input type="checkbox"/> Ideation <input type="checkbox"/> Intent <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Action <input type="checkbox"/> None	<input type="checkbox"/> Ideation <input type="checkbox"/> Intent <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Action <input type="checkbox"/> None	
Property	<input type="checkbox"/> Ideation <input type="checkbox"/> Intent <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Action <input type="checkbox"/> None	<input type="checkbox"/> Ideation <input type="checkbox"/> Intent <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Action <input type="checkbox"/> None	
Did your use of substances trigger your suicidal ideation? <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes, how?			
Have you ever intentionally harmed yourself (burning, cutting, picking, etc.)? <input type="checkbox"/> No <input type="checkbox"/> Yes, explain:			

MID-MICHIGAN RECOVERY SERVICES, INC.
PRE-SCREEN ASSESSMENT

PHYSICAL HEALTH

Do you have a Primary Care Physician? No Yes May we contact your PCP? No Yes

Please List any Current Medications:

Medication	Dosage & When Taken	Date Initially Prescribed	Reason Prescribed	Refills Remaining
				<input type="checkbox"/> No <input type="checkbox"/> Yes
				<input type="checkbox"/> No <input type="checkbox"/> Yes
				<input type="checkbox"/> No <input type="checkbox"/> Yes
				<input type="checkbox"/> No <input type="checkbox"/> Yes
				<input type="checkbox"/> No <input type="checkbox"/> Yes

Have your previous or current medications been effective? No Yes If no explain: _____

Have you experienced any side effects when taking your previous or current medications? No Yes If yes explain: _____

TRANSPORTATION:

Do you have a valid driver's license? No Yes

Do you own a vehicle? No Yes

Do you have reliable transportation? No Yes

Will transportation to substance use services be an issue for you? No Yes, if yes, continue below:

How do you plan to get back and forth to treatment? _____

How do you usually get back and forth to appointments? /What transportation option have you used in the past? _____

What are the most significant barriers you face to getting back and forth to your appointments? (i.e distance, lack of vehicle, no license, lack of public transportation, difficulty in getting to public transportation) _____

SUCCESS FACTORS:

What are your Strengths? _____

What are your Needs? _____

What are your Abilities? _____

What are your Preferences to treatment? _____

Do you have a spiritual or religious preference? No Yes

Are you able to effectively utilize your personal beliefs, spiritual beliefs or religious beliefs to overcome challenges or increase life satisfaction? No Yes explain: _____

MID-MICHIGAN RECOVERY SERVICES, INC.
PRE-SCREEN ASSESSMENT

Do you need any assistive technology including audio books, writing supports, timers, audio devices etc.? No Yes

GAMBLING:

Have there ever been periods lasting 2 weeks or longer when you spent a lot of time thinking about your gambling experiences or planning out future gambling ventures or bets? No Yes

Have you ever tried to stop, cut down, or control your gambling? No Yes

Have you ever lied to family members, friends, or others about how much you gamble or how much money you lost on gambling? No Yes

If you answer yes to any of these questions, below are the additional questions:

Have there ever been periods lasting 2 weeks or longer when you spent a lot of time thinking about your gambling experiences, planning out future gambling ventures or bets, or thinking about ways of getting money to gamble with? No Yes

Have there ever been periods when you needed to gamble with increasing amounts of money or with larger bets than before in order to get the same feeling of excitement? No Yes

Have you ever felt restless or irritable when trying to stop, cut down, or control your gambling? No Yes

Have you tried and not succeeded in stopping, cutting down, or controlling your gambling three or more times in your life? No Yes

Have you ever gambled to escape from personal problems, or to relieve uncomfortable feelings such as guilt, anxiety, helplessness, or depression? No Yes

Has there ever been a period when, if you lost money gambling one day, you would often return another day to get even? No Yes

Have you lied to family members, friends, or others about how much you gamble, and/or about how much money you lost on gambling, on at least three occasions? No Yes

Has your gambling ever caused serious or repeated problems in your relationships with any of your family members or friends? Or, has your gambling ever caused you problems at work or at school? No Yes

Have you ever needed to ask family members, friends, a lending institution, or anyone else to loan you money or otherwise bail you out of a desperate money situation that was largely caused by your gambling? No Yes

MILITARY SERVICE:

Was anyone close to you in the military? No Yes Do you know anyone in active combat? No Yes

Have you served in the military? No Yes, Branch? _____ Highest rank achieved? _____

Honorable Discharge? No Yes Dates of service: _____

Were you ever involved in active combat? No Yes

Step 1:

Authorizations	Mid-Michigan Recovery Services - Outpatient
Consumers / MPI	Brief Screening, Level of Care Determinations and Screening History  Complete Brief Screenings, Level of Care Determinations and review Screening History
Medicaid Lookup	SUD Treatment Episodes, Admissions and Discharges  SUD Treatment Episodes, Admissions and Discharges for a consumer
Reports and Downloads	View Authorizations by Consumer  View and Manage all consumer authorizations. Use this option to authorize and request new services.
SUD / Provider	View Authorizations for My Locations  View authorizations for my primary program / location. Use this option to review authorizations issued to all consumers at my provider / program.
Staff To-Do List	
Change Password	

Step 2:

You must SEARCH master patient index first.

Initial Attempt - Search on Last Name and First Initial - confirm spelling of Last Name with caller.

Second Attempt - Search on SSN, DOB, and/or Medicaid #. Review search results carefully. This increases the probability of correctly locating the consumer and not creating a duplicate.

Click on "New Consumer Triage" link below to generate a new case # if you weren't able to locate an existing record.

First Name	Last Name	AKA or Other Information
<input type="text"/>	<input type="text"/>	<input type="text"/>
PIHP Case #	SSN	Birth Date (mmddyy)
<input type="text"/>	<input type="text"/>	<input type="text"/>
Affiliate Case #	Medicaid ID	WSA Case ID
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="button" value="SEARCH"/>		

If this call is NOT for an existing or closed consumer:

- Click [here](#) to complete a [Brief Screening for a New Consumer](#)

PIHP Consumers

Name	Case #	SSN	DOB	Current Status / Affiliation	Open / Discharged	Screening History
				MMRS Outpatient	Open: 10/04/2019	Screening History
						Screening History
				MMRS Outpatient	Discharged: 11/16/2018	Screening History

Step 3: Level of Care Determination

Name: Nichols, [REDACTED] (23/M)	PIHP Case #: [REDACTED]	SUD Status: Discharged
Date of Birth: [REDACTED]	Phone: [REDACTED]	Current Status at Provider / Affiliation: MMRS Outpatient
Address: [REDACTED] Mason, MI 48854	County of Residence: Ingham	Discharged: 11/16/2018
		<input type="button" value="Chart Documents"/> <input type="button" value="Eligibility/Insurance"/> <input type="button" value="Authorizations"/>

Jump to: [Consumer's Chart](#) [Treatment Episodes / Admissions](#) [Authorizations](#)

Activity since: 10/30/2018	<input type="button" value="SEARCH"/>
One Month Three Months Six Months	

2 Records

Type/Date	Provider	Disposition	Notes	Status	Add Brief Screening Add Level of Care Determination
Brief Screening 10/05/2020 10:55AM	Mid-Michigan Recovery Services - Outpatient	Eligible for Level of Care Determination	Former client is seeking Outpatient Services once again	SIGNED BY: Angelica Gonzales	View Print Document History
				<input type="button" value="0 Attachments"/> <input type="button" value="0 Follow-Up Notes"/>	
Brief Screening 12/18/2019 4:01PM	Mid-Michigan Recovery Services - Outpatient	Eligible for Level of Care Determination (SA)	self	SIGNED BY: Leigha Czanstke	View Print Document History
				<input type="button" value="0 Attachments"/> <input type="button" value="0 Follow-Up Notes"/>	

Step 4:



Index	
1. Basic Information	
2. Substance Use History	
3. Mental Health Symptoms	
4. Risk Assessment / Legal History	
5. Medical Information	
6. ASAM	
7. Diagnostic Impression / Service Disposition	
8. Gambling Disorder Screening	
9. Signatures	

f. Level of Care Determination: Basic Information			
Date	10/30/2020	Date of Request	10/05/2020
LOC Completed by Provider Mid-Michigan Recovery Services - Outpatient			
Brief Screening Information			
Contact Date / Time 10/05/2020 10:55AM			
Presenting Problem Former client is seeking Outpatient Services once again.			
Consumer Information			
PIHP Case #	Date Of Birth	Gender	Male
[REDACTED]	[REDACTED]	SSN	[REDACTED]
First Name	Middle Name	Last Name	Nichols
Aliases and Other Identifying Information			
Home Address		Medicaid ID #	[REDACTED]
[REDACTED]		Primary Phone	[REDACTED]
		<input type="checkbox"/> Do not leave a message	
		Alternate Phone	
County Of Residence Ingham			
Primary Spoken Language ENGLISH			
Veteran Status Not a veteran			
Designated Substance Use Priority Populations			
Pregnant <input type="radio"/> Yes <input checked="" type="radio"/> No			
Please select which of the following is true for this individual:			
<input type="checkbox"/> Parent at Risk of Losing a Child			
<input type="checkbox"/> Injecting Substance User			
<input type="checkbox"/> Individual Under Supervision of MDOC and Referred by MDOC or Individual Being Released Directly from an MDOC Facility Without Supervision and Referred by MDOC			
<input checked="" type="checkbox"/> None of the above			
Crisis Situations			
Please indicate if any of the following conditions exist for this person (multiple fields may be selected if applicable). If any of the conditions exist, the person must be offered a face-to-face appointment within 24 hours or a referral with warm handoff to a provider who can offer a face-to-face appointment within 24 hours.			
<input type="checkbox"/> Suicidal/Homicidal			
<input type="checkbox"/> Other Mental Health Crisis			
<input type="checkbox"/> Referral from Hospital Emergency Room			
<input type="checkbox"/> Recent Overdose (Last 30 days)			
<input checked="" type="checkbox"/> None of the above			
ROUTINE This individual is considered a ROUTINE referral and must be offered a face-to-face appointment within 14 days of requesting services.			
Record Added sdaly1 10/30/2020 01:35:12 PM		Record Changed sdaly1 10/30/2020 02:00:04 PM	
<input type="button" value="Continue to Substance Use History"/>		<input type="button" value="Cancel"/>	

Step 5:

Index		2. Level of Care Determination: Substance Use History					
1. Basic Information		Substance Use History					
2. Substance Use History		Substance Use Chart					
3. Mental Health Symptoms		Substance	Route	Substance Rank	Age At First Use	Frequency of Use / Amount	Date of Last Use
4. Risk Assessment / Legal History		Methamphetamine / Speed	Smoking	1st	15	No use in the past month	05/25/2020
5. Medical Information		Marijuana/Hashish	Smoking	2nd	12	Daily	10/05/2020
6. ASAM		Is there a history of overdose in the last 30-days?					
7. Diagnostic Impression / Service Disposition		<input checked="" type="radio"/> Yes <input type="radio"/> No					
8. Gambling Disorder Screening		History of DTs/Seizures					
9. Signatures		Denies					
		Record Added sdaly1 10/30/2020 01:35:12 PM			Record Changed sdaly1 10/30/2020 02:09:04 PM		
		Continue to Mental Health Symptoms		Cancel			

Step 6:

Index		3. Level of Care Determination: Mental Health Symptoms		
1. Basic Information		Mental Health Symptoms		
2. Substance Use History			Yes	No
3. Mental Health Symptoms		During the past month, have you felt depressed, sad, or helpless most days?	<input checked="" type="radio"/>	<input type="radio"/>
4. Risk Assessment / Legal History		Have you lost interest in things you used to enjoy?	<input type="radio"/>	<input checked="" type="radio"/>
5. Medical Information		Are you worried or nervous most days?	<input checked="" type="radio"/>	<input type="radio"/>
6. ASAM		Have you been involved in a traumatic event that caused you to fear for your life? (e.g. sexual assault, a physical attack, military combat, robbery, a severe car accident, or sexual abuse as a child)	<input type="radio"/>	<input checked="" type="radio"/>
7. Diagnostic Impression / Service Disposition		Do you feel others can read your mind or control your thoughts?	<input type="radio"/>	<input checked="" type="radio"/>
8. Gambling Disorder Screening		Do you hear voices or see things that others do not?	<input type="radio"/>	<input checked="" type="radio"/>
9. Signatures		Do you sometimes feel full of energy and on top of the world?	<input checked="" type="radio"/>	<input type="radio"/>
		Do you sleep little and not feel tired?	<input type="radio"/>	<input checked="" type="radio"/>
		Have you had severe difficulty falling asleep, staying asleep or sleeping all day lasting a month or more?	<input checked="" type="radio"/>	<input type="radio"/>
		Have you lost a lot of weight without dieting or gained a lot of weight not due to a physical health condition? (more than 5% change)	<input type="radio"/>	<input checked="" type="radio"/>
		Do your mental health symptoms severely affect your daily life most days? (school, work, relationships, self care)	<input checked="" type="radio"/>	<input type="radio"/>
		Do you have thoughts or plans to hurt yourself or someone else?	<input checked="" type="radio"/>	<input type="radio"/>
		Record Added sdaly1 10/30/2020 01:35:12 PM		Record Changed sdaly1 10/30/2020 02:09:04 PM
		Continue to Risk Assessment / Legal History		Cancel

Step 7:

Index		4. Level of Care Determination: Risk Assessment / Legal History		
1. Basic Information		Lethality Assessment		
2. Substance Use History		Danger To	Past	Current
3. Mental Health Symptoms			<input checked="" type="checkbox"/> Ideation	<input type="checkbox"/> Ideation
4. Risk Assessment / Legal History			<input checked="" type="checkbox"/> Intent	<input type="checkbox"/> Intent
5. Medical Information		Self	<input checked="" type="checkbox"/> Plan	<input type="checkbox"/> Plan
6. ASAM			<input checked="" type="checkbox"/> Means	<input type="checkbox"/> Means
7. Diagnostic Impression / Service Disposition			<input checked="" type="checkbox"/> Action	<input type="checkbox"/> Action
8. Gambling Disorder Screening			<input type="checkbox"/> None	<input checked="" type="checkbox"/> None
9. Signatures				
				Explain Had a suicide attempt in 2016 at age 19 when he overdosed on Heroin and Methamphetamine. Reports it was a dark time, was at rock bottom in his drug addiction, living in house without electricity. Last thought was last time he used : 5/26/2020 Thoughts about killing self and wanting relief.
		Others	<input type="checkbox"/> Ideation	<input type="checkbox"/> Ideation
			<input type="checkbox"/> Intent	<input type="checkbox"/> Intent
			<input type="checkbox"/> Plan	<input type="checkbox"/> Plan
			<input type="checkbox"/> Means	<input type="checkbox"/> Means
			<input type="checkbox"/> Action	<input type="checkbox"/> Action
			<input checked="" type="checkbox"/> None	<input checked="" type="checkbox"/> None
		Property	<input type="checkbox"/> Ideation	<input type="checkbox"/> Ideation
			<input type="checkbox"/> Intent	<input type="checkbox"/> Intent
			<input type="checkbox"/> Plan	<input type="checkbox"/> Plan
			<input type="checkbox"/> Means	<input type="checkbox"/> Means
			<input type="checkbox"/> Action	<input type="checkbox"/> Action
			<input checked="" type="checkbox"/> None	<input checked="" type="checkbox"/> None
Legal History / Current Involvement				
Corrections Related Status			Arrests in Past 30 Days	
Not under jurisdiction of corrections or law enforcement program			0	
Record Added		Record Changed		
sdaly1 10/30/2020 01:35:12 PM		sdaly1 10/30/2020 02:09:04 PM		
Continue to Medical Information		Cancel		

Step 8:

Index	5. Level of Care Determination: Medical Information
1. Basic Information	Are you currently taking medications for a Mental Health and/or Substance Disorder? <input type="radio"/> Yes <input type="radio"/> No
2. Substance Use History	If Yes, please describe
3. Mental Health Symptoms	Past psychotropic medications
4. Risk Assessment / Legal History	Do you have a Primary Care Doctor? Last seen (Reason / When) <input type="radio"/> Yes <input type="radio"/> No
5. Medical Information	If Yes, specify Primary Care Doctor
6. ASAM	
7. Diagnostic Impression / Service Discontinuation	
8. Gambling Disorder Screening	
9. Signatures	
	Current Medical Problems
	<input checked="" type="checkbox"/> None
	<input type="checkbox"/> Chronic Pain
	<input type="checkbox"/> Diabetes
	<input type="checkbox"/> Seizure Disorder
	<input type="checkbox"/> High Blood Pressure
	<input type="checkbox"/> Tuberculosis
	<input type="checkbox"/> Sexually Transmitted Disease
	<input type="checkbox"/> Hepatitis
	<input type="checkbox"/> Terminal Disease
	<input type="checkbox"/> Heart Problems
	<input type="checkbox"/> Allergies
	<input type="checkbox"/> Other Medical Conditions
	Medical History not otherwise covered
	Record Added Record Changed sdaly1 10/30/2020 01:35:12 PM sdaly1 10/30/2020 02:09:04 PM
	<input type="button" value="Continue to ASAM"/> <input type="button" value="Cancel"/>

Step 9:

- 1. Substance Use History
- 2. Substance Use History
- 3. Mental Health Symptoms
- 4. Risk Assessment / Legal History
- 5. Medical Information
- 6. ASAM**
- 7. Diagnostic Impression / Service Disposition
- 8. Gambling Disorder Screening
- 9. Signatures

Dimension 1: Intoxication and/or Withdrawal Management Potential	
<input type="radio"/> Level 0.5 Early Intervention	No withdrawal risk
<input type="radio"/> Level OTP Opioid Treatment Program	Physiologically dependent on opiates and requires OTP to prevent withdrawal
<input checked="" type="radio"/> Level 1 Outpatient Services	Not experiencing significant withdrawal, or at minimal risk of severe withdrawal. Manageable at Level 1-WM (See withdrawal management criteria)
<input type="radio"/> Level 2.1 Intensive Outpatient Services	Minimal risk of severe withdrawal, manageable at Level 2-WM (See withdrawal management criteria)
<input type="radio"/> Level 2.5 Partial Hospitalization Services	Moderate risk of severe withdrawal, manageable at Level 2-WM (See withdrawal management criteria)
<input type="radio"/> Level 3.1 Clinically Managed Low-Intensity Residential Services	No withdrawal risk, or minimal or stable withdrawal. Concurrently receiving Level 1-WM (minimal) or Level 2-WM (moderate) services (See withdrawal management criteria)
<input type="radio"/> Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Services	At minimal risk of severe withdrawal. If withdrawal is present, manageable at Level 3.2-WM (See withdrawal management criteria)
<input type="radio"/> Level 3.5 Clinically Managed High-Intensity Residential Services	At minimal risk of severe withdrawal. If withdrawal is present, manageable at Level 3.2-WM (See withdrawal management criteria)
<input type="radio"/> Level 3.7 Medically Monitored Intensive Inpatient Services	At high risk of withdrawal, but manageable at Level 3.7-WM and does not require the full resources of a licensed hospital (See withdrawal management criteria)
<input type="radio"/> Level 4 Medically Managed Intensive Inpatient Services	At high risk of withdrawal and requires Level 4-WM and the full resources of a licensed hospital (See withdrawal management criteria)
As Evidenced By Client has currently been using alcohol and marijuana but reports no current withdrawal symptoms. Client is not at risk currently for severe withdrawal.	
Dimension 2: Biomedical Conditions / Physical Health & Complications	
<input type="radio"/> Level 0.5 Early Intervention	None or very stable
<input type="radio"/> Level OTP Opioid Treatment Program	None or manageable with outpatient medical monitoring
<input checked="" type="radio"/> Level 1 Outpatient Services	None or very stable, or is receiving concurrent medical monitoring
<input type="radio"/> Level 2.1 Intensive Outpatient Services	None or not a distraction from treatment. Such problems are manageable at Level 2.1
<input type="radio"/> Level 2.5 Partial Hospitalization Services	None or not sufficient to distract from treatment. Such problems are manageable at Level 2.5
<input type="radio"/> Level 3.1 Clinically Managed Low-Intensity Residential Services	None or stable, or receiving concurrent medical monitoring
<input type="radio"/> Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Services	None or stable, or receiving concurrent medical monitoring
<input type="radio"/> Level 3.5 Clinically Managed High-Intensity Residential Services	None or stable, or receiving concurrent medical monitoring
<input type="radio"/> Level 3.7 Medically Monitored Intensive Inpatient Services	Requires 24-hour medical monitoring but not intensive treatment
<input type="radio"/> Level 4 Medically Managed Intensive Inpatient Services	Requires 24-hour medical and nursing care and the full resources of a licensed hospital
As Evidenced By Client reports he does not have a PCP but would like help finding one. Client reported no medical concerns and states he is not on any medication.	

Continued on next few pages

Dimension 3: Behavioral Health Conditions and Complications		
Level 0.5 Early Intervention	None or very stable	
Level OTP Opioid Treatment Program	None or manageable in an outpatient structured environment	
Level 1 Outpatient Services	None or very stable, or is receiving concurrent mental health monitoring	
Level 2.1 Intensive Outpatient Services	Mild severity, with potential to distract from recovery, needs monitoring	
Level 2.5 Partial Hospitalization Services	Mild to moderate severity, with potential to distract from recovery; needs stabilization	
Level 3.1 Clinically Managed Low-Intensity Residential Services	None or minimal; not distracting to recovery. If stable, a co-occurring capable program is appropriate. If not, a co-occurring enhanced program is required	
Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Services	Mild to moderate severity; needs structure to focus on recovery. Treatment should be designed to address significant cognitive deficits. If stable, a co-occurring capable program is appropriate. If not, a co-occurring enhanced program is required	
Level 3.5 Clinically Managed High-Intensity Residential Services	Demonstrates repeated inability to control impulses, or unstable and dangerous signs/symptoms require stabilization. Other functional deficits require stabilization and a 24-hour setting to prepare for community integration and continuing care. A co-occurring enhanced setting is required for those with severe and chronic mental illness	
Level 3.7 Medically Monitored Intensive Inpatient Services	Moderate severity; needs a 24-hour structured setting. If the patient has a co-occurring mental disorder, requires concurrent mental health services in a medically monitored setting	
Level 4 Medically Managed Intensive Inpatient Services	Because of severe and unstable problems, requires 24-hour psychiatric care with concomitant addiction treatment (co-occurring enhanced)	

As Evidenced By

Client reports being diagnosed at the age of 12 from a psychiatrist with Schizoaffective Disorder, PTSD, Major Depressive Episodes, Bipolar Depression and Anxiety-NOS. Client reports he is not receiving mental health therapy and is not prescribed any medications for the diagnoses. Client could potentially benefit from mental health counseling and a PCP to discuss the possibility of medications. Client reports currently feeling depressed, sad, or helpless most days, being worried or nervous most days, mental health symptoms moderately affecting daily life most days. Client has had suicidal thoughts and action taken in the past. He has the potential to distract him from recovery.

Dimension 4: Readiness / Motivation to Change

Level 0.5 Early Intervention	Willing to explore how current alcohol, tobacco, other drug, or medication use, and/or high-risk behaviors may affect personal goals	
Level OTP Opioid Treatment Program	Ready to change the negative effects of opiate use, but is not ready for total abstinence from illicit prescription or non-prescription drug use	
Level 1 Outpatient Services	Ready for recovery but needs motivating and monitoring strategies to strengthen readiness. Or needs ongoing monitoring and disease management. Or high severity in this dimension but not in other dimensions. Needs Level 1 motivational enhancement strategies	
Level 2.1 Intensive Outpatient Services	Has variable engagement in treatment, ambivalence, or lack of awareness of the substance use or mental health problem, and requires a structured program several times a week to promote progress through the stages of change	
Level 2.5 Partial Hospitalization Services	Has poor engagement in treatment, significant ambivalence, or a lack of awareness of the substance use or mental health problem, requiring a near-daily structured program or intensive engagement services to promote progress through stages of change	
Level 3.1 Clinically Managed Low-Intensity Residential Services	Open to recovery, but needs a structured environment to maintain therapeutic gains	
Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Services	Has little awareness and needs interventions available only at Level 3.3 to engage and stay in treatment. If there is high severity in Dimension 4 but not in any other dimension, motivational enhancement strategies should be provided in Level 1	
Level 3.5 Clinically Managed High-Intensity Residential Services	Has marked difficulty with, or opposition to, treatment, with dangerous consequences. If there is high severity in Dimension 4 but not in any other dimension, motivational enhancement strategies should be provided in Level 1	
Level 3.7 Medically Monitored Intensive Inpatient Services	Low interest in treatment and impulse control is poor, despite negative consequences; needs motivating strategies only safely available in a 24-hour structured setting. If there is high severity in Dimension 4 but not in any other dimension, motivational enhancement strategies should be provided in Level 1	

As Evidenced By

Client is a self-referral and stated he has struggled with relapses a lot and wants to be able to stay sober. Client has internal motivation.

