

Advanced Behavioral Health
Access to Recovery II
Intake Assessment

Demographics

Name: _____ Phone: () _____ - _____
Address: _____ City _____ Zip _____
Social Security #: _____ - _____ - _____ Date of birth: ___/___/___ Veteran: No Yes
Marital status: Single Co-habiting Married Separated Divorced Widowed
Emergency contact: _____ Phone: () _____ - _____ Relationship: _____
Emergency contact address/alternate address: _____

SAGA Status

EMS #: _____ Status: _____ Is address current? No Yes Accepted? No Yes
Does case need to be transferred from another region? No Yes Comments: _____

Legal Status

Name of probation officer: _____ Name of parole officer: _____
Outstanding charges: _____ Pending court dates: _____ Court location: _____

Current Behavioral Health Treatment Status

Current provider: _____ Admission date: _____ Clinician: _____
Phone#: () _____ - _____ Type: MH SA Co-occurring Methadone Reason for admission: _____
Meds prescribed during current treatment: _____ Do you attend AA/NA? _____
What is the most recent period of use? _____
What is longest period of sobriety or stability? _____ Last period sobriety/stability: _____
Comments: _____

Medical

Current medical problems: No Yes Explain: _____
Comments: _____

Entitlements

Refer for other entitlements? No Yes Title 19 Social Security Disability (SSD) Supplemental Security Income (SSI)

Family and Supports

Current relationship with family members: _____

Current Support System: _____

Client's Words

Client's reported Identified issue: _____

Are you interested in maintaining a sober lifestyle? No Yes Not sure

Identified triggers to relapse? _____

What are your strengths? _____

Short-term goal: _____

What are the barriers to your goals?: _____

What assistance/support do you need to reach these goals? _____

What is your preference for services? _____

Is there anything else you can tell us about yourself that would assist us in helping you meet your initially stated goals?

Agreed Upon Case Management Services for Initial Recovery Plan

Initial Screening Summary Plan:

1. Treatment linkages: Yes No

Agreed upon Treatment Level of Care: _____

Agency: _____ Anticipated admit date: _____

2. Engagement in exploring a treatment option? No Yes

8. Vocational referral: No Yes

3. Relapse prevention? No Yes

9. Educational referral: No Yes

4. Sober housing referrals? No Yes

10. Medical referral: No Yes

5. Entitlement assistance? No Yes

11. Legal referral: No Yes

6. Transportation assistance? No Yes

12. Recovery supports assistance? No Yes

7. Advocacy ? No Yes

13. Agreed upon accepting case management outreach services? No Yes

14. Agreed upon meeting schedule with case manager for monitoring? No Yes

15. Other: No Yes _____