Central Care Mission of Orlando

Pre-Screening Survey

Name:

Do you have any health conditions that require treatment of any kind, including medication? For example, Diabetes, Asthma, Hepatitis C, HIV Positive, etc.

Do you have any sexual crime convictions?

Are you physically able to work?

Do you have any physical limitations? Is there anything you can't do because of your health?

Do you have any outstanding legal obligations (probation, court dates, warrants, etc.)?

(On this portion of the intake packet—only input a name and date)

NAME:

Application Process	**[Initials]**
Interview with client; review rules and financial agreement	*Case Manager:* _____
CHR – Chemical History Report	*Case Manager:* _____
ASAM – Detox assessment for placement	*Case Manager:* _____
Send text or e-mail to staff with client's name	*Case Manager:* _____
Once Accepted	**[Initials]**
All electronics should be taken and stored	*Case Manager:* _____
Collect medication as well as any prescriptions	*Case Manager:* _____
Collect any cash or credit/debit cards	*Case Manager:* _____
I.D. assessment – what does the client need?	*Case Manager:* _____
Present the client with a *Letter of Residency*	*Case Manager:* _____
Biopsychosocial Packet	*Case Manager:* _____
Issue a journal, phase checklist, and book to the client; *CCM Initial Treatment Plan*	*Case Manager:* _____
Administer a drug test	*Case Manager:* _____
Assign to a phase group for class placement	*Case Manager:* _____
Intake	**[Initials]**

Intake packet is complete, and all forms are signed	*Case Manager:* _____
Transfer client data to Apricot	*Case Manager:* _____
Make copies of client's Driver's License and Social Security Card	*Case Manager:* _____ *Job Coordinator:* _____
Search client's property; search all items by emptying bags and backpacks*	*Support Admin:* _____ *House Man:* _____
Assign client linen, laundry, and hygiene products	*Support Admin:* _____ *House Man:* _____
Introduce client to the program with a brief orientation	*Support Admin:* _____ *House Man:* _____
*Note: One small gym bag of clothes is the limit for personal use; three pairs of shoes maximum (1 for work, 1 for church, 1 for casual)	*Support Admin:* _____ *House Man:* _____
*Note: All clothing should be put in the laundry with hot water followed by the dryer for 1 hour on high heat to kill possible bed bugs	*Support Admin:* _____ *House Man:* _____
*Note: If needed; shoes, bag, and luggage should be put into a black garbage bag, tied up, and put into the sun for 4 hours with paper towels soaked in rubbing alcohol	*Support Admin:* _____ *House Man:* _____
Mission Clerk	**[Initials]**
Food Stamp registration (SNAP)	*Support Staff:* _____
Notary	**[Initials]**
Notarize legal paperwork	*Notary:* _____
SENIOR STAFF SIGNATURE	_____

Limited Power of Attorney

(*to be executed upon admittance to CCM*)

Know all by these present:

That the undersigned, _____ does hereby appoint Spencer T. Pfleiderer, President of Central Care Mission, as his/her attorney to receive, endorse, and collect payroll checks and/or debit card payroll funds received by Central Care Mission from Team Staffing, Select Staffing, and any staffing agency or person employing for work performed while the undersigned is a client of Central Care Mission, made payable in favor of _____, and to give full discharge for same; hereby ratifying and confirming all that said attorney shall lawfully do or cause to be done by virtue hereof.

WITNESS the signature of the undersigned, this _____ day of _____, 2018.

_____

(*Signature of grantor*)

_____

(*Signature of witness*)

Personally appeared before me the above-named _____, known or proved to me to be the same person who executed the foregoing instrument, and acknowledged to me that he executed the same as his free act and deed. WITNESS my signature, official designation, and seal.

_____

[**IMPRESS SEAL HERE**] (*Signature of attesting officer*)

To: Central Care Mission Clients

From: Spence Pfleiderer, *CEO and President*

To Our New Clients,

Welcome to Central Care Mission,

Central Care Mission has been providing care to men in need for over 30 years. Our staff and leadership team are committed to your successful completion of the program. Central Care Mission operates on an annual budget determined by its President and CEO along with the Board of Directors.