Dimension 6: Relapse / Continued Use or Continued Problem Potential

<input type="radio"/> Level 0.5 Early Intervention	Needs an understanding of, or skills to change, current alcohol, tobacco, other drug, or medication use patterns, and/or high risk behavior
<input type="radio"/> Level OTP Opioid Treatment Program	At high risk of relapse or continued use without OTP and structured therapy to promote treatment progress
<input type="radio"/> Level 1 Outpatient Services	Able to maintain abstinence or control use and/or addictive behaviors and pursue recovery or motivational goals with minimal support
<input checked="" type="radio"/> Level 2.1 Intensive Outpatient Services	Intensification of addiction or mental health symptoms indicate a high likelihood of relapse or continued use or continued problems without close monitoring and support several times a week
<input type="radio"/> Level 2.5 Partial Hospitalization Services	Intensification of addiction or mental health symptoms, despite active participation in a Level 1 or 2.1 program, indicates a high likelihood of relapse or continued use or continued problems without near-daily monitoring and support
<input type="radio"/> Level 3.1 Clinically Managed Low-Intensity Residential Services	Understands relapse but needs structure to maintain therapeutic gains
<input type="radio"/> Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Services	Has little awareness and needs interventions available only at Level 3.3 to prevent continued use, with imminent dangerous consequences, because of cognitive deficits or comparable dysfunction
<input type="radio"/> Level 3.5 Clinically Managed High-Intensity Residential Services	Has no recognition of the skills needed to prevent continued use, with imminently dangerous consequences
<input type="radio"/> Level 3.7 Medically Monitored Intensive Inpatient Services	Unable to control use, with imminently dangerous consequences, despite active participation at less intensive levels of care

As Evidenced By

Client reported that his longest period of sobriety has been 2 years (2017-2019) though he was on probation at the time. Client reported relapsing due to mental health symptoms and getting off probation. Client reported he has not used any substances other than marijuana and alcohol since 5/26/2020 which shows some level of staying sober from his major problem substances. Client's mental health symptoms and current usage of alcohol and marijuana indicate a high likelihood of relapse or continued use without close monitoring and support several days a week.

Dimension 6: Social support system or significant others increase the risk of personal conflict about alcohol or drug use

<input type="radio"/> Level 0.5 Early Intervention	Social support system or significant others increase the risk of personal conflict about alcohol, tobacco, and/or other drug use
<input type="radio"/> Level OTP Opioid Treatment Program	Recovery environment is supportive and/or the patient has skills to cope
<input checked="" type="radio"/> Level 1 Outpatient Services	Recovery environment is supportive and/or the patient has skills to cope
<input type="radio"/> Level 2.1 Intensive Outpatient Services	Recovery environment is not supportive, but with structure and support, the patient can cope
<input type="radio"/> Level 2.5 Partial Hospitalization Services	Recovery environment is not supportive, but with structure and support and relief from the home environment, the patient can cope
<input type="radio"/> Level 3.1 Clinically Managed Low-Intensity Residential Services	Environment is dangerous, but recovery is achievable if Level 3.1 24-hour structure is available
<input type="radio"/> Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Services	Environment is dangerous and patient needs 24-hour structure to learn to cope
<input type="radio"/> Level 3.5 Clinically Managed High-Intensity Residential Services	Environment is dangerous and the patient lacks skills to cope outside of a highly structured 24-hour setting
<input type="radio"/> Level 3.7 Medically Monitored Intensive Inpatient Services	Environment is dangerous and the patient lacks skills to cope outside of a highly structured 24-hour setting

As Evidenced By

Client reports that he receives 3-6 days a week of support. He stated that his girlfriend and his best friend are his support system and that they are very close. Client has a stable and supportive living environment.

Record Added
sday1 10/30/2020 01:35:12 PM

Record Changed
sday1 10/30/2020 02:09:04 PM

Continue to Diagnostic Impression / Service Disposition

Cancel

Step10: (Don't touch ASAM Results)

<p>Index</p> <ol style="list-style-type: none"> Basic Information Substance Use History Mental Health Symptoms Risk Assessment / Legal History Medical Information ASAM Diagnostic Impression / Service Disposition Gambling Disorder Screening Signatures 	<p>7. Level of Care Determination: Diagnostic Impression / Service Disposition</p> <p>Diagnosis</p> <table border="0"> <tr> <td>F15.21 Amphetamine-type Substance Use Disorder, Severe, in early or sustained remission</td> <td><input type="radio"/> MH</td> <td><input checked="" type="checkbox"/> Primary SUD Diagnosis</td> </tr> <tr> <td></td> <td><input checked="" type="radio"/> SUD</td> <td></td> </tr> <tr> <td>F15.21 Other stimulant dependence, in remission</td> <td><input type="radio"/> MH</td> <td><input type="checkbox"/> Primary SUD Diagnosis</td> </tr> <tr> <td></td> <td><input checked="" type="radio"/> SUD</td> <td></td> </tr> <tr> <td>F10.20 Alcohol use disorder, Moderate</td> <td><input type="radio"/> MH</td> <td><input type="checkbox"/> Primary SUD Diagnosis</td> </tr> <tr> <td></td> <td><input checked="" type="radio"/> SUD</td> <td></td> </tr> <tr> <td>F13.21 Sedative, Hypnotic, or Anxiolytic Use Disorder, Severe, in early or sustained remission</td> <td><input type="radio"/> MH</td> <td><input type="checkbox"/> Primary SUD Diagnosis</td> </tr> <tr> <td></td> <td><input checked="" type="radio"/> SUD</td> <td></td> </tr> <tr> <td>F12.20 Cannabis use disorder, Moderate</td> <td><input type="radio"/> MH</td> <td><input type="checkbox"/> Primary SUD Diagnosis</td> </tr> <tr> <td></td> <td><input checked="" type="radio"/> SUD</td> <td></td> </tr> <tr> <td>F39 Unspecified mood [affective] disorder</td> <td><input type="radio"/> MH</td> <td><input type="checkbox"/> Primary SUD Diagnosis</td> </tr> <tr> <td></td> <td><input checked="" type="radio"/> SUD</td> <td></td> </tr> </table> <p>Clinical Impression Client reports being diagnosed with Schizoaffective Disorder, PTSD, Major Depressive Episodes, Bipolar Depression and Anxiety-NOS</p> <p>ASAM Results</p> <table border="0"> <tr> <td>Level 0.5: 0</td> <td>Level OMT: 0</td> <td>Level 1: 4</td> <td>Level 2.1: 2</td> <td>Level 2.5: 0</td> <td><input type="checkbox"/> ASAM Worksheet</td> </tr> <tr> <td>Level 3.1: 0</td> <td>Level 3.3: 0</td> <td>Level 3.5: 0</td> <td>Level 3.7: 0</td> <td>Level 4: 0</td> <td></td> </tr> </table> <p>Recommended Level of Care 2.1 Intensive Outpatient</p> <p><input type="checkbox"/> Consumer chose to be served outside of recommended Level of Care</p> <p>Disposition</p> <p><input checked="" type="radio"/> Eligible - Assessment scheduled with this Provider</p> <p>Date of Appointment 10/27/2020</p> <div style="border: 1px solid black; padding: 5px;"> <p>Reason appointment is outside of the 14 days of the request for services. List other admission dates offered and reason why refused earlier appointments Client was given first available appointment</p> <p><input type="checkbox"/> Consumer requested a First appointment outside of 14 days or refused an appointment offered within 14 days</p> </div> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <p>SUD Episode to Mid-Michigan Recovery Services - Outpatient (SUD License #: 0330001) has been created.</p> </div> <p><input type="radio"/> Eligible - Referred to another SUD Provider</p> <p><input type="radio"/> Eligible - Consumer refused services</p> <p><input type="radio"/> Not Eligible</p> <p>Disposition Notes</p> <p>Record Added sdaly1 10/30/2020 01:35:12 PM</p> <p>Record Changed sdaly1 10/30/2020 02:09:04 PM</p> <p><input type="button" value="Continue to Gambling Disorder Screening"/> <input type="button" value="Cancel"/></p>	F15.21 Amphetamine-type Substance Use Disorder, Severe, in early or sustained remission	<input type="radio"/> MH	<input checked="" type="checkbox"/> Primary SUD Diagnosis		<input checked="" type="radio"/> SUD		F15.21 Other stimulant dependence, in remission	<input type="radio"/> MH	<input type="checkbox"/> Primary SUD Diagnosis		<input checked="" type="radio"/> SUD		F10.20 Alcohol use disorder, Moderate	<input type="radio"/> MH	<input type="checkbox"/> Primary SUD Diagnosis		<input checked="" type="radio"/> SUD		F13.21 Sedative, Hypnotic, or Anxiolytic Use Disorder, Severe, in early or sustained remission	<input type="radio"/> MH	<input type="checkbox"/> Primary SUD Diagnosis		<input checked="" type="radio"/> SUD		F12.20 Cannabis use disorder, Moderate	<input type="radio"/> MH	<input type="checkbox"/> Primary SUD Diagnosis		<input checked="" type="radio"/> SUD		F39 Unspecified mood [affective] disorder	<input type="radio"/> MH	<input type="checkbox"/> Primary SUD Diagnosis		<input checked="" type="radio"/> SUD		Level 0.5: 0	Level OMT: 0	Level 1: 4	Level 2.1: 2	Level 2.5: 0	<input type="checkbox"/> ASAM Worksheet	Level 3.1: 0	Level 3.3: 0	Level 3.5: 0	Level 3.7: 0	Level 4: 0	
F15.21 Amphetamine-type Substance Use Disorder, Severe, in early or sustained remission	<input type="radio"/> MH	<input checked="" type="checkbox"/> Primary SUD Diagnosis																																															
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Level 0.5: 0	Level OMT: 0	Level 1: 4	Level 2.1: 2	Level 2.5: 0	<input type="checkbox"/> ASAM Worksheet																																												
Level 3.1: 0	Level 3.3: 0	Level 3.5: 0	Level 3.7: 0	Level 4: 0																																													

Step 11: (Enter signature once done with step 11.)

<p>Index</p> <ol style="list-style-type: none"> Basic Information Substance Use History Mental Health Symptoms Risk Assessment / Legal History Medical Information ASAM Diagnostic Impression / Service Disposition Gambling Disorder Screening Signatures 	<p>8. Level of Care Determination: Gambling Disorder Screening</p> <p>Short Problem Gambling Screen - NODS-CLIP</p> <p>Have there ever been periods lasting 2 weeks or longer when you spent a lot of time thinking about your gambling experiences or planning out future gambling ventures or bets? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>Have you ever tried to stop, cut down, or control your gambling? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>Have you ever lied to family members, friends, or others about how much you gamble or how much money you lost on gambling? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p><input type="checkbox"/> Check here if Gambling Screening (NODS-CLIP) was not administered or could not be completed in full (unable to obtain all answers). Specify Reason.</p> <p>Gambling Disorder Diagnosis: Rule/out</p> <p>Record Added sdaly1 10/30/2020 01:35:12 PM</p> <p>Record Changed sdaly1 10/30/2020 02:09:04 PM</p> <p><input type="button" value="Continue to Signatures"/> <input type="button" value="Cancel"/></p>
--	--

Step 12: Admission

Jump to: [Consumer's Chart](#) [Treatment Episodes / Admissions](#) [Authorizations](#)

Activity since:

[One Month](#) | [Three Months](#) | [Six Months](#)

3 Records

Type/Date	Provider	Disposition	Notes	Status	Add Brief Screening Add Level of Care Determination
Level of Care Determination 10/30/2020 1:35PM	Mid-Michigan Recovery Services - Outpatient	Eligible - Assessment scheduled with this Provider	Client reports being diagnosed with Schizoaffective Disorder, PTSD, Major Depressive Episodes, Bipolar Depression and Anxiety-NOS	SIGNED BY: Samantha Daly	Change Signed Document View Copy Print Fax Document History
<input type="button" value="0 Attachments"/> <input type="button" value="0 Follow-Up Notes"/>					
Brief Screening 10/05/2020 10:55AM	Mid-Michigan Recovery Services - Outpatient	Eligible for Level of Care Determination	Former client is seeking Outpatient Services once again.	SIGNED BY: Angelica Gonzales	View Print Document History
<input type="button" value="0 Attachments"/> <input type="button" value="0 Follow-Up Notes"/>					
Brief Screening 12/18/2019 4:01PM	Mid-Michigan Recovery Services - Outpatient	Eligible for Level of Care Determination (SA)	self	SIGNED BY: Leigha Czanszke	View Print Document History
<input type="button" value="0 Attachments"/> <input type="button" value="0 Follow-Up Notes"/>					

Step 13: Enter in/check for correct info, fill out rest of document, then go to gambling and signatures

Index

- 1. Admission Information**
- 2. Gambling Disorder Screening
- 3. Signatures

1. SUD Admission: Admission Information

Identifying information

First Name: Middle Name: Last Name:

SSN: Date of Birth: Gender: Female Male Unknown

Address:

City: State: Zip:

Medicaid ID #: Medicare ID: County of Residence:

Service / Treatment Information

ATTENTION:
- Prior to completing this form verify that provider / site and referral information is correct.
- Double check that entered Admission Date and Type of Treatment are correct before signing this form.

Date of First Request / Contact: 10/05/2020 Provider / Licensed Site: Mid-Michigan Recovery Services - Outpatient (License #: 0330001)

Admission Date: 10/27/2020 Admission Time: 1:30PM Date of Next Appointment:

Type Of Treatment Service Setting: Ambulatory - Intensive Outpatient

Time to Treatment: Prior Treatment Episodes:

Codependent/Collateral Person Served: Client Codependent/collateral individual

Referral Source: Individual

Is this individual under supervision of MDOC (Michigan Department of Corrections) AND referred by MDOC? OR is this individual being release directly from an MDOC facility without supervision AND referred by MDOC?
 Yes No

Was Level of Care Determination completed by a different SUD Provider?
 Yes No

Pregnant on Service Start Date: N/A - male adult or prepubescent child

Race / Ethnic Origin: White Hispanic or Latino Ethnicity: Not of Hispanic or Latino origin

Designations

I/DD Designation: Yes No Not Evaluated MI or SED Designation: Yes No Not Evaluated

Co-occurring Disorder/Integrated Substance Use and Mental Health Treatment: Yes, client with co-occurring SU and MH problems is being treated with an integrated Tx plan by an integrated team

Step 14: Add Assessment

Provider: * All SEARCH

4 SUD Treatment Episodes Add SUD Treatment Episode
◀ PREVIOUS 1 2 3 4 NEXT ▶

Date	Provider	Type	Admit / Discharge	Change View
10/05/2020	Mid-Michigan Recovery Services - Outpatient (350)	SUD Intensive Outpatient	10/27/2020 - (open)	

Admission / Discharge	Type	Case	Type of Treatment	TEDS Submission Status	Status	End SUD Discharge
Admission	10/27/2020	Intensive Outpatient	Pending Submission (Add)	SIGNED BY: Samantha Daly	Change Signed Document	View First Document History

Related Documentation

No documents have been attached to this episode
[Scan Upload Assessment](#) [Scan Upload Treatment Plan](#)
[Scan Upload Other Document](#) [Add Text/voice Screen](#)

Authorizations

No Authorizations Exist
[Request Initial Authorization](#)

1. Assessment: Scan or Upload

Date of Assessment: 10/27/2020

Use Current Case

Provider: Mid-Michigan Recovery Services - Outpatient

Select a file to upload

Click the Browse button to select the file on your local PC to be uploaded. Then click the 'Upload' button.

I. Select a file to upload

Files to be uploaded cannot exceed 30MB. Try compressing (ZIP) large files.

current.docx

II. Click "Upload" to begin uploading the file you've selected. This may take several minutes depending on the file size.

Notes

characters left: 2000

After click on Home button at top. Then do what you did originally when starting off by choosing top option: Brief screening level of care determination and screening history

Mid-Michigan Recovery Services - Outpatient

- Brief Screening, Level of Care Determinations and screening History**
Complete Brief Screenings, Level of Care Determinations, and review Screening History
- SUD Treatment Episodes, Admissions and Discharges**
SUD Treatment Episodes, Admissions and Discharges for a consumer
- View Authorizations by Consumer**
View and Manage all consumer authorizations. Use this option to authorize and request new services.
- View Authorizations for My Locations**
View authorizations for my primary program / location. Use this option to review authorizations issued to all consumers at my provider / program.

You must SEARCH master patient index first.

Initial Attempt - Search on Last Name and First Initial - confirm spelling of Last Name with caller.

Second Attempt - Search on SSN, DOB, and/or Medicaid #. Review search results carefully. This increases the probability of correctly locating the consumer and not creating a duplicate.

Click on "New Consumer Tringo" link below to generate a new case if you weren't able to locate an existing record.

First Name	Last Name	AKA or Other Information
<input type="text"/>	<input type="text"/>	<input type="text"/>
PHP Case #	SSN	Birth Date (mm/dd/yyyy)
<input type="text"/>	<input type="text"/>	<input type="text"/>
Medicaid Case #	Medicaid ID	WSA Case ID
<input type="text"/>	<input type="text"/>	<input type="text"/>

If this call is NOT for an existing or closed consumer:
 - Click [here](#) to complete a **Brief Screening for a New Consumer**

1 PHP Consumer

Name	Case #	SSN	DOB	Current Status / Affiliation
Micho...	4135921217			MMRS Outpatient Open: 10/27/2020 Screening History

Step 15: Authorizations

Jump to: [Clinical Chart](#) | [Treatment Episode / Admissions](#) | **Authorizations**

Activity Area: 10/06/2015 [SEARCH]

Records: 3

Type/Date	Provider	Disposition	Notes	Status	See Also Documents
Level of Care Determination 10/30/2010 1:32PM	Michigan Recovery Services - Outpatient	Eligible - Assessment scheduled with the Provider	Client reports being diagnosed with Schizophrenia, Bipolar, PTSD, Major Depressive Episodes, Bipolar Depression and Anxiety-NDP.	WAIVED BY: Sumner Daily	Case: 10/30/2010 Document: Case: 10/30/2010 Document: 10/30/2010
Brief Screening 10/05/2010 10:56AM	Michigan Recovery Services - Outpatient	Eligible for Level of Care Determination	Former client is seeking Outpatient Services once again	WAIVED BY: Angela O'Connell	Case: 10/05/2010 Document: 10/05/2010
Brief Screening 12/18/2010 4:01PM	Michigan Recovery Services - Outpatient	Eligible for Level of Care Determination (SA)	SA	WAIVED BY: Laura Combs	Case: 12/18/2010 Document: 12/18/2010

Initial Authorization Request

Provider: Michigan Recovery Services - Outpatient
613 W. Holmes Rd.
Suite 200
Lansing, MI 48101-0411

Consumer: [REDACTED]

Type of Treatment: Ambulatory - Intensive Outpatient

Authorization Effective Date: 10/05/2010

Authorization Expiration Date: 12/25/2010

Related Documentation: Assessment 10/27/2010 [View]

Level of Care: [2.1 Intensive Outpatient]

Needs that require attention of the following services:

Recovery Housing

Transportation

Authorizing Agent Name:

Provider Comments:

Initial Authorization Request

Provider: Michigan Recovery Services - Outpatient
613 W. Holmes Rd.
Suite 200
Lansing, MI 48101-0411

Consumer: [REDACTED]

Type of Treatment: Ambulatory - Intensive Outpatient

Authorization Effective Date: 10/27/2010

Authorization Expiration Date: 11/25/2010

Related Documentation: Assessment 10/27/2010 [View]

Level of Care: [2.1 Intensive Outpatient]

Needs that require attention of the following services:

Recovery Housing

Transportation

Authorizing Agent Name:

Provider Comments:

Select a Service Package

Service Package Type: * Select Service Package Type

Service Package Name: [SEARCH] [CANCEL]

Ok to Use Only

11 Service Packages <PREVIOUS 12 NEXT>

Service Package Type	Service Package Name	Duration
SUD Case Management/Recovery Sup	Case Management/Recovery Support Only	Select
SUD Early Intervention	Early Intervention	Select
SUD IOP	IOP	Select
SUD MAT	MAT- Suboxone	Select
SUD MAT	MAT- Methadone	Select
SUD Outpatient	Outpatient	Select
SUD Recovery Housing	Recovery Housing	Select
SUD Residential	Residential ASAM 3.7	Select
SUD Residential	Residential ASAM 3.5	Select
SUD Residential	Residential ASAM 3.3	Select

<PREVIOUS 12 NEXT>

Enter units and hit calculate: Check Guide for correct units. Michael has copies

Service Package: [Dropdown] [Link] [Close]

ICOP

Requested Date: 10/30/2020 Requested / Added By: Semantha Daly

Services [Request Service]

Service	Effective Dates	Units per Period	Frequency	Unit Type	Total Units Requested
9700UP Group Therapy Bundle	10/27/2020 - 12/29/2020	12	Per Auth	Encounters	12 [Calculate]
H5004 Individual behavioral health counseling and therapy	10/29/2020 - 12/29/2020	2	Per Auth	15 Minutes	2 [Calculate]
H2027 Psychoeducational Service, Disease/Educational Group	10/27/2020 - 12/29/2020	12	Per Auth	15 Minutes	12 [Calculate]
H4001 Alcohol and/or Drug Assessment	10/27/2020 - 12/29/2020	1	Per Auth	Encounters	1 [Calculate]
9543C Individual Therapy Bundle	10/27/2020 - 12/29/2020	8	Per Auth	Encounters	8 [Calculate]

Record Added: 10/30/2020 02:32:19 PM Record Changed: 10/30/2020 02:32:10 PM

[Process Request] [Check Request] [Save and Print] [Cancel]

Check request

Service Package: [Dropdown] [Link] [Close]

ICOP

Requested Date: 10/30/2020 Requested / Added By: Semantha Daly

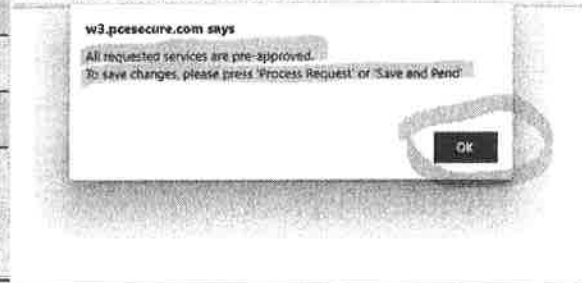
Services [Request Service]

Service	Effective Dates	Units per Period	Frequency	Unit Type	Total Units Requested
9700UP Group Therapy Bundle	10/27/2020 - 12/29/2020	12	Per Auth	Encounters	12 [Calculate]
H5004 Individual behavioral health counseling and therapy	10/29/2020 - 12/29/2020	2	Per Auth	15 Minutes	2 [Calculate]
H2027 Psychoeducational Service, Disease/Educational Group	10/27/2020 - 12/29/2020	12	Per Auth	15 Minutes	12 [Calculate]
H4001 Alcohol and/or Drug Assessment	10/27/2020 - 12/29/2020	1	Per Auth	Encounters	1 [Calculate]
9543C Individual Therapy Bundle	10/27/2020 - 12/29/2020	8	Per Auth	Encounters	8 [Calculate]

Record Added: 10/30/2020 02:32:14 PM Record Changed: 10/30/2020 02:32:10 PM

[Process Request] [Check Request] [Save and Print] [Cancel]

/J3MRX15ilbD2Lw2a3kUlw0/247.db2460b5



Save and Pend if needing to check numbers with someone or Process request if completely done

TREATMENT CONTRACT

Client Name: _____

By signing this document I understand that I have entered into a behavioral agreement with the staff of MMRS, Inc. and clients of the MMRS, Inc. program in which I am a participant. My commitment, in general, is to be involved within the program limits and guidelines and to engage in “work” as defined by this document. Specifically, I agree to the following:

~Guidelines~

1. To know and to comply with the program rules/guidelines.
2. To request help in clarifying any rules/guidelines which are unclear to me.
3. To help other group members meet the programs rules/guidelines.

~Attendance~

4. To attend all group therapy and individual sessions as scheduled.
5. To contact my therapist at least twenty four hours in advance and speak with him/her directly regarding my reason for canceling.
6. To provide written documentation when requesting to be excused from scheduled treatment sessions.
7. To schedule all appointments/activities after group therapy while in residential treatment.

~Involvement~

8. To develop, to know, and to keep current a treatment plan with specific goals and objectives related to recovery.
9. To share the goals and objectives of my treatment plan with group members.
10. To learn the treatment plan goals and objectives of the other members.

~Cooperation~

11. To help other members meet the goals and objectives of their treatment plans.
12. To seek and accept help from other members in accomplishing the goals and objectives of my treatment plan.
13. To help other members meet the group expectations and responsibilities.

~Inform~

14. To keep the membership and staff informed regarding my physical condition, my mood, my energy level, and my level of commitment to the program.
15. Commit to stating my confusion with any part of the contract with the membership.
16. To notify staff if there is a change in medications prescribed to me – prescriptions discontinued, or new prescriptions.

Furthermore, I understand that any pattern of disregard I show for the above items will be addressed by my therapist. Interventions may include an attendance contract, treatment improvement contract, safety plan, support plan, or a progress report to my referral source if applicable). I understand that continued disregard for the above items could lead to my discharge from the program.

Client Signature

Date

Counselor Signature

Date

Statement of commitment to the group process: *It is an essential responsibility of each individual member as well as that of the group, to strive to conform to the practices and guidelines of the group by actively seeking to participate in supporting chosen goals and objectives for each present session.*

PRACTICES

Mindfulness

Commitment

Personal Integrity

Positive Attitude

Continued Learning

Community Building

- 1) Each group will begin with practicing meditation/mindfulness in preparation for the group. Individuals will commit to turn all electronic devices to off or silence and store them out of sight.
VALUE: Mindfulness

- 2) Please consider the nature of professional services we are providing to you and others. We ask individuals to choosing clothing that demonstrates a respectful, clean and covered appearance. Strong perfumes, scents or aftershave are discouraged. You will not be allowed to wear clothing or hairstyles that cover your face (i.e. sun glasses or hoodies). We ask you to refrain from behaviors or actions that may distract individuals or the process; in this practice you will demonstrate a willingness to respect yourself, the group and the counselors and staff. You may be asked to leave and will not receive credit for attendance if you continue to demonstrate that you do not respect these guidelines or wear clothing promoting violence and/or advertising religious, racial or gender slurs; sex; gangs and/or drugs/alcohol.
VALUE: Engagement

- 3) Please inform your counsellor for any upcoming court hearing or court requirement or legal concerns that can interfere with your group attendance in treatment.
VALUE: Communication/ Accountability

- 4) Beverages in tightly lidded no-spill containers are allowed in group meetings. Food is not allowed but you may use hard candy, cough drops or gum so long as it does not distract (i.e. unwrapping, loud chewing or passing during the group) from the group process.
VALUE: Respect

- 5) All group members should be prepared to stay in the room for an entire 90-minute session. If an individual must leave the room for any reason, he/ she is asked to do so without interrupting other group members and to return to the group room as promptly as possible. If an individual consistently leaves the group room your counsellor will address this behavior with you.
VALUE: Time

Group Therapy Guidelines & Practices Continued...

- 6) On-time arrival means committing to arriving early enough to check in at the front office and be ready in your seat in the group room promptly for group start. If the group-room door is closed, you should consider your entrance an unwelcome interruption. If you arrive late and the front office staff indicates that you may not join the group, you may contact your therapist by phone or discuss this at your next individual to discuss excusing absences due to circumstances beyond your control.

VALUE: Commitment

- 7) Each individual will be asked to check-in to the session by sharing how are they feeling. They will then read their current treatment goal and pick an objective related to their individual treatment goal on which to focus.

VALUE: Goal Achievement

- 8) In entering the group therapy, you are committing to accountability and growth in community. You will be encouraged to build relationships with your group-peers and in the recovery community at-large.

VALUE: Community Connection

- 9) Whatever is spoken in the session stays in the session (confidentiality); the information shared is not to be mentioned or discussed by a peer at any other community meeting. No names are identified during discussing the situation.

VALUE: Confidentiality

- 10) Our work focuses on allowing each individual to genuinely work through/with emotions and feelings; providing the safe environment and tools to assist in identifying and building skills for dealing with emotions. There should be no rescuing, advising or otherwise assisting someone away from the emotional moments experienced in group. A waste basket and facial tissue are made available for when strong emotions arise. Individual must get, use, and discard tissue without the assistance of others.

VALUE: Individual Experience

- 11) Individual will use "I" statements and discuss their own personal thoughts and feelings when sharing in the group. Furthermore, individuals will not give advice or tell other group members what they should do.

VALUE: Self Accountability

- 12) To encourage peers in sharing during group, individuals are asked to focus on open-ended questions to foster further exploration and explanations. This will be demonstrated by the staff and encouraged as a programmatic goal.

VALUE: Encouragement

- 13) Cross talk and whispering are not productive communication. Cross talk is defined as two people talking back and forth; interjecting a comment during someone else's share; criticizing what another person has said; telling someone what to do about their problems or analyzing someone situation.

VALUE: Integrity

Group Therapy Guidelines & Practices Continued...

14) Clients are asked to refrain from excessive swearing. Brief, "In the moment," swearing may be permitted in certain emotionally-charged situations with the understanding that all situations will be redirected into more constructive and appropriate communication skills. Language that is derogatory, degrading and or violently directed lends to an unsafe environment.

VALUE: Effective/Safe Communication

15) Focus is important. If you are struggling to stay awake or become excessively agitated or angry, constructive action is encouraged. Individuals may stand and take a couple of steps in the space around their chair, or to or just beyond the doorway to wake-up or gain composure. It is important to return and actively participate in the session as quickly as possible. The boundary for the group is the doorway. Exiting the door will indicate a strong need to take space; leaving the building will indicate a decision to exit treatment altogether. Peers should commit to assist each-other in focusing. A peer may follow out the door to help an individual process, if the individual indicates they do not want/need help, it is important to respect their decision.

VALUE: Focus

16) It is encouraged and acceptable to verbally communicate or to put a hand up to signal the need to stop and take an extra moment to process at times when you feel overwhelmed or out-of-control as you are asked to individually to participate in the group process.

VALUE: Process

17) At the Counselor's suggestion, a group member may leave to support and encourage their peer to rejoin the session. Please do not exit the building; doing so means the risk of discharge from the program.

VALUE: Community Connection

Client Name: _____

Client Signature: _____

Clinician Signature: _____

MID-MICHIGAN RECOVERY SERVICES, INC.
OUTPATIENT GROUP ORIENTATION PROGRESS NOTE

CLIENT NAME:

CLIENT NUMBER:

DATE:

START TIME:

END TIME:

Attendance: Attended Cancelled No Call/No Show

Comments:

Behavioral Presentation:

General Behavior: Cooperative Passive Withdrawn Mute Dramatic Tearful

Argumentative Guarded Hostile Restless Bizarre Overly Cooperative Suspicious

Mood: Euthymic Sad Elevated Apathetic Euphoric Anxious Irritable

Depressed

Affect: Broad Exaggerated Labile Restricted Flat Bland

Comments:

Intervention:

- Reviewed Biopsychosocial Assessment with Client
- Program Rules and Treatment Contract Signed
- Discussed Attendance Policy with Client
- Treatment Plan Discussed and/or Created
- Treatment Plan Copy Signed
- Discussion of Recovery Activities: (support group meetings, etc.)
- Case Management Needs Discussed
- Referral to Peer Recovery Coach Made
- Discussed Drug Screening Requirements and/or Referral Made for Drug Testing
- Discussed and Problem-Solved Barriers for Treatment: (Transportation, Work, etc.)
- Other: (Referrals, etc.)

Comments:

Treatment Plan Progress: Compliant Non-Compliant Active Participation
 Quiet/Guarded Resistance Observed

Comments:

Counselor Signature, Credentials

DATE

Welcome to Mid-Michigan Recovery Services
Group Orientation

During this orientation our goal is to help you understand how MMRS process groups operate, what you expect during your time here and what our responsibilities are.

The following items are included in this packet for your information and reference:

- Treatment Contract
- Group Member Responsibilities
- Treatment Plans
- Feelings Words List
- AA, NA, CA Meeting Information
- List of Websites offering Prescription Drug Assistance

Please remember that the following fee policies apply to all clients:

If you have problems or questions about your fees or your bill, it is important that you contact our billing department at 517-887-0226. Ask for Toni

Summary of Fee and Attendance Policies

You must check-in at the reception desk prior to being seen by a counselor each time you come to MMRS.

Your account is considered delinquent when the balance exceeds the rate for one session. (Example: If your fee is \$4.00 per session, the balance may never be greater than \$4.00)

If your account becomes delinquent you will not be allowed to attend treatment until it is brought current.

If you miss a session without providing us at least 24-hour notice you may be assessed a \$20.00 fee.

It is always important to call and let your counselor know if you can't attend, however if it is not at least 24-hours in advance the fee may be charged.

Also please remember that calling, even in advance does not mean you are "excused".

Print Client Name

Client Signature

Date

Staff Signature

Date

Mid-Michigan Recovery Services, Inc.
Treatment Plan

Client Name: _____

Client #: _____

Level of Care: Residential IOP OP # per week: 1

Would you like a family member or support person involved in your treatment planning sessions? Yes No

_____ | **Plan Start Date:** _____ | **Next Update Due:** _____

Client's Strengths:

Abilities:

Needs:

Preferences:

GOALS:

Goal # 1	
Clinician's Understanding of Client's Goal	
Client's Understanding of Goal	
Goal Statement	

OBJECTIVES:

Objective/Method: A	
Intervention/Frequency:	

Target Date: _____ | **Status: Active** | **Date Completed:** _____

Objective/Method: B	
Intervention/Frequency:	

Target Date: _____ | **Status: Active** | **Date Completed:** _____

Mid-Michigan Recovery Services, Inc.
Treatment Plan

Objective/Method: C			
Intervention/Frequency:			
Target Date 5/8/2020	Status: Active	Date Completed:	

Objective/Method: D			
Intervention/Frequency:			
Target Date: 5/8/2020	Status: Active	Date Completed:	

Client Feedback

Readiness for Change: Pre-contemplation Contemplation Preparation Action Maintenance

Clinician's Feedback

Client Signature		Date:	
Primary Counselor Signature		Date:	
Sec. Counselor Signature		Date:	
PRC Signature		Date:	
Case Manager Signature		Date:	
Support Person Signature		Date:	

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or other drug abuse patient.

Client Name: _____ Client Number: _____

Intake Counselor: _____ Today's Date: _____

Primary Therapist: _____

Client scheduled to attend: _____ Starting: _____

- | | |
|--|--|
| _____ IOP 1 (Mon, Wed, Fri 8:30a to 11:35am) | _____ Thursday Men's Group (10:00am to 11:30am) |
| _____ IOP 2 (Tue, Wed, Thurs 4:00pm to 7:005pm) | _____ Thursday Mixed Group (5:30pm to 7:00pm) |
| _____ Monday Mixed Group (10:00am to 11:30am) | _____ Thursday Woman's TREM (10:00am to 11:30am) |
| _____ Tuesday Women's Group (5:30pm to 7:00pm) | _____ Friday Mixed group (10:00am to 11:30am) |
| _____ Tuesday Men's Group (5:30pm to 7:00pm) | _____ Friday ICARUS Group (10:00am to 11:30am) |
| _____ Wednesday Mixed Group (10:00am to 11:30am) | _____ MRT - Tues. & Thurs. (3:00pm to 4:30pm) |
-

Client Name: _____ Client Number: _____

Intake Counselor: _____ Today's Date: _____

Primary Therapist: _____

Client scheduled to attend: _____ Starting: _____

- | | |
|--|--|
| _____ IOP 1 (Mon, Wed, Fri 8:30am to 11:35am) | _____ Thursday Men's Group (10:00am to 11:30am) |
| _____ IOP 2 (Tue, Wed, Thurs 4:00pm to 7:005pm) | _____ Thursday Mixed Group (5:30pm to 7:00pm) |
| _____ Monday Mixed Group (10:00am to 11:30am) | _____ Thursday Woman's TREM (10:00am to 11:30am) |
| _____ Tuesday Women's Group (5:30pm to 7:00pm) | _____ Friday Mixed group (10:00am to 11:30am) |
| _____ Tuesday Men's Group (5:30pm to 7:00pm) | _____ Friday ICARUS Group (10:00am to 11:30am) |
| _____ Wednesday Mixed Group (10:00am to 11:30am) | _____ MRT - Tues. & Thurs. 3:00pm to 4:30pm) |
-

Client Name: _____ Client Number: _____

Intake Counselor: _____ Today's Date: _____

Primary Therapist: _____

Client scheduled to attend: _____ Starting: _____

- | | |
|---|--|
| _____ IOP 1 (Mon, Wed, Fri 8:30am to 11:35am) | _____ Thursday Men's Group (10:00am to 11:30am) |
| _____ IOP 2 (Tue, Wed, Thurs 4:00pm to 7:005pm) | _____ Thursday Mixed Group (5:30pm to 7:00pm) |
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| _____ Tuesday Men's Group (5:30pm to 7:00pm) | _____ Friday ICARUS Group (10:00 am to 11:30am) |
| _____ Wednesday Mixed Group (10:00 am to 11:30am) | _____ MRT - Tues. & Thurs. (3:00pm to 4:30pm) |

Client Name: _____ Orientation Appointment: _____
Primary Therapist: _____ Orientation Counselor: _____
Case Manager Appointment: _____ PRC Appointment: _____
Start (Group): _____ On (Date): _____

Start (Group): _____ On (Date): _____
_____ IOP 1(Mon, Wed, Fri 8:30am to 11:35am) _____ Thursday Men's Group (10:00am to 11:30am)
_____ IOP 2 (Tue, Wed, Thurs 4:00pm to 7:05pm) _____ Thursday Mixed Group (5:30pm to 7:00pm)
_____ Monday Mixed Group (10:00am to 11:30am) _____ Thursday Woman's TREM (10:00am to 11:30am)
_____ Tuesday Women's Group (5:30pm to 7:00pm) _____ Friday Mixed group (10:00am to 11:30am)
_____ Tuesday Men's Group (5:30pm to 7:00pm) _____ Friday ICARUS Group (10:00am to 11:30am)
_____ Wednesday Mixed Group (10:00am to 11:30am) _____ MRT - Tuesday & Thursday (3:00pm to 4:30pm)

Client Name: _____ Orientation Appointment: _____
Primary Therapist: _____ Orientation Counselor: _____
Case Manager Appointment: _____ PRC Appointment: _____
Start (Group): _____ On (Date): _____

Start (Group): _____ On (Date): _____
_____ IOP 1(Mon, Wed, Fri 8:30am to 11:35am) _____ Thursday Men's Group (10:00am to 11:30am)
_____ IOP 2 (Tue, Wed, Thurs 4:00pm to 7:05pm) _____ Thursday Mixed Group (5:30pm to 7:00pm)
_____ Monday Mixed Group (10:00am to 11:30am) _____ Thursday Woman's TREM (10:00am to 11:30am)
_____ Tuesday Women's Group (5:30pm to 7:00pm) _____ Friday Mixed group (10:00am to 11:30am)
_____ Tuesday Men's Group (5:30pm to 7:00pm) _____ Friday ICARUS Group (10:00am to 11:30am)
_____ Wednesday Mixed Group (10:00am to 11:30am) _____ MRT - Tuesday & Thursday (3:00pm to 4:30pm)

Client Name: _____ Orientation Appointment: _____
Primary Therapist: _____ Orientation Counselor: _____
Case Manager Appointment: _____ PRC Appointment: _____
Start (Group): _____ On (Date): _____

Start (Group): _____ On (Date): _____
_____ IOP 1(Mon, Wed, Fri 8:30am to 11:35am) _____ Thursday Men's Group (10:00am to 11:30am)
_____ IOP 2 (Tue, Wed, Thurs 4:00pm to 7:05pm) _____ Thursday Mixed Group (5:30pm to 7:00pm)
_____ Monday Mixed Group (10:00am to 11:30am) _____ Thursday Woman's TREM (10:00am to 11:30am)
_____ Tuesday Women's Group (5:30pm to 7:00pm) _____ Friday Mixed group (10:00am to 11:30am)
_____ Tuesday Men's Group (5:30pm to 7:00pm) _____ Friday ICARUS Group (10:00am to 11:30am)
_____ Wednesday Mixed Group (10:00am to 11:30am) _____ MRT - Tuesday & Thursday (3:00pm to 4:30pm)

FEELING WORD LIST

LOVE

Affection
Compassion
Care
Tenderness

WONDER

Awe
Surprise
Marvel
Shock
Uncertainty

SERENITY

Contentment
Sedate
Tranquility
Calm
Patient

SHAME

Remorse
Regret
Degraded
Humiliated
Confused

HURT

Anguish
Pain
Misery
Agony

SAD

Sorrow
Heartache
Disappointment
Despair
Sullen

FEAR

Anxiety
Afraid
Scared
Apprehension
Nervous
Terror
Fright
Dread
Worry

ANGER

Irritation
Mad
Frustration
Irate
Wrath
Indignant
Pique
Bitter
Enmity

EMBARRASSMENT

Modesty
Humility
Mortified
Bashful

JOY

Bliss
Elation
Happy
Glad
Pleasure
Amused
Giddy
Delight

EXCITEMENT

Passion
Enthusiasm
Eager
Anticipation

LONELINESS

Alienated
Alone
Desolation
Withdrawn

ENVY

Jealous
Grudge
Resentment
Spite

AA MEETING LIST

ALL MEETINGS LISTED ARE ONLY OPEN TO PEOPLE WHO HAVE OR THINK THEY HAVE A

PROBLEM (AN OPEN MEETING LIST IS AVAILABLE BY CALLING (517) 377-1444)

ALANO CLUB EAST 220 S. Howard Lansing

(All meetings at this location are Wheelchair Accessible)

Sunday 9:00 AM	CLEAN AIR (Discussion)
Sunday 9:00 AM	A STEP & GRATITUDE (Step Meeting)
Sunday 1:00 PM	NUEVOS CAMINOS de RECUPERATION (Spanish)
Sunday 1:00 PM	DISCUSSION (Discussion)
Sunday 3:00 PM	12 STEP GROUP (Step Meeting)
Sunday 6:30 PM	SUNDAY NIGHT SERENITY (step Meeting)
Sunday 7:00 PM	EACH DAY GROUP (Women only)
Sunday 8:00 PM	FIRST 4 STEPS (Step Meeting)
Monday 8:15 AM	BIG BOOK STUDY (Big Book Meeting)
Monday 11:30 AM	TOPIC MEETING (Discussion)
Monday 11:30 AM	12 STEPS (Discussion; Step Meeting)
Monday 3:30 PM	RECOVERY and RELAPSE (Discussion)
Monday 5:15 PM	BRING YOUR OWN CANDLE Candlelight meeting
Monday 6:30 PM	TRADITIONS MEETING (Tradition Meeting)
Monday 8:00 PM	BEGINNERS MEETING (Beginners; Discussion)
Monday 8:00 PM	BEGINNERS MEETING (Beginners; Discussion; Step Meeting)
Tuesday 8:15 AM	BEGINNERS GROUP (Beginners; step Meeting)
Tuesday 11:30 AM	12 STEPS (step Meeting)
Tuesday 11:30 AM	12 x12 (Step Meeting; Tradition Meeting)
Tuesday 1:00 PM	NEW HORIZONS (Discussion)
Tuesday 3:30 PM	BIG BOOK STUDY (Big Book Meeting)
Tuesday 6:30 PM	CLEAN AIR (Step Meeting)
Tuesday 6:30 PM	HAPPY STEPPERS TOO (step Meeting)
Tuesday 8:00 PM	12 X 12 (Step Meeting; Tradition Meeting)
Wednesday 8:15 AM	TRADITIONS MEETING (Tradition Meeting)
Wednesday 11:30 AM	BAREFOOT GROUP
Wednesday 11:30 AM	WILLINGNESS STEP GROUP (step Meeting)
Wednesday 3:30 PM	STEP MEETING (step Meeting)
Wednesday 3:30 PM	PHOENIX STEP MTG. (step Meeting)
Wednesday 5:30 PM	HAPPY HOUR EAST (step Meeting)
Wednesday 5:30 PM	WOMANS WAY (step Meeting; Women only)
Wednesday 6:00 PM	AA MEETING (step Meeting; Women only)
Thursday 8:15 AM	TOPIC MEETING (Discussion)
Thursday 11:30 AM	TOPIC MEETING

*For updated information, check the website and/or local listings

Thursday 1:30 AM	12 STEP GROUP (step Meeting)
Thursday 3:30 PM	BIG BOOK STUDY (Big Book Meeting)
Thursday 3:30 PM	DISCUSSION GROUP (Discussion) WOMEN
Thursday 3:30 PM	STEP (Step Meeting; Women Only)
Thursday 5:30 PM	SERENITY GROUP (step Meeting)
Thursday 6:40 PM	EARLY OLDS (Men only; step Meeting)
Thursday 8:00 PM	MNA MNADIZI WIN (Native American; Discussion)
Thursday 8:00 PM	DOBIE ROAD GROUP (Discussion)
Friday 8:15 AM	PROMISES MEETING (Discussion)
Friday 11:30 AM	FREE FOR ALL FRIDAY (Discussion)
Friday 11:30 AM	HUMBLE BEST (Discussion)
Friday 3:30 PM	FOUNDATIONS GROUP (Discussion)
Friday 5:30 PM	NEW HOPE GROUP (Discussion)
Friday 6:00 PM	CLEAN AIR (Discussion)
Saturday 8:00 AM	OUTER CIRCLE (Discussion)
Saturday 8:00 AM	SUNRISE GROUP (Discussion)
Saturday 9:15 AM	LEARNING TO LIVE (Discussion)
Saturday 9:15 AM	12 STEP STUDY (Discussion)
Saturday 11:30 AM	PROMISES GROUP (Discussion; Big Book Meeting)
Saturday 11:30 AM	BIG BOOK STUDY (Big Book Meeting)
Saturday 2:00 PM	MARATHON MEETING (step Meeting) 2:00 - 5:00 PM
Saturday 8:00 PM	THE FIRST MEETING (Beginners; step Meeting)
Saturday 8:00 PM	CLEAN-AIR (Discussion)

ALANO CLUB WEST 2909 W. Genesee Lansing
(MEETINGS AT THIS LOCATION ARE NOT WHEELCHAIR ACCESSIBLE)

Sunday 8:15 AM	EARLIER BIRDS (Discussion)
Sunday 9:00 AM	EARLY BIRDS (Discussion)
Sunday 9:00 AM	FOUNDATIONS (step Meeting)
Sunday 9:00 AM	NON-SMOKING (Discussion)
Sunday 10:30 AM	ALTERNATIVES GROUP (Discussion)
Sunday 10:30 AM	NON-SMOKING AA (Discussion)
Sunday 10:30 AM	STEP MEETING (step Meeting)
Sunday 1:00 PM	WHERE YOU'RE AT (Discussion)
Sunday 3:00 PM	TOPIC/STEP MEETING (step Meeting; Discussion)
Monday 9:00 AM	PICK-A-TOPIC (Discussion)
Monday 9:00 AM	ROAD TO RECOVERY (Discussion)
Monday 11:00 AM	FRESH AIR (Discussion: Step Meeting: Tradition Meeting)
Monday 11:30 AM	BEGINNERS GROUP (Beginner; step Meeting)
Monday 3:00 PM	HAPPY HOUR (Discussion)
Monday 3:00 PM	NO NONSENSE (Discussion)
Monday 4:00 PM	AA MEETING
Monday 5:30 PM	SURVIVORS GROUP (step Meeting)
Monday 6:30 PM	BEGINNERS GROUP (Beginner; step Meeting)

*For updated information, check the website and/or local listings

Monday 6:30 PM	BEGINNERS GROUP (Beginner; step Meeting)
Monday 8:00 PM	BEGINNERS MEETING (Beginner; step Meeting)
Tuesday 9:00 AM	ROAD TO RECOVERY (Discussion)
Tuesday 9:00 AM	PICK-A-TOPIC (Discussion)
Tuesday 11:00 AM	FRESH AIR (Discussion; Step Meeting; Tradition Meeting)
Tuesday 11:30 AM	DISCUSSION GROUP (Discussion)
Tuesday 3:00 PM	HAPPY HOUR (Discussion)
Tuesday 4:00 PM	AA MEETING
Tuesday 6:30 PM	EARLY OLDS STAG (step Meeting; Men only)
Tuesday 6:30 PM	GRAPEVINE GROWTH GROUP (Grapevine)
Tuesday 8:00 PM	YOUNG PEOPLE GROUP (Step Meeting; Young People)
Tuesday 8:00 PM	OLDS GROUP (step Meeting; Men only)
Wednesday 9:00 AM	PICK-A-TOPIC (Discussion)
Wednesday 9:00 AM	ROAD TO RECOVERY (Discussion)
Wednesday 11:00 AM	FRESH AIR
Wednesday 11:30 AM	BEGINNERS MEETING (Beginner; step Meeting)
Wednesday 3:00 PM	NO NONSENSE (Discussion)
Wednesday 3:00 PM	AA MEETING (Discussion)
Wednesday 4:00 PM	AA MEETING
Wednesday 5:30 PM	HAPPY HOUR (step Meeting)
Wednesday 6:30 PM	WEDNESDAY NIGHT LIVE (Discussion)
Wednesday 8:00 PM	WEDNESDAY STAG (Men Oonly; Discussion)
Thursday 9:00 AM	ROAD TO RECOVERY (Discussion)
Thursday 9:00 AM	PICK-A-TOPIC (Discussion)
Thursday 11:00 AM	FRESH AIR (Discussion)
Thursday 11:30 AM	12 x 12 (Step Meeting)
Thursday 3:00 PM	HAPPY HOUR (Discussion)
Thursday 3:00 PM	NO NONSENSE (Discussion)
Thursday 4:00 PM	AA MEETING
Thursday 5:30 PM	PROMISES GROUP (Discussion)
Thursday 5:30 PM	EARLY PROMISES (Discussion)
Friday 9:00 AM	PICK-A-TOPIC (Discussion)
Friday 9:00 AM	ROAD TO RECOVERY (Discussion)
Friday 11:00 AM	FRESH AIR (Discussion; Step Meeting; Tradition Meeting)
Friday 11:30 AM	PROBLEM SOLVERS (Discussion)
Friday 3:00 PM	NO NONSENSE (Discussion; Step Meeting; Tradition Meeting)
Friday 3:00 PM	CLOSED AA (Discussion)
Saturday 3:00 PM	NO NONSENSE (Discussion)
Friday 4:00 PM	AA MEETING
Friday 5:30 PM	HAPPY HOUR (Discussion)
Friday 6:30 PM	MESSAGE IN THE WIND (Discussion)
Friday 6:30 PM	FRIDAY NIGHT 12 STEPS (step Meeting)
Saturday 9:00 AM	RISE AND SHINE (Discussion; step Meeting)

*For updated information, check the website and/or local listings

Saturday 9:00 AM RISE AND SHINE (Discussion; Step Meeting)
 Saturday 11:30 AM 1 STEP AT A TIME (step Meeting)
 Saturday 3:00 PM AFTERNOON DELIGHT (Discussion)
ALANO CLUB SOUTH 3500 S. Cedar St, Suite 106 Lansing (Everett Plaza by CADL)

(MEETINGS AT THIS LOCATION ARE WHEELCHAIR ACCESSIBLE)