Congratulations! You have made a commitment to recovery and renewal that will lead to your transition back to the community of your choice once you have completed the phased recovery program. Part of that program requires you to address financial issues in your life; debt, probation, court costs, child support, and back taxes to name a few. Our purpose is to create and maintain a clean, safe environment for all of our clients. In order to accomplish this goal, we currently charge $155 per week to each client. Although we require no money to enter into the program, a one-time fee of $135 to your account is assessed upon entry, to be deducted on top of the first week's program fees of $155. It is necessary that you work in order to afford your time in the program.

As you enter into the program, you are also entering into an agreement with Central Care Mission. You agree to turn all personal finances over to the care and management of the Director of Operations; all income, including income tax returns, are to be submitted through the proper channels upon receipt. The Director will assist you in meeting your financial obligations and help you start a savings account as you progress through the program. You also agree to a minimum commitment of 1-year for program fees that are due during the first year of the program. If you leave the Mission or have been asked to leave the mission for any reason prior to your 1-year commitment, you will forfeit $1,000.00 of any remaining savings as payment of any outstanding annual program fees due at the time of your departure. If you choose on your own accord to leave Central Care Mission and do not return to claim the balance of your savings within 30 calendar days all funds will be returned to Central Care Mission.

This agreement is put in place to ensure that you are committed to this program. CCM relies on client program fees for approximately one third of the total operating budget annually. If you have any questions, please ask the Director of Operations before you sign this agreement.

I, _____ fully agree to the terms listed above and will abide by it to the fullest.

Signature: _____ Date: _____

Kindest Regards,

Spence Pfleiderer*, President and CEO*

Central Care Mission, *Board of Directors*

Partnership Agreement

Central Care Mission has partnerships with many private employers. This is includes, but is not limited to: Accounts Receivable Inc, Ace Staffing, All Glass Construction Inc, All Wood Construction Inc, Coleman-Allied Moving, Dynamic Tours Inc, Fence Outlet, GAG Pest Control, Gary's Glass, GEM Supply, KBI Staffing, Labor for Hire Inc, Jack Jennings & Sons Inc., Mid-State Plumbing, McCree General Contractors, Team Staffing Inc, Titan Electric, and TNG Inc. By working at one of these employers, you understand that you job is tied to Central Care Mission. This means that if you leave the mission, you will no longer hold your position at one of these employers. By signing this document, you understand and fully agree to these terms.

Accepted and Agreed:

Client Name (Printed): _____

Client Signature: _____

Date: _____

Witness Name (Printed): _____

Witness Signature: _____

Date: _____

Authorization to Release Paychecks and Security Pledge

(*to be signed upon acceptance into CCM*)

I, _____, hereby authorize and agree that Team Staffing, Ace Staffing, or other staffing agencies may release any and all paychecks of the undersigned, earned while the undersigned was a client of Central Care Mission, to an authorized representative of Central Care Mission. This authorization shall remain in force and effect and apply to any paycheck made payable to the undersigned for work performed while the undersigned was a client of Central Care Mission, notwithstanding the fact that the undersigned may no longer be a client.

The undersigned pledges to Central Care Mission that all paychecks and wages made payable to the undersigned and earned by the undersigned while a client of Central Care Mission should be used as a security deposit of payment for all fees and costs owed to Central Care Mission.

The undersigned releases and holds harmless all staffing agencies from any claim of liability arising out of the staffing agency delivering the undersigned's paychecks to Central Care Mission in accordance with the terms of the agreement.

Accepted and Agreed:

Client Name (Printed): _____

Client Signature: _____

Date: _____

Client Waiver and Release from Liability

(*to be signed upon acceptance into CCM*)

I, _____, for, and in exchange of fair consideration, the receipt of which is acknowledged, hereby waive and release, indemnify, hold harmless, and forever discharge Central Care Mission of Orlando, Inc. ("Central Care Mission") and its agents, employees, officers, directors, representatives, successors, assigns and agents of and from any and all claims, debts, costs, demands, contracts, expenses, causes of action, lawsuits, damages, and liabilities of every kind and nature whatsoever, whether known or unknown, in law or equity, that I ever had or may have, arising from or in a way related to my participation in any of the events, activities or fundraisers conducted by Central Care Mission on the premises of Central Care Mission or elsewhere conducted for the benefit of Central Care Mission or associated with the Central Care Mission program.

By this waiver and release I agree to assume any and all risk associated with such event, activity or fund raiser and I take full responsibility for my actions arising out of my involvement in such activities, events or fundraisers.

I sign this document freely and of my own accord and not under any duress or threat of duress, without inducement or harassment. I certify that I am over the age of 18, a United States citizen, and am legally authorized to sign this document on my own behalf.

Accepted and Agreed:

Client Name (Printed): _____

Client Signature: _____

Date: _____

Keith B. Vennum, MD

Psycho-pharmacology Medicine and Mental Health Counseling

(Patient Authorization for Release of Health Records to External Parties)

I authorize ***Keith B. Vennum*** to disclose information from the health records of: (*Client Name*)

_____

Date of Birth: _____

The information contained in this form is to be disclosed to Central Care Mission, Spence Pfleiderer, and whoever he may designate regarding the dispensing and control of medications at Central Care Mission

Address: 4027 Lenox Blvd., Orlando, Florida 32811

I authorize this information to be disclosed in the following ways:

Written/Photocopy/Paper

Verbal

Fax

Electronic Mail

Purpose of this disclosure: Dispensing of medication and coordination of care while a client of Central Care Mission

Dates of Treatment:

From: _____ **To:** _____

Specific reports to be disclosed:

Progress Notes

Laboratory Reports

Discharge Summary

Radiology Reports

Consultation Reports

X-ray Films or Other Images

Photographs/Videotapes

Records from other facilities

Entire Health Records (Including, but not limited to; information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities)

Other: _____

I give specific authorization to disclose the following information:

HIV Test Results

Documentation of AIDS Diagnosis

Drug and Alcohol Abuse Treatment Records

Psychiatric/Mental Health Treatment Records

1) I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying Keith B. Vennum, MD in writing.

2) My treatment will not be based on the completion of this authorized form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Florida privacy regulations.

Unless revoked earlier, this authorization expires in one year unless I specify another time:

Specified Date: _____

I release the individuals or organizations named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

Signature of Patient (*or Patient Representative*): _____

Date: _____

Printed Name of Patient (*or Patient Representative*): _____

Authority of Representative to act for Patient (*Relationship to Patient*): _____

Consent to Background Check

In connection with your program participation, residency and/or employment with Central Care Mission of Orlando, Inc., notice is hereby given that a consumer report and/or investigative consumer report may be obtained from a consumer reporting agency for program participation or employment purposes. These reports may contain information about your character, general reputation, personal characteristics and mode of living, whichever are applicable. They may involve personal interviews with sources such as your neighbors, friends, or associates. The reports may also contain information about you relating to your criminal history, credit history, driving and/or motor vehicle records, education or employment history, or other background checks.

You have the right, upon written request made within a reasonable time after the receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report prepared by contacting Central Care Mission and Protect My Ministry (14499 N. Dale Mabry Hwy., Suite 201 South, Tampa, FL 33618; Phone: 1-800-319-5518). For information about Protect My Ministry's privacy practices, see www.protectmyministry.com. The scope of this notice and below authorization is not limited to the present and, if you are hired or granted residency, will continue throughout the course of your employment and boarding, allowing Central Care Mission to conduct future screenings for retention, promotion, or reassignment, as permitted by law and unless revoked by you in writing.

Acknowledgement and Authorization

By signing below, I hereby authorize the obtaining of consumer reports and/or investigative consumer reports by Central Care Mission at any time after receipt of this authorization and throughout the course of my employment and residency, if applicable.

Print Name: _____

Signature: _____

Last Four Digits of SSN: _____

Date: _____

Background Check Information

(*required upon admittance to CCM*)

First Name: _____

Middle Name: _____

Last Name: _____

Mother's Maiden Name: _____

Other Names Used: _____

Date of Birth: _____

Gender: **Male / Female**

Social Security Number: _____

Ethnicity (circle one):

White

Black/African American

Hispanic

Asian/Pacific Islander

Alaskan Native/American Indian

Driver's License or I.D. #: _____

Date License was Issued: _____

Address: _____

City: _____

State/Zip: _____

E-Mail Address: _____

Basic Information

Intake Date: _____

Name:_____

Social Security Number: _____

Age:_____

Date of Birth:_____

Place of Birth:_____

Phone Number: _____

Ethnicity: _____

How tall are you? _____

*How much do you weigh?*_____

What is the color of your hair? _____

*What are the color of your eyes?*_____

Do you have any tattoos? Where are they located?