Sunday 9:00 AM STEP MEETING (step Meeting) YOUNG
 Sunday 8:00 PM & SOBER (Young Peoples)
 Monday 12:00 N AS BILL SEES IT (Discussion) 1st
 Monday 5:30 PM 3 STEPS C.S
 Tuesday 12:00 N BROWN BAG (Discussion)
 Tuesday 5:30 PM ITS A GIRL THING (Women only)
 Tuesday 7:00 PM DIGNITARY SYMPATHY GROUP (Men only) Common Welfare Group
 Wednesday 12:00 N DANCE STEPS (step Meeting)
 Wednesday 6:30 PM BIG BOOK STUDY (Big Book Meeting)
 Thursday 12:00 N NICKEL AT NOON (step Meeting)
 Thursday 5:30 PM WOMENS MEETING (Women only)
 Thursday 7:00 PM DIGNITARY SYMPATHY GROUP (Men only; Discussion) Whirly-Birds
 Friday 12:00 N ROUTE 164 (Big Book Meeting)
 Friday 3:30 PM GROW OR GO GROUP (Discussion) GUIDES
 Friday 6:00 PM TO PROGRESS (step Meeting)
 Saturday 8:00 AM SATURDAY 8:00 AM (Discussion)
 Saturday 10:30 AM ACCEPTANCE AND HOPE (Discussion)
 Saturday 12:00 N DIGNITARY SYMPATHY GROUP (Men only; Discussion) Noon Dignitaries

Sunday 9:00 AM SUNDAY BREAKFAST (Discussion)
 Causeway Bay Hotel 6820 S. Cedar St. Lansing
 Sunday 7:00 PM AN AA MEETING (Step Meeting)
 St. Therese Church Turner at Randolph Lansing
 Monday 6:30 AM EARLY BIRD (Discussion)
 Pilgrim Congregational United Church 125 S. Pennsylvania Lansing formerly
 held at Unity Church
 Monday 8:00 AM MT. HOPE GROUP (Discussion)
 Mt. Hope Presbyterian Church 301 W. Jolly Rd. Lansing
 Monday 9:30 AM GRATITUDE MTG (Discussion)
 Loaves and Fishes 831 N Sycamore Lansing
 Monday 12:00 N BIG BOOK DOWNTOWN (Big Book Meeting; Lunch Meeting;
 Wheelchair Accessible)
 St. Marys Cathedral 219 Seymour Lansing Albers Room 2nd Floor
 Monday 12:00 N AA MEETING (Discussion)
 Resurrection Life Church 108 W. Grand River Lansing Washington at
 Grand River

*For updated information, check the website and/or local listings

OTHER AREAS AROUND TOWN

Monday 8:00 PM	HOLT FREEDOM GROUP (Discussion) St. Michaels Episcopal Church 6500 Amwood Dr. Lansing
Tuesday 6:30 AM	EARLY BIRD (Discussion) Pilgrim Congregationat United Church 125 S. Pennsylvania Lansing formerly held at Unity Church
Tuesday 8:00 AM	MT. HOPE GROUP (step Meeting; Wheelchair Accessible) Mt. Hope Presbyterian Church 301 W. Jolly Rd. Lansing
Tuesday 10:00 AM	LANSING MORNING GROUP Capital Area District Library 401 S. Capital Ave. Lansing Gallery C in basement
Tuesday 7:00 PM	DIGNITARY SYMPATHY GROUP (Men only) Westminster Presbyterian Church Oakland and MI-K Blvd. Lansing Basement; Westminster Group
Tuesday 7:30 PM	DIGNITARY SYMPATHY GROUP (Men only) Sparrow Hospital - Professional Bldg. 1215 E. Michigan Ave. Lansing Room A; Sparrow Dignitaries
Tuesday 8:00 PM	AN AA MEETING Sparrow Hospitat - St Lawrence Campus Oakland and MI-K Blvd. Lansing Mercy Hall
Wednesday 6:30 AM	EARLY BIRD (Discussion) Pilgrim Congregational United Church 125 S. Pennsylvania Lansing formerly held at Unity Church
Wednesday 8:00 AM	MT. HOPE GROUP (Step Meeting; Wheelchair Accessible) Mt. Hope Presbyterian Church 301 W. Jolly Rd. Lansing
Wednesday 10:00 AM	LANSING MORNING GROUP Capital Area District Library 401 S. Capital Ave. Lansing Gallery C in basement
Wednesday 12:00 N	DOWNTOWN DISCUSSION GROUP (Lunch Meeting; Wheelchair Accessible) St. Pauls Episcopal Church 218 W. Ottawa Lansing
Wednesday 6:00 PM	PENNSYLVANIA AVE GROUP (step Meeting) Pennsylvania Ave. Church of God 3500 S. Pennsylvania Lansing
Wednesday 7:00 PM	SOUTH SIDE BIG BOOK (Big Book Meeting) •Grace United Methodist Church 1905 W. Mt. Hope Lansing Youth Center Bldg.
Thursday 6:30 AM	EARLY BIRD (Discussion) Pilgrim Congregational United Church 125 S. Pennsylvania Lansing formerly held at Unity Church
Thursday 8:00 AM	MT. HOPE GROUP (Discussion) Mt. Hope Presbyterian Church 301 W. Jolly Rd. Lansing
Thursday 10:00 AM	LANSING MORNING GROUP Capital Area District Library 401 S. Capital Ave. Lansing Gallery C in basement
Thursday 12:00 N	AA MEETING (Discussion) Ressurrection Life Church 108 W. Grand River Lansing Washington at Grand River

*For updated information, check the website and/or local listings

Friday 6:30 AM	EARLY BIRD (Discussion) Pilgrim Congregational United Church 125 S. Pennsylvania Lansing formerly held at Unity Church
Friday 8:00 AM	ST. MICHAELS MORNfNG (Discussion) St. Michaels Episcopat Church 6500 Amwood Dr. Lansing
Friday 8:00 AM	MT. HOPE GROUP (Discussion) Mt. Hope Presbyterian Church 301 W. Jolly Rd. Lansing

Friday 12:00 N	DAYBREAK LUNCH GROUP (Lunch Meeting; step Meeting) St. Paul's Episcopal Church 218 W. Ottawa Lansing
Friday 7:00 PM	AA MEETING (Discussion) St. Lawrence Hospital 1210 W. Saginaw Lansing
Saturday 8:00 AM	MT. HOPE GROUP (Discussion; Wheelchair Accessible) Mt. Hope Presbyterian Church 301 W. Jolly Rd. Lansing
Saturday 7:30 PM	SATURDAY NfGHT LIVE (Discussion) Resurrection Church Rectory 1531 E. Michigan Lansing In basement

AL-ANON MEETING LIST

Lansing Area Al-Anon does not publish the location of Alateen meetings.
Call 517-646-0029 or 517-282-2335 for information.

MONDAY:

6:30pm Rectory House
St. Jude Catholic Church
409 Wilson St., Dewitt

TUESDAY:

7:00pm Mason Community Health Center
800 E. Columbia Rd., Mason
7:00pm Catholic Church
Annex Blue House
508 N. Main St., Morrice
8:00pm Alano Club East
220 S. Howard St., Lansing
8:00pm 1st Baptist Church
11068 N Dewitt Rd., Dewitt

WEDNESDAY:

12:00pm Haslett Community Church
1427 Haslett Rd., Haslett
6:30pm Alano Club South
3320 S. Cedar St., Lansing
8:00pm Congregational Church
210 W. Saginaw St. (M-43), Grand Ledge
8:00pm Alano Club East
220 S. Howard St., Lansing
8:00pm Congregation Church (Basement)
108 Bostwick St., Charlotte

THURSDAY:

12:00pm N. Presbyterian Church (Basement)
108 W. Grand River, Lansing
7:00pm Catholic Church
Annex Blue House
508 Main St., Morrice
8:00pm All Saint's Church
800 Abbott Rd., E. Lansing

FRIDAY:

7:30pm Mt. Hope Presbyterian Church
301 W. Jolly Rd., Lansing

SATURDAY:

9:30am St. Lawrence Hospital
Fitzpatrick Room
1210 W. Saginaw, Lansing

SUNDAY:

10:45am Alano Club West
2909 W. Genesee, Lansing
8:00pm St. Thomas Aquinas
955 Alton Rd., E. Lansing

***For updated information, check website and/or local listings**

MONDAY / LUNES

8:00 AM	Serenity in the Morning (O) 1 hr Glass storefront 124 S. Salisbury St., Raleigh
9:30 AM	A New Beginning (D,O) 1.5 hr Fairmont United Methodist Church, Downstairs enter from Horne st. door 2501 Clark Ave., Raleigh
NOON	Mid Day Miracles (D) 1.5 hr Suite C 2860 Ward Blvd., Wilson
NOON	Out To Lunch (D,IP,JT,St,Tr,O) 1 hr Fairmont United Methodist Church, Downstairs enter from Horne st. door 2501 Clark Ave., Raleigh
6:00 PM	Constantly Searching (BT,SD,O) 1 hr First Baptist Church, Family Life Center 101 S. Wilmington St., Raleigh
6:00 PM	Southside Recovery (D,O) 1 hr Tupper Memorial Church 501 S. Blount St., Raleigh
6:30 PM	Our Common Welfare (D,IP,SD,St) 1 hr Friendship Chapel, Behind brick Chapel in gravel parking lot. 237 Friendship Chapel Rd, Wake Forest
7:00 PM	Miracles In Progress (BT,D,IP,O) 1 hr Wakefiled Central Baptist Church 308 Proctor St., Zebulon
7:00 PM	Principles and Traditions (C,JT,SD,St) 1.5 hr Milner Presbyterian Church 1950 New Bern Ave., Raleigh
7:00 PM	Together We Can (O) 1.5 hr Wilson Medical Center, Wells Fargo Room 1705 Tarboro St. S.W., Wilson
7:30 PM	Living Clean & Serene (O) 1 hr New Horizons Fellowship, West Wing 816 E. Williams St., Apex
7:30 PM	The Primary Purpose Group (B,O) 1 hr United Methodist Church 300 Powell Dr., Raleigh
8:00 PM	Lunatic Fringe (D,IP,O) 1 hr St. Giles Church 5101 Oak Park Rd., Raleigh

TUESDAY / MARTES

8:00 AM	Serenity in the Morning (St,Tr,O) 1 hr Glass storefront 124 S. Salisbury St., Raleigh
9:30 AM	A New Beginning (D,O) 1.5 hr Fairmont United Methodist Church, Downstairs enter from Horne st. door 2501 Clark Ave., Raleigh
NOON	Experience, Strength, and Hope 1 hr White Plains Methodist Church, Room# C-203 313 S.E. Maynard Rd., Cary
NOON	Out to Lunch (JT,O) 1 hr Fairmont United Methodist Church 2501 Clark Ave., Raleigh
7:00 PM	Expect A Miracle (D,O) 1 hr First Alliance Church 4400 Buffalo Rd., Raleigh
7:00 PM	Principles B4 Personalities (JT,St,Tr,O) 1 hr Ambrose Church 813 Darby Dr., Raleigh
7:30 PM	Spiritual Change 1.5 hr First United Methodist Church 100 Green St. N.E., Wilson
8:00 PM	New Way Of Life II (O) 1 hr Fuquay Varina Presbyterian, Entrance on Oak St. 310 N. Ennis St., Fuquay-Varina

8:00 PM **Tuesday Night Live** (D,SD,O) 1 hr
Greenwood Forest Baptist Church
110 S.E. Maynard Rd., Cary

WEDNESDAY / MIÉRCOLES

8:00 AM	Serenity in The Morning (St,Tr,O) 1 hr Glass storefront 124 S. Salisbury St., Raleigh
9:30 AM	A New Beginning (D,O) 1.5 hr Fairmont United Methodist Church, Downstairs enter from Horne st. door 2501 Clark Ave., Raleigh
NOON	Out to Lunch (St,O) 1 hr Fairmont United Methodist Church 2501 Clark Ave., Raleigh
6:00 PM	Southside Recovery (BT,IP,WC,JT,St,Tr,O) 1 hr Tupper Memorial Baptist Church 501 S. Blount St., Raleigh
6:30 PM	The Journey Continues (O) 1.5 hr 124 S. Salisbury St., Raleigh
7:00 PM	Together We Can (D,O) 1.5 hr Wilson Medical Center, Wells Fargo Room 1705 Tarboro St. S.W., Wilson
7:30 PM	The Primary Purpose Group (C,St,Tr) 1 hr United Methodist Church 300 Powell Rd., Raleigh
8:00 PM	Man Up (D,M,C,To) 1 hr 1401 Boyer St., Raleigh
8:00 PM	The Seekers Group (BT,WC,O) 1 hr Community Service Center 401 E. Whitaker Mill Rd., Raleigh

THURSDAY / JUEVES

8:00 AM	Serenity in the Morning (St,Tr,O) 1 hr Glass storefront 124 S. Salisbury St., Raleigh
9:30 AM	A New Beginning (D,O) 1.5 hr Fairmont United Methodist Church, Downstairs enter from Horne st. door 2501 Clark Ave., Raleigh
NOON	Out to Lunch (IP,O) 1 hr Fairmont United Methodist Church 2501 Clark Ave., Raleigh
6:00 PM	Life On Life's Terms (O) 1 hr Ship of Zion Ministries 105 E. Lee St., Raleigh
6:30 PM	Basic Text Study Group (BT,St,Tr,O) 1 hr Tower Shopping Center, Suite 116 3540 Maitland Dr., Raleigh
7:00 PM	I Can't We Can (D,O) 1 hr Saint James Church 3808 St. James Church Rd., Raleigh
7:30 PM	Let The Healing Begin (BT,D,WC,C,So) 1 hr Healing Transitions, Women's Campus 3304 Glen Royal Dr., Raleigh
7:30 PM	Spiritual Change (WC,BK,O) 1.5 hr First United Methodist Church 100 Green St. N.E., Wilson
7:30 PM	Way to Grow Group (D,WC,So,To,Tr,O) 1 hr Knightdale United Methodist Church 7071 Forestville Rd., Knightdale
8:00 PM	Freedom Thru Recovery (D,C,CL) 1 hr Greenwood Forest Baptist Church 110 S.E. Maynard Rd., Cary
8:00 PM	In From The Storm (BT,IP,So,O) 1 hr Healing Transitions Men's Campus 1251 Goode St., Raleigh
8:00 PM	Welcome Home (O,D,CL,So,Tr) 1 hr Grace Lutheran Church 5010 Six Forks Rd., Raleigh

FRIDAY / VIERNES

8:00 AM	Serenity in The Morning (St,Tr,O) 1 hr Glass storefront 124 S. Salisbury St., Raleigh
9:30 AM	A New Beginning (D,O) 1.5 hr Fairmont United Methodist Church, Downstairs enter from Horne st. door 2501 Clarke Ave., Raleigh
NOON	Mid Day Miracles (D) 1.5 hr Suite C 2860 Ward Blvd., Wilson
NOON	Out to Lunch (Tr,O) 1.5 hr Fairmont United Methodist Church 2501 Clark Ave., Raleigh
7:00 PM	Never Alone Never Again (D,O) 1 hr Faith Baptist Church 1004 US-64, Apex
7:00 PM	New Way of Life II (Tr,O) 1 hr Fuquay Varina Presbyterian, Entrance on Oak St. 310 N. Ennis St., Fuquay-Varina
7:00 PM	Recovery in The Hood (BT,D,WC,CS,O) 1 hr Healing Transitions Men's Campus 1251 Goode St., Raleigh
7:00 PM	Southside Recovery (IP,JT) 1.5 hr Tupper Memorial Church 501 S. Blount St., Raleigh
7:00 PM	Together We Can (O) 1.5 hr Wilson Medical Center, Wells Fargo Room 1705 Tarboro St. S.W., Wilson
7:00 PM	Trust The Process (WC,IW,St,Tr,BK,O) 1.5 hr Celebration Church, In Office Annex Building 8700 Capital Blvd., Raleigh
8:00 PM	New Horizons Group (D,C,So,To) 1 hr Millbrook United Methodist Church 1712 E. Millbrook Rd., Raleigh
8:00 PM	Way to Grow Group (D,WC,To,O) 1 hr Knightdale United Methodist Church 7071 Forestville Rd., Knightdale
8:00 PM	Why Are We Here (RF,O) 1.5 hr 509 Hilltop Dr., Raleigh
10:00 PM	Candlelight Recovery (D,CL,JT,O) 1 hr Fairmont United Methodist, 2nd floor up fire escape 2501 Clark Ave., Raleigh

SATURDAY / SÁBADO

9:00 AM	Peace in the AM (C,IW,St,Tr) 1.5 hr Mount Peace Baptist Church 1601 Martin Luther King Blvd., Raleigh
11:00 AM	Women In Recovery (W,C) 1.5 hr 2321 Crabtree Blvd. Suite 100, Raleigh
NOON	Mid Day Miracles (D) 1.5 hr Suite C 2860 Ward Blvd., Wilson
NOON	NA at Noon (WC,JT,O) 1 hr Fountain Church, No smoking on the grounds 9621 Six Forks Rd., Raleigh
1:00 PM	NA ND PM (BT,So) 1 hr Glass storefront 124 S. Salisbury St., Raleigh
2:00 PM	Seeking Similarities (D,IP,WC,JT,St,To,O) 1 hr Healing Transitions Men's Campus 1251 Goode St., Raleigh
3:30 PM	Faith Through Principles (So,O) 1.5 hr 509 Hilltop Dr., Raleigh
5:30 PM	We Do Recover (D,JT,So,St,O) 1 hr Lincoln Park Church, White building across street 13 Heath St., Raleigh
6:30 PM	Rediscovery Thru Recovery (D,IP,WC,St,Tr,O) 1 hr The Camel Club 4015 Spring Forest Rd., Raleigh

COCAINE ANONYMOUS

ALL MEETINGS ARE NON-SMOKING

TUESDAY 7:00-8:00 P.M. (517)485-2232

Central Free Methodist Church
828 N. Washington Ave, Lansing

WEDNESDAY 5:30-6:30 P.M. (517)321-4989

Alano Club West
2909 W. Genesee St, Lansing

THURSDAY 7:00-8:00 P.M. (517)485-2232

Central Free Methodist Church
828 N. Washington Ave, Lansing

FRIDAY 7:00-8:00 P.M. (517)485-2232

Central Free Methodist Church
828 N. Washington Ave, Lansing

SATURDAY 10:00-11:00 A.M. (517)882-9733

St. Michaels Episcopal Church
6500 Amwood Dr, Lansing

***Cocaine Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from their addiction. The only requirement for membership is a desire to stop using cocaine and all other mind-altering substances. There are no dues or fees for membership. We are fully self-supporting through our own contributions. We are not allied with any sect, denomination, politics, organizations or institutions. We do not wish to engage in any controversy and we neither endorse nor oppose any causes. Our primary purpose is to stay free from cocaine and all other mind-altering substances, and to help others achieve the same freedom.

Below is a list of websites that are available to assist in finding financial support for medications.

www.merckhelps.com

www.scbn.org

www.freemedicinerevolution.com

www.freemedicinefoundation.com

www.rxoutreach.com

www.pparx.org

www.rxassist.org

www.rxpathway.com

www.themedicineprogram.com

www.patientassistance.com

www.needymeds.com

www.pfizerhelpfulanswers.com

www.access2wellness.com

www.mihealth.org

www.rxhope.com

Below is a list of websites that are available to assist in finding financial support for medications.

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www.rxoutreach.com

www.pparx.org

www.rxassist.org

www.rxpathway.com

www.themedicineprogram.com

www.patientassistance.com

www.needymeds.com

www.pfizerhelpfulanswers.com

www.access2wellness.com

www.mihealth.org

www.rxhope.com

MID-MICHIGAN RECOVERY SERVICES, INC.

REFERRAL FORM

CASE MANAGEMENT

PEER RECOVERY COACH

CLIENT NAME: _____

CLIENT #: _____

CLIENT PHONE NUMBER: _____

REFERRING AGENCY: _____

DATE: ____ / ____ / ____

TREATMENT GROUP: _____ DAY(s) _____ TIME _____

IS THE CLIENT LIVING AT RISE: YES / NO. (If YES, please put in case manager's mailbox.)

REASON FOR REFERRAL/CLIENT NEEDS:

___ Dental – Comments: _____

___ Employment - Comments: _____

___ Housing – Comments: _____

___ Education – Comments: _____

___ Transportation – Comments: _____

___ Health – Comments: _____

___ SSN/Birth Cert/ID: _____

___ Other – Comments: _____

Additional Comments: _____

Contact Date: _____

Phone / Email / Face-to-Face

Counselor Notified: YES / NO

Contact Date: _____

Phone / Email / Face-to-Face

Counselor Notified: YES / NO

Contact Date: _____

Phone / Email / Face-to-Face

Counselor Notified: YES / NO

Referral's Signature & Credentials

____ / ____ / ____
Date

Case Manager/Peer Coach Signature

____ / ____ / ____
Date

Name: ██████████ (25/F) PIHP Case #: 0064876 SUD Status: Open
 Date of Birth ██████████ Phone ██████████ Current Status at Provider / Affiliation
 Address ██████████ County of Residence Ingham MMRs Outpatient Open: 02/05/2020

Provider: * All

SEARCH

4 SUD Treatment Episodes

[Add SUD Treatment Episode](#)
1 2 3 4

Date	Provider	Type	Admit / Discharge	Change View	
01/24/2020	Mid-Michigan Recovery Services - Outpatient (350)	SUD: Intensive Outpatient	02/05/2020 - (open)	Change View	
Admission / Discharge					
Type	Date	Type of Treatment	TEDS Submission Status	Status	
Admission	02/05/2020	Intensive Outpatient	Accepted	SIGNED BY: Fadi Sour	
				Add SUD Discharge	
				Change Signed Document	
				View Print Document History	
Related Documentation					
Date	Status	Scan/Upload Assessment Scan/Upload Treatment Plan			
		Scan/Upload Other Document Add Toxicology Screen			
Treatment/Recovery Plan 06/02/2020		Change View Delete			
		View Upload			
Treatment/Recovery Plan 04/02/2020		Change View Delete			
		View Upload			
Assessment 02/05/2020		Change View Delete			
		View Upload			
Authorizations					
Authorization #	Effective Dates	Status	Request Re-Authorization		
			Request Ancillary Authorization		
2007A0174036	07/04/2020 - 10/02/2020	Approved	View Early Terminate Void and Copy		
Re-Authorization Request			Request Add-On / Correction Auth		
Authorized Service	Dates	Units Authorized	Claimed	Paid	Available
9083X Individual Therapy Bundle	07/04/2020 - 10/02/2020	12 (12 Per Auth)	0	0	12
GROUP Group Therapy Bundle	07/04/2020 - 10/02/2020	12 (12 Per Auth)	0	0	12
H0004 Individual behavioral health counseling and therapy	07/04/2020 - 10/02/2020	6 (6 Per Auth)	0	0	6
2005A0164629	04/04/2020 - 07/03/2020	Approved	View Early Terminate Void and Copy		
Re-Authorization Request			Request Add-On / Correction Auth		
Authorized Service	Dates	Units Authorized	Claimed	Paid	Available
9083X Individual Therapy Bundle	04/04/2020 - 07/03/2020	24 (24 Per Auth)	19	16	8
GROUP Group Therapy Bundle	04/04/2020 - 07/03/2020	24 (24 Per Auth)	3	3	21
H0004 Individual behavioral health counseling and therapy	04/04/2020 - 07/03/2020	6 (6 Per Auth)	1	1	5
H0006 Case Management	04/04/2020 - 07/03/2020	6 (6 Per Auth)	0	0	6
2002A0152934	02/05/2020 - 04/03/2020	Approved	View Early Terminate Void and Copy		
Initial Authorization Request			Request Add-On / Correction Auth		
Authorized Service	Dates	Units Authorized	Claimed	Paid	Available
9083X Individual Therapy Bundle	02/05/2020 - 04/03/2020	6 (6 Per Auth)	4	4	2
GROUP Group Therapy Bundle	02/05/2020 - 04/03/2020	12 (12 Per Auth)	9	9	3
H0001 Alcohol and/or Drug Assessment	02/05/2020 - 04/03/2020	1 (1 Per Auth)	1	1	0
H0004 Individual behavioral health counseling and therapy	02/05/2020 - 04/03/2020	2 (2 Per Auth)	0	0	2
H0006 Case Management	02/05/2020 - 04/03/2020	4 (4 Per Auth)	0	0	4
H2027 Psychoeducational Service; Didactic/Educational Group	02/05/2020 - 04/03/2020	72 (72 Per Auth)	58	54	18

1 2 3 4

MID-MICHIGAN RECOVERY SERVICES, INC.
GROUP PROGRESS NOTE

CLIENT NAME: _____ CLIENT #: _____

MODE OF TREATMENT: _____ DATE: ____/____/____

STARTING TIME: _____ ENDING TIME: _____ # IN GROUP: _____

CLIENT ATTENDANCE: ___Present ___Excused Absence/Called Ahead (24Hrs) ___No Show

TOPICAL TASKS OF THE SESSIONS:

- Introductions and Guidelines
- Guided Imagery / Meditation
- Assessing Progress of Group / Individuals
- Identifying Feelings / Goals for Session
- Tx. Plan Update(s) as indicated
- Closing

THEME OF DISCUSSION: _____

COUNSELOR INTERVENTION: _____

CLIENT PARTICIPATION:

Client checked in as feeling: _____

Client stated goal(s) for group session: _____

As related to Tx Goal #: _____, Objective: _____ Initial Tx Plan _____ Updated Tx Plan _____

___ Engaged with peers, reflected on self, and/or provided feedback to peers (comments, inquiries).

___ Remained silent, but appeared engaged in listening.

___ Remained silent and did not appear engaged in the session.

CLINICIANS ASSESSMENT OF PROGRESS IN GROUP: ___ MINIMAL ___ MODERATE ___ MAJOR

Addressing stated goal ___ Addressing alternate goal(s) ___ Identified new goal ___

Taking healthy risks during group sessions: Yes ___ No ___

Taking steps and demonstrating willingness to work through challenges in making progress: Yes ___ No ___

Maintaining and practicing skills that are being learned: Yes ___ No ___

Strategy implementation or Tx plan update needed to address impasse: Yes ___ No ___.

Making steady progress toward accomplishing goals: Yes ___ No ___

Tx goals met on current plan Tx plan update needed: Yes ___ No ___

CLINICAL OBSERVATIONS:

Counselor Signature/Credentials

Date

ATTENDANCE SHEET

Group Therapy Didactic Life Skill PRC Other

Date: ____/____/____ Time: _____AM/PM

Resident Signatures:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____
- 11. _____
- 12. _____
- 13. _____
- 14. _____

Missing:

- _____
- _____
- _____
- _____
- _____

Staff Signature: _____

MID-MICHIGAN RECOVERY SERVICES, INC.
OUTPATIENT INDIVIDUAL SESSION PROGRESS NOTE

CLIENT NAME:

CLIENT NUMBER:

DATE:

START TIME:

END TIME:

Attendance: Attended Cancelled No Call/No Show

Comments:

Behavioral Observations:

General Behavior: Cooperative Passive Withdrawn Mute Dramatic Tearful
 Argumentative Guarded Hostile Restless Bizarre Overly Cooperative Suspicious
Mood: Euthymic Sad Elevated Apathetic Euphoric Anxious Irritable
 Depressed
Affect: Broad Exaggerated Labile Restricted Flat Bland

Comments:

Intervention:

- Current Treatment Plan Number Reviewed: _____ Objective Letter(s) Reviewed: _____
- Treatment Plan Update Discussed
- Treatment Plan Update Created and Copy of Treatment Plan Signed
- Reviewed Participation in Recovery Activities: (support group meetings, etc)
- Treatment Plan Homework Assigned: (Worksheet, etc)
- Discussion of Alternative Way of Coping: (Progressive Muscle Relaxation, Yoga, Breathing Techniques, etc)
- Discuss past and current Medical status that impact your overall health. (Discuss need to establish PCP, therapist working with their medical provider, etc.
- Reviewed Drug Screening Status
- Reviewed Case Management Needs
- Reviewed Progress with Peer Recovery Coach
- Progress Report Sent to Referral Source
- Other: (Referrals, etc)

Comments:

Treatment Plan Progress: Compliant Non-Compliant Active Participation
 Quiet/Guarded Resistance Observed

Treatment Progress Overall: Excellent Good Fair Poor Compliant

Comments:

Counselor Signature, Credentials

DATE

Mid-Michigan Recovery Services Inc. Client Progress Report

Client Name: Click here to enter text. Client #: Click here to enter text.
Date of Review: Click here. Mode of Tx: Click here to enter text.
Time In: Click here to enter text. Time Out: Click here to enter text.

Medical Care:

- Client Referred to Medical Care
- Client followed through on medical care referral

Housing:

- Client lives in stable housing
- Client is homeless or in precarious housing

Employment:

- Client is currently employed

Substance Use:

- Client experienced a relapse
- Client has engaged in 4 or more consecutive treatment sessions

IMPORTANT NOTICE

This information has been disclosed to you from records protected by HIPAA and the Federal confidentiality rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. *A general authorization for the release of medical or other information is NOT sufficient for this purpose.*

The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Attitude & Motivation Toward Treatment: Excellent Good Fair Poor

Treatment Goals and Objectives: Click here to enter text.

Comments Regarding Client's Participation/Treatment Status: Click here to enter text.

Outcome: Click here to enter text.

Counselor Signature & Credentials

Date

CC: Client file

MID-MICHIGAN RECOVERY SERVICES, INC.

NEEDS ASSESSMENT

Case Management

Peer Recovery

Client Name: _____

Client #: _____

Date of Assessment: ____/____/____

HMIS #: _____

Date of Admission: ____/____/____

Date Of Discharge: ____/____/____

GENERAL INFORMATION

Program Name: **GH HH Transitions OP/IOP**

Gender: Male Female

SS Number _____

Date of Birth _____

City of Birth _____

State of Birth _____

Marital Status: Single Divorced Separated Married

Race: _____
White, African American, Hispanic etc.

Ethnicity: _____

Does client have a driver's license/state ID? Yes No Provided documentation? Yes No

Does client have a birth certificate? Yes No Provided documentation? Yes No

If no, does client want assistance with obtaining one? Yes No

If yes, fill out Birth Certificate application and email.

Do you have a SS card? Yes No Provided documentation? Yes No

HOUSING

Is client working with any homeless assistance provider (Holy Cross/VOA, Advent House, City Rescue Mission, Women's Rescue Shelter, and Homeless Angels)? Yes No

Does client have a Service Point ID? Yes No

Has client completed VI-SPDAT? Yes No

If yes, check Service Point to get score.

Was client homeless prior to entering residential treatment? Yes No

Prior living situation (where did the client sleep last night): _____

Housing owned by client/no ongoing housing subsidy? Yes No

Length of stay in previous place: _____

What was client's living situation the last 3 months (where/with whom)? _____

What was client's living situation the last 6 months (where/with whom)? _____

Last known permanent address: Street Address: _____

City _____ Zip Code _____ County: _____

Length of stay at this address: 1 week or less; more than a week; less than a month; 1 to 3 months; more than 3 months; 1 year or longer

Does client plan to return to prior living arrangements? Yes No

If yes, is this an environment supportive of recovery? Yes No

Does client plan to relocate to another community/area? Yes No

Where? _____ Why? _____

Current Housing Status: (See categories below and request required documentation)

Literally Homeless

Imminent risk of losing housing

Homeless under other Federal Statues

Fleeing/Attempting to Flee Domestic Violence

Stably housed

Recovery housing—Transitions, Rise, Endeavor, etc.

Doubling up/couch surfing—staying on friend/family member couch

Temporary housing

Don't Know

Refused

Category 1: Literal Homeless- Individual or family who lacks a fixed, regular and adequate nighttime residence, meaning:

- i. Has a primary nighttime residence that is a public or private place not meant for human habitation.
- ii. Is living in a publically or privately operated shelter designated to provide temporary living arrangements?

To certify homeless status for the above must provide documentation of one of the following:

- Written observation by the outreach worker
- Written referral by another housing service provided
- Certification by the individual seeking assistance (Self-Certification)

Individual or family who lacks a fixed, regular and adequate nighttime residence, meaning:

- iii. Is exiting an institution where (s) he has resided for 90 days or less and who residence in an emergency shelter or place not mean for human habitation immediately before entering that institution.

Include one of the above forms of evidence AND 1 of the following:

- Discharge paperwork or written/oral referral
- Written record of intake worker's due diligence to obtain above evidence and certification but individual that they exited institution (Self-Certification)

Category 2: Imminent Risk of Homelessness- Individual or family who will imminently lose their primary nighttime residence, provided that

- i. Residence will be lost within 14 days of the date of application for homeless assistance

- ii. No subsequent residence has been identified; and
- iii. The individual or family lacks the resources or support networks needed to obtain other permanent housing.

Documentation must include 1 of the following:

- A court order resulting from an eviction action notifying individual or family that they must leave;
- For individual or family leaving a hotel or motel- evidence that they lack the financial resources to stay (Self-Certification)
- A documented and verified oral statement

In addition to 1 of the above, documentation must include BOTH of the following:

- Certification that no subsequent resident has been identified (Self-Certification)
- Self-certification or other written document that the individual lack the financial resources and support necessary to obtain permanent housing (Self Certification).

Category 3: Homeless under other Federal Statues- Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition but who:

- i. Are defined as homeless under the other listed federal status;
- ii. Have not had a lease, ownership interest, or occupancy agreement in permanent housing during 60 days prior to the homeless assistance application;
- iii. Have experienced persistent instability measured by 2 moves or more during the preceding 60 days; and
- iv. Can be expected to continue in such status for an extended period of time due to special needs or barriers.

Documentation must include all of the following:

- Certification by the non-profit or state or local government that the individual or head of household seeking assistance met the criteria of homelessness under the federal statute; and
- Certification of no public housing in the last 60 days; and
- Certification by the individual or head of household, and any available supporting documentation, that (s)he has moved 2 or more time in the past 60 days; and
- Documentation of special needs or 2 or more barriers.

Category 4: Fleeing/Attempting to Flee Domestic Violence- Any individual or family who:

- i. Is fleeing, or attempting to flee, domestic violence
- ii. Has no other residence; and
- iii. Lacks the resources or support networks to obtain permanent housing.

Documentation required:

- An oral statement by the individual or head of household seeing assistance which states they are fleeing; they have no subsequent residence; and they lack resources (Self-Certification).

Is client a domestic violence victim/survivor? Yes No If yes, when experience occurred? _____

Is the client dealing with divorce issues? Yes No

If yes, does this have an impact on housing for client? Yes No

Is Client Chronically Homeless? Yes No

HUD Definition of Chronically Homeless- Client is homeless and resides in a place not meant for human habitation, a safe haven, or in an emergency shelter and has been homeless and residing in such a place for at least 12 months or on at least four separate occasions in the last three years where the combined occasions must total at least 12 months.

Extent of homeless: first time; 1-2 times in the past; 3-4 time in the past; long term 1 year; chronic (4 times in the past 3 years)

Reason for homelessness: _____

Does client need an emergency shelter? Yes No

Does client need assistance with locating suitable and affordable housing? Yes No

Comments: _____

FINANCIAL & EMPLOYMENT

Are you currently receiving cash income from any source? Yes No Don't Know Refused

	Source of Income (Monthly)	Family Member	Amount from Source
	General Assistance		\$
	TANF		\$
	Other		\$
	Worker's Compensation		\$
	VA Non-Service Connected Disability Pension		\$
	VA Service Connected Disability Compensation		\$
	Unemployment Insurance		\$
	SSI		\$
	SSDI		\$
	Retirement Income from Social Security		\$
	Pension or retirement income from another job		\$
	Earned Income		\$
	Private Disability Insurance		\$
	Alimony or Other Spousal Support		\$
	Child Support		\$
	No Financial Resources		\$
	Total Monthly Income Reported		\$

Are you currently receiving non-cash benefits? Yes No Don't Know Refused

	Source of Non-Cash Benefits (Monthly)	Family Member	Amount from Source
	Supplemental Nutrition Assistance Program (Food)		\$
	Other Source		\$
	TANF Child Care Services		\$

TANF Transportation Services		\$
Special Supplemental Nutrition Program for WIC		\$
Other TANF-Funded Services		\$
Medicaid Health Insurance Program		\$
Medicare Health Insurance Program		\$
State Children's Health Insurance Program		\$
Veteran Administration Medical Services		\$
Section 8, public housing or other rental assistance		\$
Other sources:		\$
No Non-Cash Benefits		\$
Total Monthly Non-Cash Benefits		\$

Consumer has been referred to other potential benefit programs: Yes No N/A Declined

Has the Consumer Applied for SSI/SSDI? Yes No N/A Declined

Referred to Ability Law Clinic: Yes No N/A If Applied: Accepted Denied

Is client currently employed? Yes No Place of employment: _____

If yes, what is monthly income? _____

If no, is client able to work? Yes No If no, explain: _____

If yes, does the client have a resume? Yes No

If no, does the client want assistance with Resume? Yes No

If yes, then please assist them by either sending them to Michigan Works or helping them on next one on one.

If client is able to work and has a resume, do they want assistance with locating a job? Yes No

If yes, give them resource list of jobs.

Has client ever had stable employment? Yes No Last job: _____

What is the longest period that client has had steady employment? _____

Is the client interested in job training or retraining? Yes No

Are there any job skills that the client possesses? _____

What are the client's long-term work goals? _____

Comments: _____

Has client ever had budget/credit counseling? Yes No

Does client want assistance with budgeting/credit counseling? Yes No

Comments: _____

TRANSPORTATION

Does client have a valid driver's license? Yes No

Does client have reliable transportation? Yes No

What is client's primary means of transportation? Bus; owns a car; family/friends; taxi; walks; bicycle

Is client familiar with the public transportation system? Yes No

If no, could client benefit from becoming familiar with the public transportation system? Yes No

Will the client benefit from having a bike? Yes No

If yes, type up a bike voucher for the client, also print out instructions for the voucher.

Comments: _____

EDUCATION

What is the highest grade that client has completed? _____

If not a high school graduate, does client have a GED? Yes No N/A

Does client have any vocational training? Yes No

Is client currently in school? Yes No Name of school: _____

Is client interested in returning to school? Yes No

If yes, what supportive services might client need? _____

Does client have any long term educational goals? Yes No

If yes, please explain: _____

Comments: _____

VETERAN ELIGIBILITY

Is client a veteran? Yes No When: _____ Branch: _____

Did you serve active duty? Yes No When: _____ Where: _____

If yes, is client interested in any programs that are available through the VA? Yes No

(Have client sign a release and forward to the VA)

Comments: _____

If yes, when were you discharged? _____ Discharge Type: _____

LEGAL

Is client experiencing legal problems at this time? Yes No

Convictions: Felony? Yes No Misdemeanor? Yes No

Does client have an attorney? Yes No

If yes, name: _____ Telephone number: _____

Does client have any legal action pending? Yes No

If yes, please explain: _____

Is client on probation? Yes No Charges: _____

Is client on parole? Yes No Charges: _____

Was client in jail prior to be admitted to residential treatment? Yes No N/A

If yes, how long was client in jail? _____

Documentation required for homelessness certification:

- Discharge paperwork from jail affirming the beginning/ending dates of incarceration; **or**
- A detail record of caseworker's due diligence to obtain above evidence from the jail; **and**
- A written statement by the client that (s)he has just exited jail; (s)he was there less than 90 days; and was homeless upon entering jail (Self-Certification)

PARENTING

Are there any child custody issues? Yes No

If yes, please explain: _____

If yes, do the children need child abuse intervention or counseling services? Yes No

Does the client have court ordered parenting time? Yes No

If yes, please explain and request court order: _____

Comments: _____

HEALTH/DISABILITY INFORMATION

How is their health condition compared to people their age? Poor Fair Excellent

Is client pregnant? Yes No If yes, estimated due date: _____

Does client need an OB/GYN referral? Yes No

Are there any STI concerns? Yes No

Is client at high risk for STI/Hepatitis (see assessments)? Yes No

If client indicates STI concerns and and/or is at risk, provide resource list for STI testing.

STI Testing Resource List Provided? Yes No N/A

Does client want to be tested for STIs? Yes No

If yes, please fill out a medical consultation form for testing to be done.

Consultation form completed? Yes No N/A

Does client have a Primary Care Physician (PCP) Yes No

If no, provide resource list for PCP. Resource list provided? Yes No

Has the client had a physical within the past 6 months? Yes No Documentation in file? Yes No

If documentation is not found and client reports no, please fill out medical consultation form.

Client needs to complete a physical within 14 days of admission.

Consultation Form Completed? Yes No N/A

Does client need glasses and/or an eye exam? Yes No

Does client have any dental needs? Yes No

Does client wear a hearing aid? Yes No

Does client need a hearing aid or have a need for a hearing test? Yes No

Comments: _____

CLOTHING

Does client currently have adequate clothing? Yes No

If no, is there clothing available that can be obtained by friends/family members? Yes No N/A

Does client have a need to obtain clothing through alternative resources? Yes No

Comments: _____

Personal needs

Does the client need personal needs: Deodorant, Shampoo/Conditioner, Body Wash, Etc.? Yes
No

If yes, fill out Lend a Helping Hand or 2 application.

AGENCY INVOLVEMENT:

Are you currently working with any other? Yes No If yes, which agencies and with
whom are you working? _____

Case Management Summary: _____

_____/_____/_____
Client's Signature

_____/_____/_____
Signature, Credentials Date

Date Reviewed:

_____/_____/_____
Client's Signature

_____/_____/_____
Signature, Credentials Date

MID-MICHIGAN RECOVERY SERVICES, INC.
PEER RECOVERY COACH INTAKE PROGRESS NOTE

CLIENT NAME:

CLIENT NUMBER:

DATE:

START TIME:

END TIME:

Attendance: Attended Cancelled No Call/No Show

Behavioral Observations:

General Behavior: Cooperative Withdrawn Tearful Argumentative
 Guarded

Intervention:

- Assessed Client's Recovery Needs
- Discussed and Provided Resources to Client Regarding Needs
- Peer Recovery Coach Treatment Plan(s) Created
- Peer Recovery Coach Treatment Plan(s) Signed by Client and Peer Recovery Coach
- Plan for upcoming weeks/Assignments Assigned
- Other:

Comments:

Treatment Plan Progress: Compliant Non-Compliant Active Participation
 Quiet/Guarded Resistance Observed

Peer Recovery Coach Signature, Credentials

DATE

MID-MICHIGAN RECOVERY SERVICES, INC.
Peer Recovery Coach Treatment Plan

Client Name: _____ Client #: _____

Level of Care: Residential CABHI OP # per week _____

Other Providers: _____

Problem #: _____ Client statement / understanding of problem: _____

Goal #: _____ Goal Statement: _____

Objective A: _____ Review Date: _____

Modality: _____

Objective B: _____ Review Date: _____

Modality: _____

Objective C: _____ Review Date: _____

Modality: _____

Client Statement: How will you know when you have achieved this goal(s): _____

I have participated in the development of my treatment goals and have received a copy of my plan.

Client Signature: _____ Date: _____

Recovery Coach Signature: _____ Date: _____

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or other drug abuse patient.

MID-MICHIGAN RECOVERY SERVICES, INC.
PEER RECOVERY COACH PROGRESS NOTE

CLIENT NAME:

CLIENT NUMBER:

DATE:

START TIME:

END TIME:

Attendance: Attended Cancelled No Call/No Show

Behavioral Observations:

General Behavior: Cooperative Withdrawn Tearful Argumentative
 Guarded

Intervention:

- Case Management/Peer Coach Needs Assessment Reviewed
- Discussed and Provided Resources to Client Based on Individual Needs
- Transportation for Services (discuss in comments section)
- Current Treatment Plan Number Reviewed: _____ Objective Letter(s) Reviewed: _____
- Peer Recovery Coach Treatment Plan(s) Updated
- Peer Recovery Coach Treatment Plan(s) Update Signed by Client and Peer Recovery Coach
- Other:

Comments:

Treatment Plan Progress: Compliant Non-Compliant Active Participation
 Quiet/Guarded Resistance Observed

Peer Management Progress Overall: Excellent Good Fair Poor Compliant

Peer Recovery Coach Signature, Credentials

DATE

Name: [REDACTED] PIHP Case #: [REDACTED] SUD Status: New/Not Open

Date of Birth: [REDACTED] Phone: [REDACTED] Current Status at Provider / Affiliation: [REDACTED]

Address: [REDACTED] County of Residence: [REDACTED]

Chart Documents
Eligibility/Insurance
Authorizations

Chart Links | Chart Documents | To-Do Items

<p>Administrative/Financial</p> <p>Demographics - Change Demographics - View</p> <p>Claims and Outbound Encounters Medicaid Eligibility History</p>	<p>Access / Admissions</p> <p>Authorizations Screening History</p>
<p>SUD / CA</p> <p>Screening History SUD Episodes, Admissions and Discharges Toxicology Screens (via Episode)</p>	<p>Legal / Consents</p> <p>Consents to Exchange Health Information External Authorizations for ROI Other Scanned Documents</p>

Eligibility Verification

To receive a subscriber's eligibility information, enter :

- the subscriber's **Medicaid ID** number
- OR the subscriber's **MICHild ID** number (ATTENTION: Check Box has to be checked to indicate MICHild Eligibility Request)
- OR their **Last Name, First Name AND Date of Birth**
- OR their **Last Name, First Name AND SSN**

Then, press *Request Eligibility Information* button. This process will take a few seconds, so please be patient.

<p>Subscriber Information</p> <p>Medicaid/MICHild ID: [REDACTED]</p> <p>Check if Requesting ICO Deeming Eligibility: <input type="checkbox"/></p>		<p>Request Date Range</p> <p>Start Date: [10/01/2020] End Date: [10/31/2020]</p>
<p>or</p> <p>Last Name: [REDACTED] First Name: [REDACTED]</p> <p>Date of Birth: [REDACTED] or SSN: [REDACTED]</p> <p>Date of Death: [REDACTED]</p>		
<p>Request Eligibility Information</p> <p>CLOSE</p>		

Jump To: [Medicaid / HMP / HSW Enrollment](#) | [MChild Enrollment](#) | [Insurance Policies](#) | [Medicaid Eligibility Inquiry](#)

Last 6 Months of CHAMPS (270/271) Medicaid/HMP Eligibility

No MPHI Medicaid Eligibility Requests / Responses found

Medicaid / HMP / HSW Enrollment (from DCH) Medicaid ID #: 000014589637 [lookup](#)
 (use LOOKUP button for complete listing)

Type	Month	Scope / Coverage	Name	DOB / Gender	County
MA - Medicaid / HMP / MI Child 2016+	11/01/2020	1 / F (Eligible)	[REDACTED]	[REDACTED]	Ingham
Benefit Plan Code(s): • BHMAMHP Behavioral Health Initiative - Medicaid MHP Enrolled Scope Code: 1 - Medicaid (Group 1) Coverage Code: F - Full Medicaid coverage Program Code: N - Medicaid for caretaker relatives and families with dependent children Recipient SSN: [REDACTED] Plan Provider ID: [REDACTED] Recipient Address: [REDACTED] BMP Enrollment: N Redetermination Date: 02/28/2021 ICO Member: N Homeless Indicator: N ICO Deeming Indicator: N MAGI Category: C - MAGI-PCR Parents/Caretakers (FPL % Test: Old) Record Generated: 10/25/2020 06:35:19 AM					
COB: EXPRESS SCRIPTS Group Number: [REDACTED] Payer ID: [REDACTED] Policy Number: [REDACTED] Coverage Type: RX					
COB: Meridian Health Plan of MI Inc. Group Number: [REDACTED] Payer ID: [REDACTED] Policy Number: [REDACTED] Coverage Type:					
COB: Group Number: [REDACTED] Payer ID: [REDACTED] Policy Number: [REDACTED] Coverage Type:					
File Date: 11/01/2020		File ID: 173262		File Received: 10/25/2020	
+ MA - Medicaid / HMP / MI Child 2016+	10/01/2020	1 / F (Eligible)	CODY R JONES	02/03/1996 / M	Ingham
+ MA - Medicaid / HMP / MI Child 2016+	09/01/2020	1 / F (Eligible)	CODY R JONES	02/03/1996 / M	Ingham
+ MA - Medicaid / HMP / MI Child 2016+	08/01/2020	3 / G (Eligible) - Healthy MI	CODY R JONES	02/03/1996 / M	Ingham
+ MA - Medicaid / HMP / MI Child 2016+	07/01/2020	3 / G (Eligible) - Healthy MI	CODY R JONES	02/03/1996 / M	Ingham
+ MA - Medicaid / HMP / MI Child 2016+	06/01/2020	3 / G (Eligible) - Healthy MI	CODY R JONES	02/03/1996 / M	Ingham
+ MA - Medicaid / HMP / MI Child 2016+	05/01/2020	3 / G (Eligible) - Healthy MI	CODY R JONES	02/03/1996 / M	Ingham
+ MA - Medicaid / HMP / MI Child 2016+	04/01/2020	3 / G (Eligible) - Healthy MI	CODY R JONES	02/03/1996 / M	Ingham

Results of the verification check

Champs verification check

Changing Patient [REDACTED]

General | Additional | Bill To | Next of Kin | User-Defined Fields

ID 1120-0025 Last Name [REDACTED] First [REDACTED] Initial [REDACTED]

Alternate ID Patient # 4154

Direct all communications to... Date of Birth 2/12/1998 22 YRS

Address 817 N. MLK Sex Male Female

City LANSING Social Sec # [REDACTED]

State MI Zip 48933 Marital Status [REDACTED]

Home 853-9009 Ext Employment Status [REDACTED]

Work Ext Student Status [REDACTED]

E-Mail Ext Notes

1 [REDACTED]

2 [REDACTED]

LAST SEEN BY [REDACTED] AT LOCATION 11

Intake info

Changing Patient [REDACTED]

General | **Additional** | Bill To | Next of Kin | User-Defined Fields

Primary Provider [REDACTED]

Referred by [REDACTED]

Referral Date [REDACTED] First Contact Date [REDACTED]

Intake Date 2/05/2020 Discharged on [REDACTED] Court Ordered Tx

Patient Category [REDACTED]

Usersort Fields [REDACTED] 2 [REDACTED] 3 [REDACTED]

Copay Portion Percentage 0 Maximum Session Charge Covered by Ins 0.00

OR

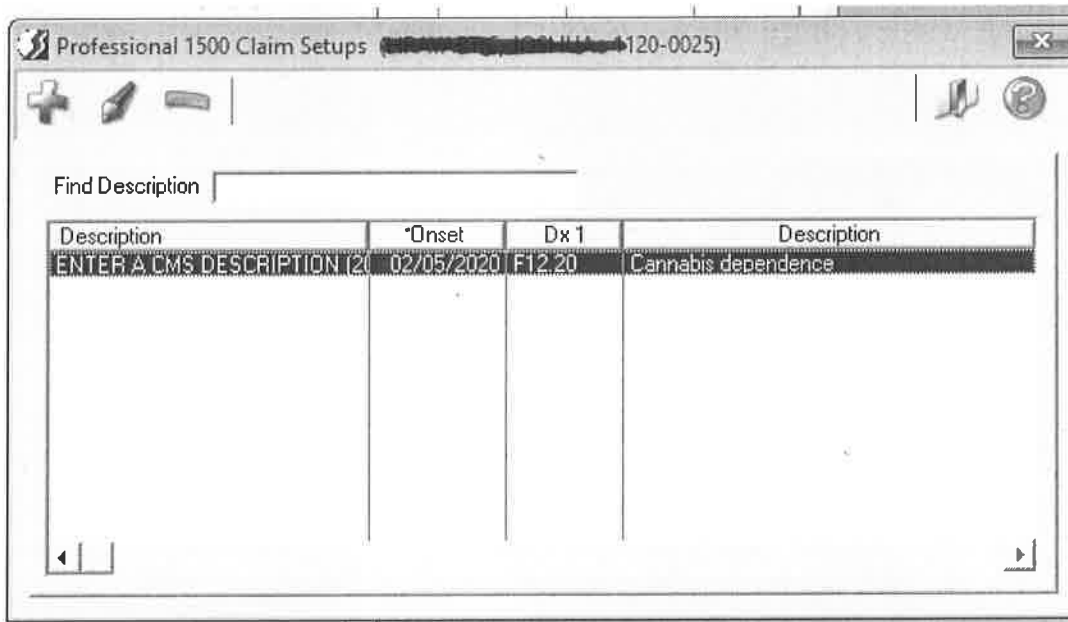
Fixed Copay Portion Amount 0.00 %

Scheduler Reminder [REDACTED]