_____

List another program you've previously been enrolled in:

_____

_____

Did you graduate your previous treatment program(s)?

_____

How did you hear about Central Care Mission?

_____

_____

Were you referred to CCM by Compassion Corner or Goodnews Breakfast?

_____

_____

*What is your **1st** drug of choice?*

_____

*What is your **2nd** drug of choice?*

_____

*What is your **3rd** drug of choice?*

_____

PLEASE LIST SOMEONE WE MAY CONTACT IN THE CASE OF AN EMERGENCY
(Emergency Contact Information)

Name: _____

Number: _____

Relation: _____

Personal History

Please circle 'YES' or 'NO' to the applicable items listed:	
You have never finished ***high school*** or completed your ***GED***:	**YES / NO**
You have received your ***high school diploma*** or ***GED***:	**YES / NO**
You have received your ***AA Degree***:	**YES / NO**
You have received your ***BS Degree***:	**YES / NO**
You have received your ***MA Degree***:	**YES / NO**
Are you currently working?	**YES / NO**
Do you have a valid Driver's License?	**YES / NO**
Are you registered to vote?	**YES / NO**
Do you smoke tobacco, vape, or dip?	**YES / NO**
Were you living with family prior to CCM?	**YES / NO**
Were you living with friends prior to CCM?	**YES / NO**
Were you homeless prior to CCM?	**YES / NO**
Were you in another shelter or program prior to CCM?	**YES / NO**
Were you in the hospital or a mental health facility prior to CCM?	**YES / NO**
Were you in jail or prison prior to CCM?	**YES / NO**
(Note: If you are not currently paying a legal lease/rent in your name then you are technically homeless)	
Are you currently homeless?	**YES / NO**
If you're currently homeless, 1st time?	**YES / NO**
If you're currently homeless, 2nd time?	**YES / NO**
If you're currently homeless, 3rd time?	**YES / NO**
If you're currently homeless, 4th time?	**YES / NO**
If you're currently homeless, 5th time?	**YES / NO**

What is the time frame to the nearest month you've been homeless for?

_____

What state have you spent the most time in?

_____

Family & Benefits

What is your current marital status? _____	Have you been divorced? How many times? _____	Number of mothers to biological children? _____
Are you required to pay child support? YES / NO	If you owe child support, how much per month? _____	How many children do you have? _____
Are you estranged from family? YES / NO	Were you raised in foster care? YES / NO	Were you raised by a single parent? YES / NO
Are your parents divorced? YES / NO	Was your parent a drug addict, homeless, or alcoholic? YES / NO	Are you a victim of family violence or abuse? YES / NO

Are you a Veteran? Yes / No	Are you receiving VA benefits? Yes / No	Are you receiving food stamps? (SNAP) Yes / No
What is your benefit coverage? _____	Are you receiving SSI, SSDI, or other benefits besides the VA? List here: _____	If you receive SSI, SSDI, or other benefits, list financial details: _____

Do you have any pending medical or dental appointments?	**YES / NO**
If you have any pending medical or dental appointments, list the details: _____	
Are you currently taking any medication?	**YES / NO**
What medication do you need that you aren't taking? _____	
List the name(s) of medication you are currently taking: _____	
Do you have a physical or mental disability?	**YES / NO**
If you have a physical or mental disability, list the details: _____	
Please circle 'YES' or 'NO' to any of the applicable conditions listed:	
You have experienced or are experiencing ***Schizophrenia***:	**YES / NO**
You have experienced or are experiencing ***Depression*****:**	**YES / NO**
You have experienced or are experiencing ***Anxiety*****:**	**YES / NO**
You have experienced or are experiencing ***Bi-Polar*****:**	**YES / NO**

You have experienced or are experiencing ***Paranoia*:**	**YES / NO**
You have experienced or are experiencing ***Attention Deficit Disorder*:**	**YES / NO**
You have experienced or are experiencing ***Hyperactivity*:**	**YES / NO**
You have experienced or are experiencing ***Anger Issues*:**	**YES / NO**
You have experienced or are experiencing ***Hypertension*:**	**YES / NO**
You have experienced or are experiencing ***Obsessive Compulsive Disorder*:**	**YES / NO**
You have experienced or are experiencing ***PTSD*:**	**YES / NO**

Other: _____

Please circle 'YES' or 'NO' to any of the applicable diseases listed:

You have ***no diseases***:	**YES / NO**
You have ***HIV/AIDS***:	**YES / NO**
You have ***STD's***:	**YES / NO**
You have ***HEP C***:	**YES / NO**

Other: _____

Legal

Have you been convicted of a misdemeanor? **YES / NO**	**Have you been convicted of a felony?** **YES / NO**	**Do you have any pending court dates or charges?** **YES / NO**
Are you on probation? **YES / NO**	**Please list your Probation Officer's name and number:** _____	**Were you in jail prior to your 18th birthday?** **YES / NO**

When and where have you been incarcerated?