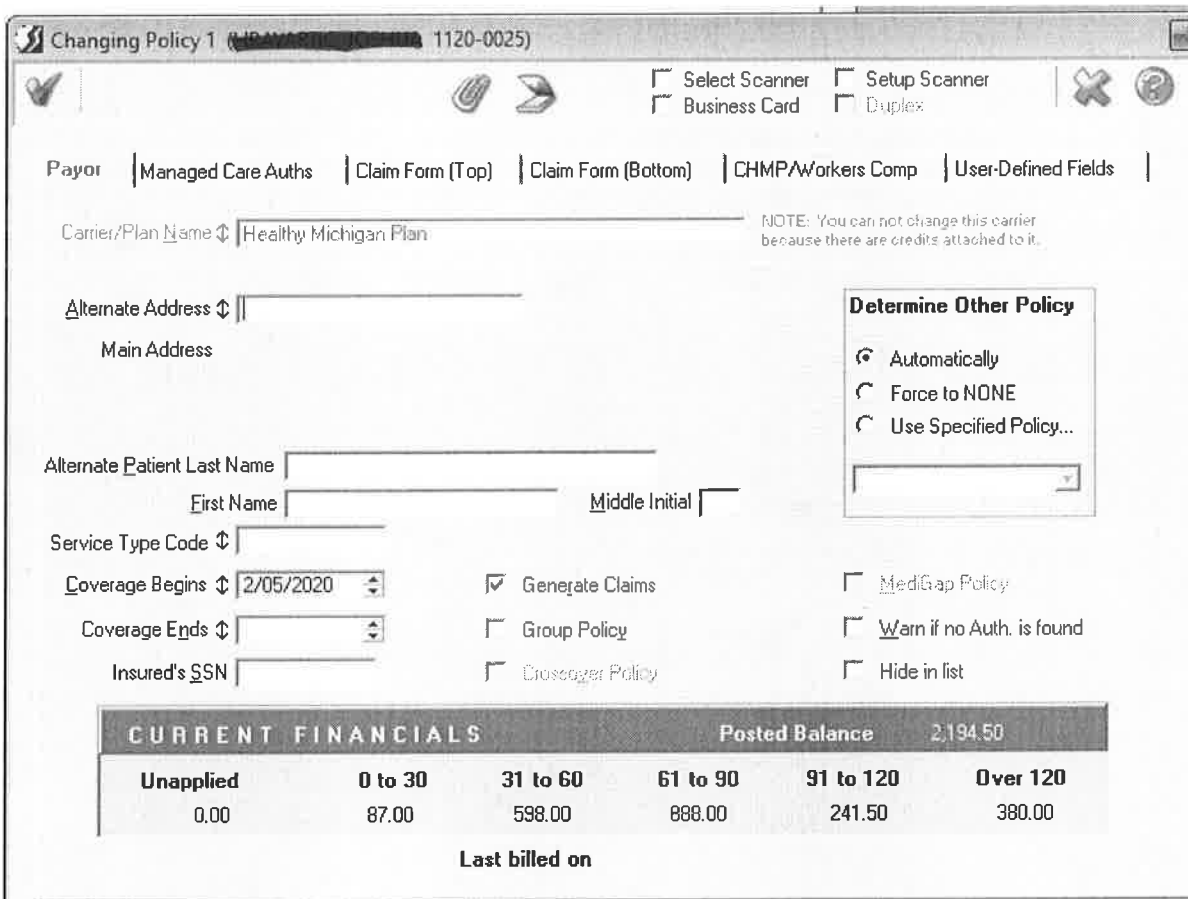
Transaction screen Reminder [REDACTED]

LAST SEEN BY [REDACTED] AT LOCATION 11

Add a diagnosis



Add an insurance



w3.pcsecure.com/cgi-bin/WebObjects/MSHAdmin.woa/1/wo/dKaxuFb6Wd3f1C8OhEwwM/16.8b9cc54c

Jump To: [Medicaid / HMP / HSW Enrollment](#) [MIChild Enrollment](#) [Insurance Policies](#) [Medicaid Eligibility Inquiry](#)

Last 6 Months of CHAMPS (270/271) Medicaid/HMP Eligibility

No MPHI Medicaid Eligibility Requests / Responses found.

Medicaid / HMP / HSW Enrollment (from DCH) Medicaid ID #: 000014589637 [lookup](#)
 (use LOOKUP button for complete listing)

Type	Month	Scope / Coverage	Name	DOB / Gender	County
MA - Medicaid / HMP / MI Child 2016+	11/01/2020	1 / F (Eligible)	[REDACTED]	[REDACTED]	Ingham
Benefit Plan Code(s): • BHMAMHP Behavioral Health Initiative - Medicaid MHP Enrolled Scope Code: 1 - Medicaid (Group 1) Coverage Code: F - Full Medicaid coverage Program Code: N - Medicaid for caretaker relatives and families with dependent children Recipient SSN: [REDACTED] Plan Provider ID: 000002813564 Recipient Address: [REDACTED] BMP Enrollment: N Redetermination Date: 02/28/2021 ICO Member: N Homeless Indicator: N ICO Deeming Indicator: N MAGI Category: C - MAGI-PCR Parents/Caretakers (FPL % Test: Old) Record Generated: 10/25/2020 06:35:19 AM					
COB: EXPRESS SCRIPTS Group Number: BMI715251000010 Payer ID: 30592020 Policy Number : 922484853 Coverage Type: RX					
COB: Meridian Health Plan of MI Inc Group Number: 0014589637 Payer ID: 4151587 Policy Number : 0014589637 Coverage Type:					
COB: Group Number: 0014589637 Payer ID: 386000134 Policy Number : 0014589637 Coverage Type:					
File Date: 11/01/2020		File ID: 173262		File Received: 10/25/2020	
+ MA - Medicaid / HMP / MI Child 2016+	10/01/2020	1 / F (Eligible)	[REDACTED]	[REDACTED]	Ingham
+ MA - Medicaid / HMP / MI Child 2016+	09/01/2020	1 / F (Eligible)	[REDACTED]	[REDACTED]	Ingham
+ MA - Medicaid / HMP / MI Child 2016+	08/01/2020	3 / G (Eligible) - Healthy MI	[REDACTED]	[REDACTED]	Ingham
+ MA - Medicaid / HMP / MI Child 2016+	07/01/2020	3 / G (Eligible) - Healthy MI	[REDACTED]	[REDACTED]	Ingham
+ MA - Medicaid / HMP / MI Child 2016+	06/01/2020	3 / G (Eligible) - Healthy MI	[REDACTED]	[REDACTED]	Ingham
+ MA - Medicaid / HMP / MI Child 2016+	05/01/2020	3 / G (Eligible) - Healthy MI	[REDACTED]	[REDACTED]	Ingham
+ MA - Medicaid / HMP / MI Child 2016+	04/01/2020	3 / G (Eligible) - Healthy MI	[REDACTED]	[REDACTED]	Ingham

Results of the verification check

Champs verification check

Close Submit

TO SUBMIT AN ELIGIBILITY INQUIRY ON A SPECIFIC MEMBER, COMPLETE ONE OF THE FOLLOWING CRITERIA SETS AND CLICK 'SUBMIT'.

- MEMBER ID/CLIENT IDENTIFICATION NUMBER/CM/CARD NUMBER/PENDING ELIGIBILITY RID OR
- LAST NAME, FIRST NAME AND DATE OF BIRTH OR
- LAST NAME, FIRST NAME AND SSN OR
- SSN AND DATE OF BIRTH
- ADDITIONAL SEARCH OPTIONS (Use if needed with one of the Search Options above to obtain a unique member match):
- GENDER
- ZIP CODE
- CASE NUMBER

MEMBER ELIGIBILITY INQUIRY

SEARCH MA PENDING ELIGIBILITY:

SEARCH BY SERVICE TYPE(S):

SERVICING PROVIDER NPI/PROVIDER ID: 1255386124 *

FILTER BY: --SELECT--

LAST NAME:

DATE OF BIRTH:

Gender: --SELECT--

MBCHLD Case Number:

INQUIRY START DATE: 10/20/2020 *

SSN:

FIRST NAME:

Zip Code:

MA Case Number:

INQUIRY END DATE: 10/20/2020 *

Close Submit

TO SUBMIT AN ELIGIBILITY INQUIRY ON A SPECIFIC MEMBER, COMPLETE ONE OF THE FOLLOWING CRITERIA SETS AND CLICK 'SUBMIT'.

- MEMBER ID/CLIENT IDENTIFICATION NUMBER/CM/CARD NUMBER/PENDING ELIGIBILITY RID OR
- LAST NAME, FIRST NAME AND DATE OF BIRTH OR
- LAST NAME, FIRST NAME AND SSN OR
- SSN AND DATE OF BIRTH
- ADDITIONAL SEARCH OPTIONS (Use if needed with one of the Search Options above to obtain a unique member match):
- GENDER
- ZIP CODE
- CASE NUMBER

MEMBER ELIGIBILITY INQUIRY

SEARCH MA PENDING ELIGIBILITY:

SEARCH BY SERVICE TYPE(S):

SERVICING PROVIDER NPI/PROVIDER ID: 1255386124 *

FILTER BY: --SELECT--

LAST NAME:

DATE OF BIRTH:

Gender: --SELECT--

MBCHLD Case Number:

INQUIRY START DATE: 10/20/2020 *

SSN:

FIRST NAME:

Zip Code:

MA Case Number:

INQUIRY END DATE: 10/20/2020 *

Close

Note: For Service Detail Coverage (Rate; Refer to Individual Provider Manual (IDPM) website for details on covered services including PA, copy and letter requirements. Some services may not be covered at age 21 and older.)

ENROLLMENT DATE RANGE: 10/20/2020 - 10/20/2020

GENDER: MALE

DATE OF BIRTH:

CASE NUMBER:

CASE PHONE:

CASE EMAIL:

COUNTRY OF RESIDENCE: MICHIGAN

IMAGE CATEGORY: C - Family/Consumers

MA PROGRAM CODE: N

CITIZENSHIP: U.S. Citizen

REDETERMINATION DATE: 02/26/2021

COMMERCIAL / OTHER: Y

CHILD RESTRICTIONS: N

MHP PCP: Y

IMP PROVIDER RESTRICTION: N

INDICATORS: Y

COST SHARE MET: Y

CAP AMOUNT REMAINING: 0.00

WORKER'S LOSS NUMBER: 00115

BENEFIT PHONE: (313) 887-6600

BENEFIT COUNTY: 3100-MICHIGAN COUNTY

Print Member Summary
Non-Covered Service Types

BENEFIT PLANS

Benefit Plan ID	PET	Benefit Plan Type	CHAMPS Provider ID	Service Type Details	Created Date	Transaction Date	Start Date	End Date
SHARLAMP	AP	REIMBURSED CARE	281388	Click To View Service Types	08/4/2020	08/4/2020	10/26/2020	10/26/2020
MA-AC	Non-Covered	REIMBURSED CARE	111158	Click To View Service Types	08/4/2020	08/4/2020	10/26/2020	10/26/2020
MA		FEE-FOR-SERVICE		Click To View Service Types	08/4/2020	08/4/2020	10/26/2020	10/26/2020

View Page: 1

Viewing Page: 1

Services Rendered But Not Billed To Insurance, Sorted by Payor Name

06/05/20

Includes Transactions Dated From 5/1/2020 To 5/31/2020

<u>Date</u>	<u>Service Description</u>	<u>CPT Code</u>	<u>Provider</u>	<u>Fee</u>
CMH Block Grant, Payor #109				
Carrier Categ:				
1120-0115				
05/15/20	Intake assessment	H0001	CD	127.50
05/20/20	45 min ind (38-52m)	90834	CD	87.00
05/29/20	45 min ind (38-52m)	90834	CD	87.00
Total for / 1120-0115				301.50
2420-0009				
05/04/20	45 min ind (38-52m)	90834	RJ	87.00
Total for / 2420-0009				87.00
1119-0385				
05/19/20	60 min ind (53m+)	90837	JH	112.50
Total for 1119-0385				112.50
(7-0396				
05/12/20	45 min ind (38-52m)	90834	CD	87.00
05/14/20	45 min ind (38-52m)	90834	CD	87.00
05/20/20	45 min ind (38-52m)	90834	CD	87.00
05/20/20	15 Min Ind	H0004	ML	92.00
05/21/20	30 min ind (16-37m)	90832	CD	56.50
05/26/20	45 min ind (38-52m)	90834	CD	87.00
Total for 1117-0396				496.50
1120-0044				
05/18/20	15 Min Ind	H0004	LE	69.00
05/27/20	15 Min Ind	H0004	RJ	23.00
Total for / 1120-0044				92.00
1120-0032				
05/07/20	30 min ind (16-37m)	90832	LW	56.50
Total for 1120-0032				56.50
1120-0083				
05/11/20	60 min ind (53m+)	90837	H,M	112.50
05/27/20	60 min ind (53m+)	90837	H,M	112.50
Total for 1120-0083				225.00
/ 1120-0123				
05/28/20	Intake assessment	H0001	SS	127.50
Total for 1120-0123				127.50
2418-0041				
05/01/20	30 min ind (16-37m)	90832	MP	56.50
Total for / 2418-0041				56.50
1120-0066				
05/05/20	30 min ind (16-37m)	90832	MP	56.50

05/08/20	30 min ind (16-37m)	90832	FS	56.50
05/12/20	45 min ind (38-52m)	90834	MP	87.00
05/15/20	15 Min Ind	H0004	FS	46.00
05/19/20	30 min ind (16-37m)	90832	MP	56.50
Total for / 1120-0066				302.50

Total for CMH Block Grant, Payor #109 1,857.50

Family Court-

Carrier Categ:

1116-0164				
05/06/20	Intake assessment	H0001	LW	127.50
Total for / 1116-0164				127.50

1120-0114				
05/13/20	Intake assessment	H0001	JH	125.00
Total for / 1120-0114				125.00

Total for Family Court 252.50

Healthy Michigan Plan, Payor #967

Carrier Categ:

2419-0216				
05/06/20	30 min ind (16-37m)	90832	MP	56.50
05/13/20	60 min ind (53m+)	90837	MP	112.50
05/20/20	30 min ind (16-37m)	90832	MP	56.50
Total for / 2419-0216				225.50

5216-0018				
05/07/20	45 min ind (38-52m)	90834	CD	87.00
05/12/20	30 min ind (16-37m)	90832	CD	56.50
05/18/20	30 min ind (16-37m)	90832	CD	56.50
05/28/20	45 min ind (38-52m)	90834	CD	87.00
Total for / 5216-0018				287.00

1119-0188				
05/04/20	60 min ind (53m+)	90837	MP	112.50
05/11/20	30 min ind (16-37m)	90832	MP	56.50
05/18/20	30 min ind (16-37m)	90832	MP	56.50
Total for / 1119-0188				225.50

1120-0110				
05/05/20	Intake assessment	H0001	JH	127.50
05/14/20	45 min ind (38-52m)	90834	RJ	87.00
05/21/20	60 min ind (53m+)	90837	RJ	112.50
05/28/20	15 Min Ind	H0004	ML	92.00
Total for / 1120-0110				419.00

2415-0240				
05/04/20	45 min ind (38-52m)	90834	H,M	87.00
05/05/20	45 min ind (38-52m)	90834	JH	87.00
05/12/20	30 min ind (16-37m)	90832	JH	56.50
05/13/20	30 min ind (16-37m)	90832	H,M	56.50
05/19/20	15 Min Ind	H0004	JH	23.00
05/22/20	45 min ind (38-52m)	90834	JH	87.00

05/29/20	45 min ind (38-52m)	90834	JH	87.00
Total for		/ 2415-0240		484.00
/ 1120-0005				
05/01/20	45 min ind (38-52m)	90834	JH	87.00
Total for BAKER, HUNTER		/ 1120-0005		87.00
/ 1120-0009				
05/07/20	60 min ind (53m+)	90837	MP	112.50
05/14/20	45 min ind (38-52m)	90834	MP	87.00
05/21/20	30 min ind (16-37m)	90832	MP	56.50
05/22/20	45 min ind (38-52m)	90834	MP	87.00
Total for		/ 1120-0009		343.00
/ 2419-0014				
05/11/20	30 min ind (16-37m)	90832	MP	56.50
Total for BOOK, CHRISTIAN		/ 2419-0014		56.50
/ 1117-0441				
05/05/20	60 min ind (53m+)	90837	DS	112.50
05/19/20	60 min ind (53m+)	90837	DS	112.50
Total for		/ 1117-0441		225.00
/ 1120-0098				
05/04/20	30 min ind (16-37m)	90832	H,M	56.50
05/06/20	30 min ind (16-37m)	90832	JS	56.50
05/07/20	30 min ind (16-37m)	90832	BM	56.50
05/04/20	60 min ind (53m+)	90837	JS	112.50
05/11/20	30 min ind (16-37m)	90832	H,M	56.50
05/13/20	30 min ind (16-37m)	90832	H,M	56.50
05/21/20	15 Min Ind	H0004	BM	46.00
05/27/20	30 min ind (16-37m)	90832	H,M	56.50
Total for		1120-0098		497.50
/ 1119-0405				
05/04/20	45 min ind (38-52m)	90834	MP	87.00
05/11/20	30 min ind (16-37m)	90832	MP	56.50
Total for		/ 1119-0405		143.50
/ 2416-0038				
05/08/20	45 min ind (38-52m)	90834	MP	87.00
05/22/20	30 min ind (16-37m)	90832	MP	56.50
Total for		2416-0038		143.50
/ 1119-0401				
05/22/20	45 min ind (38-52m)	90834	JH	87.00
Total for		/ 1119-0401		87.00
/ 1118-0282				
05/12/20	60 min ind (53m+)	90837	JH	112.50
Total for		18-0282		112.50
/ 2420-0012				
05/01/20	30 min ind (16-37m)	90832	LE	56.50
Total for		2420-0012		56.50
1120-0094				

05/07/20	30 min ind (16-37m)	90832	MP	56.50
05/12/20	15 Min Ind	H0004	BM	23.00
05/13/20	45 min ind (38-52m)	90834	JH	87.00
05/20/20	15 Min Ind	H0004	BM	23.00
05/20/20	45 min ind (38-52m)	90834	JH	87.00
05/22/20	45 min ind (38-52m)	90834	MP	87.00
05/26/20	15 Min Ind	H0004	BM	23.00
05/29/20	30 min ind (16-37m)	90832	MP	56.50
Total for		1120-0094		443.00
/ 2419-0264				
05/28/20	30 min ind (16-37m)	90832	JH	56.50
Total for		/ 2419-0264		56.50
/ 1119-0442				
05/06/20	45 min ind (38-52m)	90834	DS	87.00
05/11/20	45 min ind (38-52m)	90834	H,M	87.00
05/13/20	45 min ind (38-52m)	90834	DS	87.00
05/27/20	45 min ind (38-52m)	90834	DS	87.00
Total for		1119-0442		348.00
/ 1120-0004				
05/13/20	30 min ind (16-37m)	90832	MP	56.50
05/27/20	30 min ind (16-37m)	90832	MP	56.50
Total for		/ 1120-0004		113.00
/ 1119-0317				
05/04/20	30 min ind (16-37m)	90832	LW	56.50
05/05/20	30 min ind (16-37m)	90832	BM	56.50
05/07/20	30 min ind (16-37m)	90832	JH	56.50
05/11/20	30 min ind (16-37m)	90832	LW	56.50
05/14/20	60 min ind (53m+)	90837	JH	112.50
05/28/20	45 min ind (38-52m)	90834	JH	87.00
Total for		/ 1119-0317		425.50
/ 1116-0287				
05/04/20	15 Min Ind	H0004	MP	23.00
05/05/20	30 min ind (16-37m)	90832	MP	56.50
05/14/20	30 min ind (16-37m)	90832	MP	56.50
Total for		/ 1116-0287		136.00
/ 1119-0294				
05/12/20	45 min ind (38-52m)	90834	MP	87.00
05/19/20	30 min ind (16-37m)	90832	MP	56.50
05/20/20	45 min ind (38-52m)	90834	MP	87.00
Total for		1119-0294		230.50
/ 1119-0398				
05/21/20	30 min ind (16-37m)	90832	JH	56.50
Total for		/ 1119-0398		56.50
/ 1120-0073				
05/04/20	15 Min Ind	H0004	JS	23.00
Total for		120-0073		23.00
/ 2407-0080				

05/18/20	15 Min Ind	H0004	MP	23.00
	Total for	407-0080		23.00
	/ 1119-0395			
05/07/20	60 min ind (53m+)	90837	DS	112.50
05/14/20	60 min ind (53m+)	90837	DS	112.50
05/28/20	60 min ind (53m+)	90837	DS	112.50
	Total for			337.50
	/ 1119-0395			
	2418-0056			
05/11/20	45 min ind (38-52m)	90834	LW	87.00
	Total for			87.00
	/ 1120-0085			
05/13/20	45 min ind (38-52m)	90834	JH	87.00
05/20/20	45 min ind (38-52m)	90834	JH	87.00
05/27/20	30 min ind (16-37m)	90832	JH	56.50
	Total for			230.50
	/ 1120-0085			
	2419-0248			
05/07/20	30 min ind (16-37m)	90832	CD	56.50
05/13/20	30 min ind (16-37m)	90832	CD	56.50
05/20/20	30 min ind (16-37m)	90832	CD	56.50
05/27/20	30 min ind (16-37m)	90832	CD	56.50
	Total for			226.00
	/ 2419-0248			
	2419-0223			
05/07/20	15 Min Ind	H0004	LW	23.00
05/14/20	30 min ind (16-37m)	90832	LW	56.50
	Total for	2419-0223		79.50
	2418-0059			
05/01/20	45 min ind (38-52m)	90834	MP	87.00
05/08/20	45 min ind (38-52m)	90834	MP	87.00
05/15/20	30 min ind (16-37m)	90832	MP	56.50
05/22/20	30 min ind (16-37m)	90832	MP	56.50
	Total for	2418-0059		287.00
	1119-0307			
05/05/20	45 min ind (38-52m)	90834	JS	87.00
05/12/20	45 min ind (38-52m)	90834	JS	87.00
05/19/20	45 min ind (38-52m)	90834	JS	87.00
	Total for	1119-0307		261.00
	1110-0108			
05/14/20	45 min ind (38-52m)	90834	JS	87.00
	Total for	1110-0108		87.00
	1119-0423			
05/06/20	30 min ind (16-37m)	90832	MP	56.50
05/27/20	30 min ind (16-37m)	90832	MP	56.50
	Total for	1119-0423		113.00
	1118-0277			
05/14/20	30 min ind (16-37m)	90832	BM	169.50
05/22/20	30 min ind (16-37m)	90832	JH	56.50

05/26/20	15 Min Ind	H0004	BM	92.00
Total for (/ 1118-0277		318.00
2419-0232				
05/12/20	60 min ind (53m+)	90837	JH	112.50
05/19/20	45 min ind (38-52m)	90834	JH	87.00
05/26/20	45 min ind (38-52m)	90834	JH	87.00
Total for		2419-0232		286.50
13-0179				
05/01/20	30 min ind (16-37m)	90832	MP	56.50
05/08/20	30 min ind (16-37m)	90832	MP	56.50
05/12/20	30 min ind (16-37m)	90832	MP	56.50
05/15/20	30 min ind (16-37m)	90832	MP	56.50
05/22/20	30 min ind (16-37m)	90832	MP	56.50
05/29/20	30 min ind (16-37m)	90832	MP	56.50
Total for		/ 2413-0179		339.00
19-0450				
05/05/20	15 Min Ind	H0004	JS	23.00
05/05/20	60 min ind (53m+)	90837	DS	112.50
05/12/20	45 min ind (38-52m)	90834	DS	87.00
05/19/20	45 min ind (38-52m)	90834	DS	87.00
05/26/20	45 min ind (38-52m)	90834	DS	87.00
Total for		1119-0450		396.50
1119-0022				
05/20/20	60 min ind (53m+)	90837	DS	112.50
Total for		1119-0022		112.50
118-0308				
05/14/20	60 min ind (53m+)	90837	LE	112.50
05/22/20	30 min ind (16-37m)	90832	LE	56.50
05/26/20	30 min ind (16-37m)	90832	CD	56.50
05/28/20	30 min ind (16-37m)	90832	RJ	56.50
Total for H/		1118-0308		282.00
120-0079				
05/04/20	30 min ind (16-37m)	90832	JH	56.50
05/04/20	45 min ind (38-52m)	90834	FS	87.00
05/06/20	45 min ind (38-52m)	90834	FS	87.00
05/11/20	45 min ind (38-52m)	90834	JH	87.00
05/28/20	15 Min Ind	H0004	JH	23.00
Total for t		L / 1120-0079		340.50
1120-0122				
05/27/20	Intake assessment	H0001	JH	127.50
Total for		/ 1120-0122		127.50
2419-0243				
05/07/20	45 min ind (38-52m)	90834	DS	87.00
05/14/20	45 min ind (38-52m)	90834	DS	87.00
05/28/20	45 min ind (38-52m)	90834	DS	87.00
Total for		2419-0243		261.00
14-0180				