_____

Please circle 'YES' or 'NO' to the applicable charges listed:

Have you ever been charged or convicted of ***Domestic Violence*****?**	**YES / NO**
Have you ever been charged or convicted of a ***DUI***?	**YES / NO**
Have you ever been charged or convicted of ***Assault***?	**YES / NO**
Have you ever been charged or convicted of ***Battery***?	**YES / NO**
Have you ever been charged or convicted of ***Fraud***?	**YES / NO**
Have you ever been charged or convicted of ***Theft***?	**YES / NO**
Have you ever been charged or convicted of ***Murder***?	**YES / NO**
Have you ever been charged or convicted of ***Man Slaughter***?	**YES / NO**
Have you ever been charged or convicted of ***Trespassing/Camping***?	**YES / NO**
Have you ever been charged or convicted of ***Possession***?	**YES / NO**

Other:

_____

Job Information

Name:_____

Date of Intake:_____

Driver's License: YES / NO

State of Driver's License: _____

Driver's License Number: _____

Social Security Card: YES / NO

Work Boots: YES / NO

Steel Toe: YES / NO

If you have felonies list the details; if not, please write 'not applicable':

_____

_____

_____

Work Skills (i.e. Carpentry)

_____

_____

_____

_____

_____

Notes (i.e. Disabilities)

_____

Chemical History

Type of Drug	Date First Used	Amount Per Day	Duration	MG Per Day
Vicodin (OPIATE, LESSER)				
Percocet (OPIATE, LESSER)				
Percodan (OPIATE, LESSER)				
Oxycodone (OPIATE, LESSER)				
Hydrocodone (OPIATE, LESSER)				
Lortab (OPIATE, LESSER)				
Darvocet (OPIATE, LESSER)				
OxyContin (OPIATE, TIME RELEASE)				
Roxicodone (OPIATE, TIME RELEASE)				
MS-Contin (OPIATE, TIME RELEASE)				
Dilaudid (OPIATE, TIME RELEASE)				
Fentanyl (OPIATE, TIME RELEASE)				
Methadone (OPIATE, TIME RELEASE)				
Xanax (BENZODIAZEPINE)				
Valium (BENZODIAZEPINE)				
Klonopin (BENZODIAZEPINE)				
Soma (BENZODIAZEPINE)				
Morphine				
Heroin				
Cocaine				
THC				
Alcohol				
Nicotine				

Treatment and Detox History

Date	Program Type (Inpatient/Outpatient)	Reason for Admission

Criteria for referral to detox or treatment program:

- Multiple substance abuser; combination of 3 substances such as opiates, benzo's, and soma
- If patient stops drinking, they get delirium tremens (shaking, confusion, hallucinations)
- Opiate levels are above 300mg per day or methadone levels of over 30mg per day
- Major health issues such as heart, lung, kidney, or liver problems