05/06/20	45 min ind (38-52m)	90834	DS	87.00
05/12/20	60 min ind (53m+)	90837	DS	112.50
05/19/20	60 min ind (53m+)	90837	DS	112.50
Total for / 1114-0180				312.00
/ 1119-0250				
05/06/20	45 min ind (38-52m)	90834	JH	87.00
Total for / 1119-0250				87.00
/ 1120-0025				
05/06/20	45 min ind (38-52m)	90834	JH	87.00
05/11/20	60 min ind (53m+)	90837	JH	112.50
05/18/20	45 min ind (38-52m)	90834	JH	87.00
05/26/20	60 min ind (53m+)	90837	JH	112.50
Total for / 1120-0025				399.00
/ 2419-0040				
05/04/20	45 min ind (38-52m)	90834	FS	87.00
05/11/20	15 Min Ind	H0004	FS	69.00
05/21/20	15 Min Ind	H0004	FS	46.00
05/28/20	15 Min Ind	H0004	FS	69.00
Total for / 2419-0040				271.00
/ 1120-0093				
05/13/20	15 Min Ind	H0004	FS	69.00
Total for / 1120-0093				69.00
/ 1109-0052				
05/21/20	Intake assessment	H0001	SS	127.50
Total for / 1109-0052				127.50
/ 1119-0453				
05/12/20	30 min ind (16-37m)	90832	LE	56.50
05/12/20	30 min ind (16-37m)	90832	LE	56.50
05/19/20	30 min ind (16-37m)	90832	LE	56.50
Total for / 1119-0453				169.50
/ 420-0209				
05/13/20	30 min ind (16-37m)	90832	MP	56.50
05/13/20	30 min ind (16-37m)	90832	MP	56.50
05/14/20	45 min ind (38-52m)	90834	CD	87.00
05/18/20	45 min ind (38-52m)	90834	CD	87.00
05/19/20	15 Min Ind	H0004	ML	92.00
05/21/20	15 Min Ind	H0004	ML	92.00
05/26/20	45 min ind (38-52m)	90834	CD	87.00
05/28/20	15 Min Ind	H0004	ML	92.00
Total for / 420-0209				650.00
1119-0228				
05/15/20	60 min ind (53m+)	90837	MP	112.50
Total for / 1119-0228				112.50
/ 1120-0108				
05/05/20	Intake assessment	H0001	JH	127.50
Total for / 1120-0108				127.50

	/ 1120-0056			
05/13/20	30 min ind (16-37m)	90832	JH	56.50
	Total for	1120-0056		56.50
	/ 1120-0109			
05/11/20	30 min ind (16-37m)	90832	H,M	56.50
05/13/20	45 min ind (38-52m)	90834	H,M	87.00
05/14/20	30 min ind (16-37m)	90832	H,M	56.50
05/27/20	30 min ind (16-37m)	90832	H,M	56.50
	Total for	1120-0109		256.50
	119-0300			
05/18/20	60 min ind (53m+)	90837	MP	112.50
05/20/20	30 min ind (16-37m)	90832	MP	56.50
05/26/20	45 min ind (38-52m)	90834	MP	87.00
05/28/20	30 min ind (16-37m)	90832	MP	56.50
	Total for	119-0300		312.50
	/ 2418-0257			
05/14/20	30 min ind (16-37m)	90832	LW	56.50
	Total for	/ 2418-0257		56.50
	/ 2419-0231			
05/11/20	30 min ind (16-37m)	90832	JH	56.50
05/26/20	45 min ind (38-52m)	90834	JH	87.00
	Total for	/ 2419-0231		143.50
	/ 2419-0032			
05/05/20	30 min ind (16-37m)	90832	JH	56.50
05/15/20	15 Min Ind	H0004	JH	23.00
05/22/20	30 min ind (16-37m)	90832	JH	56.50
05/29/20	45 min ind (38-52m)	90834	JH	87.00
	Total for	19-0032		223.00
	1119-0279			
05/06/20	30 min ind (16-37m)	90832	CD	56.50
05/13/20	15 Min Ind	H0004	CD	23.00
05/27/20	30 min ind (16-37m)	90832	CD	56.50
	Total for	1119-0279		136.00
	1119-0340			
05/07/20	30 min ind (16-37m)	90832	MP	56.50
05/20/20	30 min ind (16-37m)	90832	MP	56.50
	Total for	/ 1119-0340		113.00
	120-0011			
05/04/20	45 min ind (38-52m)	90834	LW	87.00
05/20/20	30 min ind (16-37m)	90832	MP	56.50
05/26/20	30 min ind (16-37m)	90832	MP	56.50
	Total for	120-0011		200.00
	119-0308			
05/07/20	30 min ind (16-37m)	90832	JH	56.50
05/11/20	45 min ind (38-52m)	90834	JH	87.00
05/14/20	60 min ind (53m+)	90837	JH	112.50
05/14/20	15 Min Ind	H0004	FS	46.00

05/21/20	Certified PRC group/ per 15 minut	H0038	FS	9.00
05/28/20	15 Min Ind	H0004	FS	46.00
05/28/20	45 min ind (38-52m)	90834	JH	87.00
05/28/20	30 min ind (16-37m)	90832	RJ	56.50
05/21/20	60 min ind (53m+)	90837	JH	112.50
Total for		1119-0308		613.00
/ 1120-0058				
05/05/20	30 min ind (16-37m)	90832	CD	56.50
05/06/20	60 min ind (53m+)	90837	BM	112.50
05/08/20	45 min ind (38-52m)	90834	CD	87.00
05/13/20	15 Min Ind	H0004	BM	69.00
05/15/20	60 min ind (53m+)	90837	CD	112.50
05/20/20	15 Min Ind	H0004	BM	23.00
05/22/20	45 min ind (38-52m)	90834	CD	87.00
05/27/20	15 Min Ind	H0004	BM	69.00
05/29/20	60 min ind (53m+)	90837	CD	112.50
Total for		1120-0058		729.00
1120-0030				
05/01/20	30 min ind (16-37m)	90832	CD	56.50
05/06/20	15 Min Ind	H0004	BM	23.00
05/08/20	30 min ind (16-37m)	90832	CD	56.50
05/15/20	45 min ind (38-52m)	90834	CD	87.00
05/22/20	30 min ind (16-37m)	90832	CD	56.50
Total for		1120-0030		279.50
/ 1119-0420				
05/05/20	30 min ind (16-37m)	90832	LE	56.50
05/05/20	45 min ind (38-52m)	90834	LE	87.00
05/12/20	30 min ind (16-37m)	90832	LE	56.50
05/19/20	30 min ind (16-37m)	90832	LE	56.50
05/27/20	30 min ind (16-37m)	90832	RJ	56.50
Total for		1119-0420		313.00
1119-0357				
05/13/20	30 min ind (16-37m)	90832	LW	56.50
Total for		1119-0357		56.50
1120-0100				
05/06/20	45 min ind (38-52m)	90834	FS	87.00
05/08/20	60 min ind (53m+)	90837	FS	112.50
05/12/20	Certified PRC group/ per 15 minut	H0038	AS	4.50
05/13/20	45 min ind (38-52m)	90834	FS	87.00
05/15/20	15 Min Ind	H0004	FS	69.00
05/19/20	45 min ind (38-52m)	90834	JS	87.00
Total for		1120-0100		447.00
/ 1119-0416				
05/11/20	15 Min Ind	H0004	JS	23.00
Total for		9-0416		23.00
/ 1119-0194				
05/05/20	30 min ind (16-37m)	90832	CD	56.50
05/26/20	45 min ind (38-52m)	90834	CD	87.00
Total for		1119-0194		143.50

/ 2419-0011				
05/06/20	30 min ind (16-37m)	90832	MP	56.50
05/13/20	30 min ind (16-37m)	90832	MP	56.50
05/20/20	30 min ind (16-37m)	90832	MP	56.50
Total for / 2419-0011				169.50
120-0039				
05/07/20	45 min ind (38-52m)	90834	CD	87.00
05/13/20	30 min ind (16-37m)	90832	CD	56.50
05/20/20	30 min ind (16-37m)	90832	CD	56.50
05/27/20	45 min ind (38-52m)	90834	CD	87.00
Total for 120-0039				287.00
119-0038				
05/07/20	45 min ind (38-52m)	90834	CD	87.00
05/14/20	15 Min Ind	H0004	CD	23.00
Total for 119-0038				110.00
/ 1120-0080				
05/01/20	60 min ind (53m+)	90837	JH	112.50
05/05/20	30 min ind (16-37m)	90832	JH	56.50
05/06/20	30 min ind (16-37m)	90832	LE	56.50
05/14/20	45 min ind (38-52m)	90834	LE	87.00
05/26/20	45 min ind (38-52m)	90834	JH	87.00
05/28/20	45 min ind (38-52m)	90834	RJ	87.00
05/21/20	45 min ind (38-52m)	90834	JH	87.00
Total for / 1120-0080				573.50
1117-0412				
05/21/20	45 min ind (38-52m)	90834	CD	87.00
05/28/20	45 min ind (38-52m)	90834	CD	87.00
Total for / 1117-0412				174.00
/ 1117-0349				
05/06/20	30 min ind (16-37m)	90832	LE	56.50
05/12/20	30 min ind (16-37m)	90832	LE	56.50
05/19/20	30 min ind (16-37m)	90832	LE	56.50
05/27/20	30 min ind (16-37m)	90832	SS	56.50
Total for / 1117-0349				226.00
1119-0408				
05/04/20	45 min ind (38-52m)	90834	JH	87.00
05/14/20	45 min ind (38-52m)	90834	JH	87.00
Total for 1119-0408				174.00
120-0050				
05/01/20	15 Min Ind	H0004	BM	23.00
05/14/20	30 min ind (16-37m)	90832	CD	56.50
05/21/20	30 min ind (16-37m)	90832	CD	56.50
05/28/20	30 min ind (16-37m)	90832	CD	56.50
Total for 120-0050				192.50
117-0248				
05/22/20	30 min ind (16-37m)	90832	JH	56.50
05/29/20	45 min ind (38-52m)	90834	JH	87.00

	Total for	1117-0248		143.50
	119-0035			
05/04/20	45 min ind (38-52m)	90834	JH	87.00
	Total for	1119-0035		87.00
	120-0112			
05/12/20	Intake assessment	H0001	JH	127.50
05/27/20	15 Min Ind	H0004	FS	92.00
	Total for	1120-0112		219.50
	119-0461			
05/05/20	45 min ind (38-52m)	90834	MP	87.00
05/06/20	30 min ind (16-37m)	90832	FS	56.50
05/13/20	15 Min Ind	H0004	FS	46.00
05/14/20	30 min ind (16-37m)	90832	MP	56.50
05/19/20	30 min ind (16-37m)	90832	MP	56.50
05/20/20	15 Min Ind	H0004	FS	46.00
05/27/20	15 Min Ind	H0004	FS	46.00
	Total for	1119-0461		394.50
	0186			
05/06/20	45 min ind (38-52m)	90834	FS	87.00
05/12/20	45 min ind (38-52m)	90834	FS	87.00
05/13/20	15 Min Ind	H0004	FS	69.00
05/18/20	45 min ind (38-52m)	90834	JS	87.00
05/20/20	15 Min Ind	H0004	FS	69.00
05/26/20	15 Min Ind	H0004	FS	69.00
05/27/20	15 Min Ind	H0004	FS	69.00
	Total for	19-0186		537.00
	1119-0258			
05/06/20	45 min ind (38-52m)	90834	JH	87.00
	Total for	1119-0258		87.00
	119-0412			
05/14/20	45 min ind (38-52m)	90834	MP	87.00
05/14/20	15 Min Ind	H0004	FS	138.00
05/15/20	15 Min Ind	H0004	FS	46.00
05/18/20	30 min ind (16-37m)	90832	MP	56.50
05/19/20	15 Min Ind	H0004	FS	46.00
05/26/20	Case management	H0006	FS	41.00
	Total for	1119-0412		414.50
	1116-0169			
05/06/20	45 min ind (38-52m)	90834	FS	87.00
05/07/20	45 min ind (38-52m)	90834	FS	87.00
05/05/20	45 min ind (38-52m)	90834	JS	87.00
05/13/20	15 Min Ind	H0004	FS	69.00
05/14/20	15 Min Ind	H0004	FS	69.00
05/15/20	45 min ind (38-52m)	90834	JS	87.00
05/21/20	15 Min Ind	H0004	FS	69.00
05/27/20	15 Min Ind	H0004	FS	69.00
	Total for	1116-0169		624.00
	A / 2416-0248			

05/07/20	45 min ind (38-52m)	90834	LW	87.00
05/14/20	30 min ind (16-37m)	90832	LW	56.50
05/26/20	45 min ind (38-52m)	90834	DS	87.00
Total for		/ 2416-0248		230.50
/ 2419-0025				
05/01/20	60 min ind (53m+)	90837	JH	112.50
05/22/20	15 Min Ind	H0004	JH	23.00
Total for		/ 2419-0025		135.50
/ 1119-0124				
05/04/20	30 min ind (16-37m)	90832	JH	56.50
Total for		119-0124		56.50
/ 1120-0120				
05/21/20	Intake assessment	H0001	SS	127.50
Total for		120-0120		127.50
/ 1119-0203				
05/05/20	45 min ind (38-52m)	90834	FS	87.00
05/06/20	45 min ind (38-52m)	90834	FS	87.00
05/05/20	45 min ind (38-52m)	90834	JS	87.00
05/19/20	45 min ind (38-52m)	90834	JS	87.00
05/12/20	45 min ind (38-52m)	90834	JS	87.00
Total for		1119-0203		435.00
/ 1120-0087				
05/07/20	45 min ind (38-52m)	90834	FS	87.00
05/11/20	15 Min Ind	H0004	FS	69.00
05/14/20	15 Min Ind	H0004	FS	46.00
05/18/20	15 Min Ind	H0004	FS	69.00
05/20/20	60 min ind (53m+)	90837	JS	112.50
05/21/20	15 Min Ind	H0004	FS	69.00
05/28/20	15 Min Ind	H0004	FS	69.00
Total for		1120-0087		521.50
/ 2418-0041				
05/15/20	30 min ind (16-37m)	90832	MP	56.50
05/29/20	30 min ind (16-37m)	90832	MP	56.50
Total for		/ 2418-0041		113.00
1119-0040				
05/04/20	60 min ind (53m+)	90837	DS	112.50
05/27/20	60 min ind (53m+)	90837	DS	112.50
Total for		1119-0040		225.00
/ 1120-0116				
05/19/20	Intake assessment	H0001	JH	127.50
05/27/20	45 min ind (38-52m)	90834	JH	87.00
Total for		/ 1120-0116		214.50
/ 1120-0066				
05/26/20	45 min ind (38-52m)	90834	MP	87.00
05/29/20	30 min ind (16-37m)	90832	CD	56.50
Total for		1120-0066		143.50

		1120-0060			
05/27/20	60 min ind (53m+)	90837	MP	112.50	
	Total for	1120-0060		112.50	
V		1120-0090			
05/01/20	30 min ind (16-37m)	90832	MP	56.50	
05/15/20	30 min ind (16-37m)	90832	MP	56.50	
05/06/20	30 min ind (16-37m)	90832	JH	56.50	
05/20/20	30 min ind (16-37m)	90832	JH	56.50	
05/27/20	30 min ind (16-37m)	90832	JH	56.50	
05/29/20	30 min ind (16-37m)	90832	MP	56.50	
	Total for	1120-0090		339.00	
		1120-0027			
05/08/20	45 min ind (38-52m)	90834	JH	87.00	
05/11/20	30 min ind (16-37m)	90832	JH	56.50	
05/14/20	30 min ind (16-37m)	90832	JH	56.50	
05/18/20	45 min ind (38-52m)	90834	JH	87.00	
	Total for	1120-0027		287.00	
		1120-0068			
05/06/20	45 min ind (38-52m)	90834	JH	87.00	
05/06/20	45 min ind (38-52m)	90834	LE	87.00	
05/11/20	45 min ind (38-52m)	90834	JH	87.00	
05/13/20	30 min ind (16-37m)	90832	LE	56.50	
05/20/20	30 min ind (16-37m)	90832	LE	56.50	
05/28/20	15 Min Ind	H0004	RJ	23.00	
05/21/20	45 min ind (38-52m)	90834	JH	87.00	
	Total for	1120-0068		484.00	
		2419-0233			
05/21/20	30 min ind (16-37m)	90832	CD	56.50	
05/27/20	30 min ind (16-37m)	90832	CD	56.50	
	Total for	2419-0233		113.00	
		1120-0028			
05/05/20	30 min ind (16-37m)	90832	MP	56.50	
05/12/20	45 min ind (38-52m)	90834	MP	87.00	
05/19/20	30 min ind (16-37m)	90832	MP	56.50	
	Total for	1120-0028		200.00	
		420-0014			
05/12/20	Intake assessment	H0001	MP	127.50	
05/06/20	30 min ind (16-37m)	90832	LE	56.50	
05/08/20	15 Min Ind	H0004	FS	46.00	
05/12/20	30 min ind (16-37m)	90832	LE	56.50	
05/15/20	30 min ind (16-37m)	90832	LE	56.50	
05/13/20	15 Min Ind	H0004	ML	92.00	
05/19/20	45 min ind (38-52m)	90834	LE	87.00	
05/19/20	15 Min Ind	H0004	ML	92.00	
05/21/20	15 Min Ind	H0004	ML	92.00	
05/26/20	15 Min Ind	H0004	ML	92.00	
	Total for	420-0014		798.00	

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05/15/20	45 min ind (38-52m)	90834	SS	87.00
05/22/20	45 min ind (38-52m)	90834	SS	87.00
Total for		1120-0099		174.00
/ 1119-0441				
05/06/20	30 min ind (16-37m)	90832	MP	56.50
05/13/20	30 min ind (16-37m)	90832	MP	56.50
05/18/20	60 min ind (53m+)	90837	JS	112.50
05/27/20	30 min ind (16-37m)	90832	MP	56.50
Total for		1119-0441		282.00
/ 1120-0071				
05/06/20	15 Min Ind	H0004	JH	23.00
05/13/20	15 Min Ind	H0004	BM	23.00
05/14/20	45 min ind (38-52m)	90834	JH	87.00
05/20/20	15 Min Ind	H0004	BM	46.00
05/28/20	45 min ind (38-52m)	90834	JH	87.00
05/21/20	30 min ind (16-37m)	90832	JH	56.50
Total for		1120-0071		322.50
420-025				
05/05/20	45 min ind (38-52m)	90834	JS	87.00
05/06/20	15 Min Ind	H0004	BM	23.00
05/21/20	15 Min Ind	H0004	BM	46.00
05/21/20	60 min ind (53m+)	90837	JS	112.50
05/27/20	15 Min Ind	H0004	BM	46.00
Total for		420-025		314.50
420-0005				
05/01/20	30 min ind (16-37m)	90832	LE	56.50
05/13/20	30 min ind (16-37m)	90832	LE	56.50
05/21/20	30 min ind (16-37m)	90832	LE	56.50
05/28/20	30 min ind (16-37m)	90832	RJ	56.50
Total for		420-0005		226.00
1120-0081				
05/05/20	45 min ind (38-52m)	90834	CD	87.00
05/12/20	30 min ind (16-37m)	90832	CD	56.50
05/19/20	45 min ind (38-52m)	90834	CD	87.00
05/26/20	45 min ind (38-52m)	90834	CD	87.00
Total for		1120-0081		317.50
1119-0007				
05/14/20	30 min ind (16-37m)	90832	MP	56.50
05/21/20	30 min ind (16-37m)	90832	MP	56.50
05/26/20	30 min ind (16-37m)	90832	MP	56.50
Total for		1119-0007		169.50
Total for Healthy Michigan Plan, Payor #967				26,602.50
Carrier Categ:				
1-0092				
05/26/20	45 min ind (38-52m)	90834	SS	87.00
Total for		120-0092		87.00

/ 1120-0088				
05/04/20	45 min ind (38-52m)	90834	H,M	87.00
05/06/20	30 min ind (16-37m)	90832	LW	56.50
05/13/20	30 min ind (16-37m)	90832	LW	56.50
05/13/20	45 min ind (38-52m)	90834	H,M	87.00
05/26/20	60 min ind (53m+)	90837	H,M	112.50
Total for		/ 1120-0088		399.50
S / 1119-0391				
05/01/20	30 min ind (16-37m)	90832	MP	56.50
05/12/20	30 min ind (16-37m)	90832	MP	56.50
Total for		/ 1119-0391		113.00
/ 1118-0053				
05/19/20	60 min ind (53m+)	90837	MP	112.50
05/28/20	15 Min Ind	H0004	ML	92.00
05/29/20	45 min ind (38-52m)	90834	MP	87.00
Total for		/ 1118-0053		291.50
20-0020				
05/01/20	30 min ind (16-37m)	90832	MP	56.50
05/12/20	30 min ind (16-37m)	90832	MP	56.50
05/26/20	45 min ind (38-52m)	90834	MP	87.00
Total for		20-0020		200.00
/ 1119-0366				
05/07/20	30 min ind (16-37m)	90832	LW	56.50
05/19/20	30 min ind (16-37m)	90832	CD	56.50
Total for		/ 1119-0366		113.00
/ 1119-0120				
05/05/20	45 min ind (38-52m)	90834	JH	87.00
05/13/20	45 min ind (38-52m)	90834	JH	87.00
05/20/20	45 min ind (38-52m)	90834	JH	87.00
Total for E		1119-0120		261.00
1119-0421				
05/04/20	45 min ind (38-52m)	90834	JS	87.00
05/11/20	30 min ind (16-37m)	90832	JS	56.50
05/13/20	30 min ind (16-37m)	90832	DS	56.50
05/19/20	45 min ind (38-52m)	90834	JS	87.00
05/27/20	45 min ind (38-52m)	90834	DS	87.00
Total for		1119-0421		374.00
/ 2410-0241				
05/01/20	Intake assessment	H0001	BM	127.50
05/12/20	60 min ind (53m+)	90837	H,M	112.50
Total for		/ 2410-0241		240.00
1119-0446				
05/05/20	45 min ind (38-52m)	90834	DS	87.00
05/11/20	45 min ind (38-52m)	90834	LW	87.00
05/12/20	30 min ind (16-37m)	90832	DS	56.50
05/19/20	45 min ind (38-52m)	90834	DS	87.00
05/26/20	45 min ind (38-52m)	90834	DS	87.00
Total for		/ 1119-0446		404.50

/ 1120-0106				
05/04/20	60 min ind (53m+)	90837	DS	112.50
05/06/20	30 min ind (16-37m)	90832	DS	56.50
05/11/20	60 min ind (53m+)	90837	DS	112.50
05/13/20	45 min ind (38-52m)	90834	DS	87.00
05/18/20	60 min ind (53m+)	90837	DS	112.50
05/27/20	30 min ind (16-37m)	90832	DS	56.50
Total for		1120-0106		537.50
/ 1120-0007				
05/20/20	45 min ind (38-52m)	90834	CD	87.00
05/27/20	30 min ind (16-37m)	90832	CD	56.50
Total for		1120-0007		143.50
/ 1120-0003				
05/04/20	30 min ind (16-37m)	90832	JH	56.50
05/07/20	45 min ind (38-52m)	90834	JH	87.00
05/11/20	45 min ind (38-52m)	90834	JH	87.00
05/14/20	30 min ind (16-37m)	90832	JH	56.50
05/18/20	45 min ind (38-52m)	90834	JH	87.00
05/22/20	45 min ind (38-52m)	90834	JH	87.00
05/27/20	30 min ind (16-37m)	90832	JH	56.50
Total for		/ 1120-0003		517.50
/ 1120-0064				
05/01/20	45 min ind (38-52m)	90834	CD	87.00
05/06/20	30 min ind (16-37m)	90832	CD	56.50
Total for		/ 1120-0064		143.50
/ 1120-0053				
05/07/20	30 min ind (16-37m)	90832	BM	56.50
05/07/20	30 min ind (16-37m)	90832	CD	56.50
05/14/20	15 Min Ind	H0004	BM	46.00
05/20/20	30 min ind (16-37m)	90832	CD	56.50
05/21/20	15 Min Ind	H0004	BM	23.00
05/27/20	30 min ind (16-37m)	90832	CD	56.50
Total for		1120-0053		295.00
1120-0045				
05/22/20	45 min ind (38-52m)	90834	JH	87.00
Total for		/ 1120-0045		87.00
/ 1119-0386				
05/04/20	30 min ind (16-37m)	90832	LW	56.50
05/11/20	30 min ind (16-37m)	90832	LW	56.50
05/11/20	45 min ind (38-52m)	90834	H,M	87.00
05/26/20	30 min ind (16-37m)	90832	H,M	56.50
Total for		/ 1119-0386		256.50
20-0084				
05/20/20	45 min ind (38-52m)	90834	JH	87.00
Total for		20-0084		87.00
119-0460				
05/15/20	30 min ind (16-37m)	90832	CD	56.50

05/22/20	30 min ind (16-37m)	90832	CD	56.50
05/29/20	45 min ind (38-52m)	90834	CD	87.00
Total for		/ 1119-0460		200.00
L	/ 1119-0353			
05/01/20	60 min ind (53m+)	90837	DS	112.50
05/12/20	45 min ind (38-52m)	90834	DS	87.00
Total for		/ 1119-0353		199.50
	/ 1119-0155			
05/05/20	45 min ind (38-52m)	90834	DS	87.00
05/12/20	30 min ind (16-37m)	90832	DS	56.50
05/26/20	45 min ind (38-52m)	90834	DS	87.00
Total for		/ 1119-0155		230.50
	/ 1116-0086			
05/11/20	Intake assessment	H0001	BM	127.50
05/19/20	30 min ind (16-37m)	90832	CD	56.50
05/21/20	15 Min Ind	H0004	BM	23.00
05/26/20	30 min ind (16-37m)	90832	CD	56.50
Total for		/ 1116-0086		263.50
	/ 1119-0285			
05/06/20	60 min ind (53m+)	90837	DS	112.50
05/13/20	60 min ind (53m+)	90837	DS	112.50
05/20/20	45 min ind (38-52m)	90834	DS	87.00
05/28/20	30 min ind (16-37m)	90832	DS	56.50
Total for		/ 1119-0285		368.50
	/ 1119-0288			
05/28/20	45 min ind (38-52m)	90834	JH	87.00
Total for		/ 1119-0288		87.00
	/ 1120-0101			
05/01/20	30 min ind (16-37m)	90832	FS	46.00
05/04/20	30 min ind (16-37m)	90832	DS	56.50
05/06/20	15 Min Ind	H0004	BM	23.00
05/07/20	45 min ind (38-52m)	90834	DS	87.00
05/11/20	Certified PRC Individual/per 15 mi	H0038	AS	20.50
05/11/20	45 min ind (38-52m)	90834	DS	87.00
05/13/20	15 Min Ind	H0004	BM	69.00
05/14/20	45 min ind (38-52m)	90834	DS	87.00
05/18/20	45 min ind (38-52m)	90834	DS	87.00
05/20/20	30 min ind (16-37m)	90832	BM	56.50
05/26/20	30 min ind (16-37m)	90832	DS	56.50
05/27/20	15 Min Ind	H0004	BM	23.00
Total for		/ 1120-0101		699.00
	/ 1118-0097			
05/06/20	30 min ind (16-37m)	90832	MP	56.50
05/13/20	30 min ind (16-37m)	90832	MP	56.50
05/22/20	30 min ind (16-37m)	90832	MP	56.50
05/29/20	30 min ind (16-37m)	90832	MP	56.50
Total for		/ 1118-0097		226.00
	/ 20-0104			

05/11/20	60 min ind (53m+)	90837	DS	112.50
05/14/20	45 min ind (38-52m)	90834	DS	87.00
05/18/20	60 min ind (53m+)	90837	DS	112.50
Total for		-0104		312.00
1120-0208				
05/04/20	45 min ind (38-52m)	90834	JS	87.00
Total for		-0208		87.00
1120-0022				
05/04/20	30 min ind (16-37m)	90832	LW	56.50
05/11/20	30 min ind (16-37m)	90832	LW	56.50
05/18/20	45 min ind (38-52m)	90834	JS	87.00
Total for		1120-0022		200.00
1120-0097				
05/06/20	45 min ind (38-52m)	90834	JS	87.00
05/07/20	15 Min Ind	H0004	BM	23.00
05/18/20	45 min ind (38-52m)	90834	JS	87.00
05/21/20	45 min ind (38-52m)	90834	JS	87.00
05/21/20	15 Min Ind	H0004	BM	23.00
Total for		1120-0097		307.00
2419-0031				
05/07/20	30 min ind (16-37m)	90832	MP	56.50
05/12/20	15 Min Ind	H0004	DS	23.00
05/14/20	Certified PRC group/ per 15 minut	H0038	AS	9.00
05/26/20	30 min ind (16-37m)	90832	DS	56.50
05/28/20	30 min ind (16-37m)	90832	MP	56.50
Total for		2419-0031		201.50
1120-0113				
05/13/20	Intake assessment	H0001	LW	127.50
05/20/20	30 min ind (16-37m)	90832	CD	56.50
05/26/20	30 min ind (16-37m)	90832	CD	56.50
Total for		1120-0113		240.50
12420-0201				
05/06/20	45 min ind (38-52m)	90834	CD	87.00
05/06/20	30 min ind (16-37m)	90832	CD	56.50
05/20/20	15 Min Ind	H0004	CD	23.00
05/27/20	15 Min Ind	H0004	BM	69.00
05/29/20	45 min ind (38-52m)	90834	CD	87.00
Total for		A / 2420-0201		322.50
11115-0307				
05/27/20	Intake assessment	H0001	BM	127.50
Total for		11115-0307		127.50
11120-0076				
05/11/20	30 min ind (16-37m)	90832	CD	56.50
05/12/20	15 Min Ind	H0004	BM	23.00
05/18/20	45 min ind (38-52m)	90834	CD	87.00
05/22/20	15 Min Ind	H0004	CD	23.00
05/26/20	15 Min Ind	H0004	BM	46.00
05/29/20	30 min ind (16-37m)	90832	CD	56.50

	Total for	120-0076		292.00
	1117-0199			
05/04/20	60 min ind (53m+)	90837	MP	112.50
05/18/20	45 min ind (38-52m)	90834	MP	87.00
	Total for	1117-0199		199.50
	1120-0111			
05/06/20	Intake assessment	H0001	BM	127.50
	Total for	1120-0111		127.50
	1119-0343			
05/15/20	45 min ind (38-52m)	90834	JH	87.00
05/22/20	45 min ind (38-52m)	90834	JH	87.00
05/28/20	60 min ind (53m+)	90837	JH	112.50
	Total for	1119-0343		286.50
	1120-0067			
05/05/20	30 min ind (16-37m)	90832	BM	56.50
05/12/20	45 min ind (38-52m)	90834	H,M	87.00
05/12/20	15 Min Ind	H0004	BM	46.00
05/19/20	15 Min Ind	H0004	BM	46.00
05/27/20	30 min ind (16-37m)	90832	H,M	56.50
	Total for	1120-0067		292.00
	1119-0452			
05/01/20	45 min ind (38-52m)	90834	JH	87.00
05/15/20	30 min ind (16-37m)	90832	JH	56.50
05/26/20	60 min ind (53m+)	90837	JH	112.50
05/21/20	45 min ind (38-52m)	90834	JH	87.00
	Total for	1119-0452		343.00
	1119-0456			
05/06/20	30 min ind (16-37m)	90832	MP	56.50
05/13/20	30 min ind (16-37m)	90832	MP	56.50
05/20/20	45 min ind (38-52m)	90834	MP	87.00
	Total for	1119-0456		200.00
	1120-0074			
05/11/20	30 min ind (16-37m)	90832	CD	56.50
05/13/20	15 Min Ind	H0004	BM	69.00
05/18/20	45 min ind (38-52m)	90834	CD	87.00
	Total for	1120-0074		212.50
	Total for Medicaid, Payor #113			10,576.00

MPR, Payor #1440

	Carrier Categ:			
	1119-0415			
05/07/20	30 min ind (16-37m)	90832	DS	56.50
05/14/20	60 min ind (53m+)	90837	DS	112.50
05/27/20	30 min ind (16-37m)	90832	DS	56.50
	Total for	1119-0415		225.50
	1119-0261			
05/07/20	60 min ind (53m+)	90837	DS	112.50

05/20/20	30 min ind (16-37m)	90832	DS	56.50
05/28/20	60 min ind (53m+)	90837	DS	112.50
Total for		/ 1119-0261		281.50
Y / 1119-0141				
05/07/20	60 min ind (53m+)	90837	DS	112.50
05/14/20	60 min ind (53m+)	90837	DS	112.50
05/18/20	60 min ind (53m+)	90837	DS	112.50
Total for		/ 1119-0141		337.50
Total for MPR, Payor #1440				844.50
Grand Total, All Payors				\$40,133.00

Mid-Michigan Recovery Services Inc.

Mid-Michigan Recovery Services, Inc.

Transition Plan

This form is to be completed when a client is transferred to another level of care or is receiving a planned discharge from treatment.

Progress in recovery or gains achieved during program participation (i.e. sobriety, employment, housing, boundary setting, coping skills, etc.): _____

Gains achieved during program participation: _____

Support systems or other community services (i.e. 12 step meetings, church, SMART recovery, family, friends, sponsor etc.): _____

Current medications: _____

Referral information (contact name, telephone number, location, hours and days of services):

Treatment/Aftercare: _____

Case Management/PRC: _____

Medical: _____

Housing: _____

Dental/Vision: _____

Vocational: _____

Information on options and resources available if I relapse: _____

Strengths: _____

Needs: _____

Abilities: _____

Preferences: _____

Client Signature: _____ Date: _____

Counselor Signature: _____ Date: _____

**MID-MICHIGAN RECOVERY SERVICES, INC.
SUSTAINED RECOVERY PLAN**

Client Name: _____

Date: _____

Issue # _____

Goal # _____

Objective #1 _____

Objective #2 _____

Objective #3 _____

Issue # _____

Goal # _____

Objective #1 _____

Objective #2 _____

Objective #3 _____

HELPING HAND CONTRACT

At some time in my recovery I may be in a relapse process without being aware of it. Because I value your opinion, I am formally requesting that you tell me of any concerns you have regarding my sobriety at any point.

The following is a list of warning signs indicating that I might be moving back toward alcohol and/or other drug use:

1. _____
2. _____
3. _____
4. _____
5. _____

I agree to listen to your concerns. If it appears that I don't listen to your concerns and/or my behavior doesn't improve I want you to take the following steps (such as contact my sponsor or counselor, insist I return to treatment, evict me from the house, etc.):

1. _____
2. _____
3. _____
4. _____
5. _____

I agree to listen to any concerns you might have about my sobriety and to follow through with recommendations.

Client Signature

Date

Counselor Signature

Date

For Family, Friends, Others involved:

Should I notice any of these signs of relapse, I agree to speak to you about my concerns.

Signatures & Titles

Date Signed

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or other drug abuse patient



Committed to inspiring hope by providing a safe environment - teaching and modeling healthy lifestyles for all impacted by substance use disorders. **We KNOW Recovery is Possible!**

In an effort to value our own mission, we regularly ask clients to complete a brief confidential client satisfaction survey. We are committed to improving our services and goals based on this feedback as well as our personal experience with you. We are also committed to providing feedback to you regarding the information you provide. We will post the information publically for review on a regular basis.

Please complete the following information:

Group Facilitator/Counselor:

Group Time:

Individual Counselor:

Day of the week this survey was completed: MON TUE WED THU FRI SAT

Month in which this survey was completed: JAN FEB MAR APR MAY JUN JUL AUG SEPT OCT NOV DEC

The program I participated in was *(please use a separate form to survey any other group that you attend)*:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> One Day Education Course | <input type="checkbox"/> ICARUS | <input type="checkbox"/> MRT | <input type="checkbox"/> TREM |
| <input type="checkbox"/> Outpatient (OP) | <input type="checkbox"/> Intensive Outpatient (IOP) | <input type="checkbox"/> Residential (Holden) | <input type="checkbox"/> Residential (Glass) |

Please review the following survey questions by checking the answer that most closely matches your experience with us. We also encourage you to provide a brief answer where additional feedback is requested.

1 The therapists understand my individual needs and goals. Always Most of the Time Sometimes Rarely N/A

2 I feel respected by the staff of MMRS. Always Most of the Time Sometimes Rarely N/A
Please describe why or why not:

3 The staff is sensitive to my ethnic and cultural background and/or gender. Always Most of the Time Sometimes Rarely N/A
If you have concerns please explain:

- 4 I have been able to adjust my treatment as life-circumstances have changed. Always Most of the Time Sometimes Rarely N/A

Please give an example:

- 5 My rights to privacy and treatment choices have been explained to me and valued. Always Most of the Time Sometimes Rarely N/A

- 6 I believe that my individualized treatment plan is helpful and useful to my recovery. Always Most of the Time Sometimes Rarely N/A

- 7 The staff responds promptly as I express needs or concerns. Always Most of the Time Sometimes Rarely N/A

Additional comments about staff:

- 8 Would you refer someone else to come here? Yes No Maybe

Why or Why Not:

- 9 Regarding my use of alcohol or other drugs, since entering treatment I have Stopped Using Abstinence Maintained Used Less Same Use Used More

- 10 Is there anything else you would like to share with us that will help us to improve our programs and provide better service?

If you would like to be contacted directly regarding feedback please provide first name and contact number:

MID-MICHIGAN RECOVERY SERVICES, INC.
OUTPATIENT DISCHARGE PROGRESS NOTE

CLIENT NAME:

CLIENT NUMBER:

DATE:

START TIME:

END TIME:

Attendance: Attended Cancelled No Call/No Show

Comments:

Behavioral Observations:

General Behavior: Cooperative Passive Withdrawn Mute Dramatic Tearful

Argumentative Guarded Hostile Restless Bizarre Overly Cooperative Suspicious

Mood: Euthymic Sad Elevated Apathetic Euphoric Anxious Irritable

Depressed

Affect: Broad Exaggerated Labile Restricted Flat Bland

Comments:

Session Information:

- Reviewed Treatment and Provided Feedback on Treatment Progress and Barriers
- Completed Sustained Recovery Plan and Helping Hands Contract
- Completed Exit Survey
- Discussion of Recovery Activities (support group meetings, etc):
- Case Management Needs Reviewed and Referral Made if Needed
- Referral for Continued Treatment: (Individual, Change in Level of Care)
- Appointment Scheduled for Transfer of Treatment (IOP, Outpatient, Residential)
- Informed Referral Source(s) of Discharge and/or Continuing Care Plan
- Discharged from REMI
- Discharge Summary Completed
- Other:

Comments:

Treatment Plan Progress: Compliant Non-Compliant Active Participation
 Quiet/Guarded Resistance Observed

Treatment Progress Overall: Excellent Good Fair Poor Compliant

Comments:

Counselor Signature, Credentials

DATE

Mid-Michigan Recovery Services, Inc.
Discharge Summary

Client Name: [REDACTED] Client #: 1118-0191 Date: 3/5/2019
Date of Admission: 8/14/2019 Last Face to Face: 3/5/2019 Date File Closed: 3/28/2019

Reason for Discharge:	<input checked="" type="checkbox"/> Completed Tx	<input type="checkbox"/> Referred Out	<input type="checkbox"/> Client Decision	<input type="checkbox"/> Counselor Recommendation
	<input type="checkbox"/> No Contact/30 Days	<input type="checkbox"/> Transfer	<input type="checkbox"/> Incarcerated	<input type="checkbox"/> Death
	<input type="checkbox"/> Other: Click here to enter text.			

Was client employed at the time of discharge? Yes No
Permanent housing at time of discharge? Yes No
Was client a student? Yes No

Treatment program(s) in which client was involved:

Womens Group, Mixed Group, Individual

Referral source information:

RISE, 12th District Court Probation

Presenting problem:

[REDACTED] is a 28 year old Caucasian female, who is divorced and has one child. She is currently living at RISE. She is currently on probation in Jackson MI for a Retail Fraud charge in July 2017. She reports that her daughter is living with her ex-boyfriend whom is not the biological father. Prior to entering RISE, [REDACTED] was at Henry Ford Allegiance for a detox program in March 2018 then moved to the Hope House then the Sisters of Sobriety. She reports having sobriety since March 20, 2018. Her drug of choice as methamphetamines and reports a significant history with multiple substances.

Course of treatment (include identified treatment goals and progress/lack of toward those goals while in treatment)

[REDACTED] was initially placed in to twice a week outpatient groups. She was able to step out of twice a week group to once a week group by the end of December 2018. She eventually became employed full time at Peckham by the beginning of January 2019 and we decided to meet individually at this point. We met three more times individually and she struggled to make treatment a priority and stay invested. Due to having close to 1 year of sobriety and her ability to show stability with employment and managing her housing and probation requirements she was successfully completed from treatment.

[REDACTED] worked on increasing her confidence to remain substance free, developing an independent lifestyle and integrate more into the recovery community, set realistic expectations of herself, and establish healthy relationships with positive sober people. Her guilt and shame for her past use and not being the primary parent for her daughter was a significant factor in treatment. She discussed this in individual sessions. She took good steps to communicate with her daughter and her daughters care giver to set a realistic timeframe for getting custody of her daughter back. [REDACTED] also worked on maintaining boundaries with high risk people. She has trouble trusting others and this caused her to not be as open to finding supports. She has more of a mentality of her doing this alone. She was involved in an unhealthy relationship that she initially didn't want to admit that it was and later understood that she needed to set firm boundaries with this person. She was able to go to more outside meetings and by the time she ended treatment she had a positive sober friend who had a decent length of sobriety to socialize with. [REDACTED] did well in the groups to give feedback and did share about herself. I would have liked to see [REDACTED] address some underlying issues to her lack of trust in others. She struggled with relationships with females and I was happy to see that she gained a female sober support. [REDACTED] still has a tendency to cut corners or break rules if she thinks it is benefitting her or that it is not a big deal and this would be a concern moving forward. She also was in a casual relationship with a man at the time of discharge despite this person not

Mid-Michigan Recovery Services, Inc.
Discharge Summary

really offering her what she wants in relationship. [REDACTED] tends to hold her feelings close to her and has a hard time showing them to others. During the times she was emotionally charged that I worked with her she was typically covering her shame and guilt feelings towards herself for not being as far along in her life as she thought she should be.

Client's emotional, physical, and mental status at the time of treatment, during their treatment tenure, and at the time of discharge (this should include improvements as well as concerns):

Client had external motivation for treatment but was open to engaging. She had a good attitude overall however there were times when she showed irritation and frustration with counseling process when it interfered with her employment. She discussed experiencing anxiety. This was more prevalent at the beginning of treatment however she took Clonidine as needed to help address anxiety.

Medications:

Client reported that she was prescribed Clonidine .2 mg as needed.

Pregnant on discharge date? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is clt participating in prenatal care? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, who? enter text.
	Was referral made for prenatal care? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Has the client given birth while in treatment? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	If yes, was the child born drug free? <input type="checkbox"/> No <input type="checkbox"/> Yes

Education

Education Level: Grade 10	Currently in Mainstream Special Education: Not applicable (individual is over age 26)	School Attendance Status: Not applicable (Client is over age 26)
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Employment/Financial

Employment Status: Full-time competitive, integrated employment	Total Annual Income: Not reported
Number of Dependents: 1	Enrolled in SDA, SSI, or SSDI? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work/Task Hours (total in the past 2 weeks): 80	Earnings per Hours (in the past 2 weeks): \$10

Corrections/Legal Status

Corrections Related Status: Probation	Arrests in Past 30 Days: 0
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SUD Substances

Substance Rank	Substance	Route of Admin.	Frequency of Use	Age at First Use
Primary	Methamphetamine/Speed	Smoking	No use in the past month	27
Secondary				
Tertiary				

Diagnostic Impressions at time of Discharge

F11.21	Opioid Use Disorder; Severe in sustained remission
F15.21	Amphetamine-type Use Disorder, Severe, in sustained remission
	R/O Mood Disorder – She was prescribed medication for anxiety

Mid-Michigan Recovery Services, Inc.
Discharge Summary

S/N/A/P

Strengths: RISE housing, employment, daughter, meeting attendance, sober friend	Abilities: Strong willed, Has insight, Will speak up
Needs: Housing after RISE, sober support in community, stronger relationships with women	Preferences: NA AA, Group, Individual

Prognosis: Very Good Good Fair Poor Very Poor

As Evidenced By: : Client has remained sober throughout multiple sober living programs in different areas of MI. She shows a strong internal motivation for staying sober and is also on probation and has accountability to remain sober. She can struggle to open up about her real feels and show vulnerability with others. She has more sober support and is engaged with 12 step meetings. She has employment and is focused on getting her own housing to have her daughter with her more.

Recommendations for follow up/continuing care/treatment, and reasons for recommendations:

Maintain meeting attendance. Maintain support with sober people, specifically women. Continue to follow up with PCP for mood management.

Referral Agency/Aftercare Program (if needed)

NA

Reason for Transfer:

NA

**Transition Plan
Follow Up:**

Confirmed client's transfer
 Client refused to follow recommendation

Left message for referral agency
 Other: Click here to enter text.

Left message with client

Counselor Signature: _____

Date: _____

1. SUD Discharge: Discharge Information

Identifying Information

First Name [REDACTED]	Middle Name	Last Name [REDACTED]
SSN [REDACTED]	Date of Birth 11/06/1954	Gender <input type="radio"/> Female <input checked="" type="radio"/> Male <input type="radio"/> Unknown
Address [REDACTED]		Primary Phone [REDACTED]
City Lansing	State MI	Zip 48915
Medicaid ID # lookup	Medicare ID	Alternate Phone
		County of Residence Ingham

Service / Treatment Information

Admission Date 06/10/2020	Provider / Licensed Site Mid-Michigan Recovery Services - Outpatient (License #: 0330001)	
Discharge Date 07/04/2020	Discharge Time 11:00PM	Last Adjudicated Service Date 07/04/2020
Provider / Responsible CMHSP Mid-Michigan Recovery Services - Outpatient		
Reason for Discharge / Service End Dropped out of treatment		
Type Of Treatment Service Setting Ambulatory - Outpatient		
Codependent/Collateral Person Served ? <input checked="" type="radio"/> Client <input type="radio"/> Codependent/collateral individual		

Pregnant on Discharge Date

Yes No

Has the client given birth while in treatment?

Yes No

Designations

I/DD Designation

Yes No Not Evaluated

MI or SED Designation

Yes No Not Evaluated

Co-occurring Disorder/Integrated Substance Use and Mental Health Treatment [?](#)

- Yes, client with co-occurring SU and MH problems is being treated with an integrated Tx plan by an integrated team
- No, client does NOT have a co-occurring SU and MH problem
- Client with co-occurring SU and MH problems is NOT currently receiving integrated treatment
- Not collected (crisis only, unknown, other exception, etc.)

Education
 Education Level
 Grade 12 or GED
 Currently in Mainstream Special Education School Attendance Status
 Not applicable Not applicable

Residential Living Arrangement
 Living Arrangements
 Independent living (SUD)

Employment / Financial
Employment Status
 Not in competitive, integrated labor force
 Detailed 'Not in Competitive, Integrated Labor Force'
 Individual's current disability symptoms prevents him/her from competitively or non-competitively working.
 Minimum Wage
 N/A - Individual is not working
 Total Annual Income
 \$ 0
 Number Of Dependents
 1
 Enrolled in SDA, SSI or SSDI
 Yes No
 Work/Task Hours (total in the past 2 weeks)
 N/A for selected employment status
 Earnings per Hour (in the past 2 weeks)
 N/A for selected employment status

Corrections / Legal Status
 Corrections Related Status
 Probation
 Arrests in Past 30 Days
 0

Women's Specialty Services
 Is client eligible for Women's Specialty Services?
 Yes No

SUD Substances (SA or MH/Integrated Tx episodes)

Substance Rank	Substance	Route of Administration	Frequency of Use	Age at First Use
Primary	Cocaine / Crack	Smoking	No use in the past month	14
Secondary	Heroin	Injection	No use in the past month	14
Tertiary				

Attendance at Substance Use Self-Help Groups in past 30 Days
 No attendance

Diagnosis

F14.21	Cocaine Use Disorder, Severe, in early or sustained remission	<input type="radio"/> MH <input checked="" type="radio"/> SUD	<input checked="" type="checkbox"/> Primary SUD Diagnosis
F11.21	Opioid Use Disorder, Severe, in early or sustained remission	<input type="radio"/> MH <input checked="" type="radio"/> SUD	<input type="checkbox"/> Primary SUD Diagnosis

Notes
 Client was discharged from his transitional housing program due to rule violation. It appeared that he may have been trying to obtain substances to sell. Client had brief phone contact once with counselor after that and reported that he was not staying in the area and did not disclose events that lead to him moving. He was asked if he has used substances and he denied. Several attempts were made to reach him via phone and client did not return calls. Attempts were not made to reach him via mail as there wasn't a valid address on file for him.

Status Active / Finalized	Submission Status Accepted
Record Added dgwizdala 08/18/2020 01:44:06 PM	Record Changed dgwizdala 08/18/2020 01:44:06 PM
<input type="button" value="Continue to Signatures"/>	<input type="button" value="Cancel"/>

Letter to Client.

[DATE]

IMPORTANT NOTICE

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2).

The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2.

A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

[NAME]:

This letter is to confirm that you have completed outpatient substance abuse treatment with Mid-Michigan Recovery Services. You started counseling services on [FIRST SESSION DATE] and had your last individual session on [LAST SESSION DATE]. You were involved in [GROUPS INDIVIDUAL ATTENDED] and individual counseling throughout your time in outpatient treatment. You have demonstrated a good ability to maintain sobriety and have taken many positive steps to stabilize your life for yourself and your family.

Thank you for choosing Mid-Michigan Recovery Services for your treatment needs. Please feel free to contact us in the future if there is anything more you need.

Sincerely,

[CLINICIAN NAME, CRIDENTIALS]

Substance Abuse Counselor
Mid-Michigan Recovery Services
Phone: (517) 887-0226
Fax (517) 887-8121

Letter to Referral Source

IMPORTANT NOTICE

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

[DATE]

[TO WHOM IT MAY CONCERN]
[ADDRESS]

RE: [CLIENTS NAME]

Dear [TO WHOM IT MAY CONCERN],:

This letter is to confirm that [CLIENTS NAME] completed substance abuse treatment with Mid-Michigan Recovery Services. She started services on [DATE CLIENT STARTED SERVICES] and had her last appointment on [DATE CLIENT ENDED SERVICES]

If you have any questions, please feel free to contact me at (517) 887-0226.

Sincerely,

[CLINICIAN NAME, CREDENTIALS]

Substance Abuse Counselor
Mid-Michigan Recovery Services
Phone: (517) 887-0226
Fax (517) 887-8121