ASAM LEVEL III: ADMISSION CRITERIA

Dimensions	**Client Name:** _____	**Client Identification Number:** _____	**Date:** _____	
Instructions:	Circle all items in each dimension that apply to the client's situation. Place a check in the "yes" or "no" box that indicates validation or lack of validation for placement into this level of care.		YES	NO
ASAM Requirements	Must meet at least Dimensions 2 and 3 and if problems exist and does not require exclusion from the level of care then at least two of the six dimensions. Transfer criteria: Clients may be transferred to this level of care when they have met essential treatment objectives in a more intensive level and require this intensity of service provided at this level of care in at least one dimension. A client may transfer from Level I when services at that level have been insufficient to address the client's needs or when Level I has consisted of motivational interventions to prepare the client for participation in a more intensive level of care for which admission criteria are met.			
Dimension 1: Alcohol Intoxication and/or Withdrawal Potential	The client's status in this dimension is characterized by one of the following: a) Client is free from intoxication or withdrawal symptoms/risks; or b) The risk of withdrawal is present, as evidenced by a history of current alcohol/other drug use or a high index of suspicion of such use. However, withdrawal is manageable in this level			
Dimension 2: Biomedical Conditions and Complications	The client's status in this dimension is characterized by one of the following: a) The client's continued alcohol/other drug use places the client in imminent danger of serious damage to his or her physical health or concomitant biomedical conditions (such as pregnancy); or b) Biomedical complications require medical monitoring or concurrent biomedical illness requires medical monitoring but not acute medical care.			
Dimension 3: Emotional/Behavioral Conditions and Complications	The client' history indicates cognitive development of at least 11 years of age and significant impairment of social, interpersonal, occupational, and/or educational functioning, as evidenced by one of the following: a) The client is currently unable to maintain behavioral stability for more than a 48-hour period as evidenced by negative emotions, distractibility, or generalized anxiety; or b) The client is at mild to moderate risk of behaviors endangering self or others (e.g., current suicidal or homicidal thoughts with no active plan but with a history of suicidal or homicidal threats); or c) The client has a psychiatric diagnosis that requires management concurrent with the treatment of addiction (such as Attention Deficit Hyperactivity Disorder, Depression, Conduct Disorder, etc.); or d. The client's behaviors are sufficiently chronic and/or disruptive that they require separation from his/her current environment.			
Dimension 4: Treatment Acceptance/Resistance	The client is having difficulty acknowledging his/her addiction problems and attributes alcohol/drug problems to other people or external events. The client thus requires structured therapy and a programmatic milieu to receive clinically directed and repeated motivational interventions. The client's resistance however is not so high to render the treatment ineffective.			
Dimension 5: Relapse/Continued Use Potential	The client's status in this dimension is characterized by one of the following: a) The client is experiencing an intensification of addiction symptoms (such as craving and drug seeking behavior) with associated moderate risk of relapse; or			

	b) The client recognizes that his/her alcohol/other drug use is excessive and has attempted to reduce or control it but has been unable to do so as long as alcohol/other drugs are present in his/her environment; or c) If abstinent, the client is experiencing an acute crisis and appears to be in imminent danger of using alcohol/other drugs.		
Dimension 6: Recovery Environment	The client's status in this dimension is characterized by one of the following: a) The client's environment is not conducive to successful treatment at less intensive levels of care; or b) The client's parent(s) or legal guardian(s) are unable to provide the consistent participation necessary to support treatment at less intensive levels or care; or c) Logistical impediments (e.g. lack of public transportation or parent's inability or refusal to provide transportation) preclude participation in treatment at less intensive levels of care; or d) there is danger of physical, sexual, and/or severe emotional attack or victimization in the client's current living environment, which make recovery unlikely. Thus, the client must be removed from that environment.		
Counselor Name: _____ **Counselor Signature/Credential: _____**		**Date:** **_____**	

Recommendations/Notes:	

ASAM LEVEL III: CONTINUED STAY CRITERIA

Dimensions	**Client Name:** _____	**Client Identification Number:** _____	**Date:** _____	
Instructions:	Circle all items in each dimension that apply to the client's situation. Place a check in the "yes" or "no" box that indicates validation or lack of validation for placement into this level of care.		YES	NO
ASAM Requirements	Must meet one of Dimensions 1-6.			
Dimension 1: Alcohol Intoxication and/or Withdrawal Potential	Client is free from intoxication or withdrawal symptoms/risks.			
Dimension 2: Biomedical Conditions and Complications	The client's status in this dimension is characterized by one of the following: a) The client's biomedical conditions, if any, are stable or are being currently addressed and do not interfere with treatment; or b) The client is responding to treatment for biomedical conditions that are not severe enough to warrant inpatient treatment yet distract from recovery efforts. Such conditions require medical monitoring and/or medical management, which can be provided by the program or through a concurrent arrangement with another treatment provider.			
Dimension 3: Emotional/Behavioral Conditions and Complications	The client's status in this dimension is characterized by one of the following: a) The client is making progress toward resolution of an emotional/behavioral condition, but he or she has not resolved the condition(s) sufficiently to allow discharge or transfer to a less intensive level of care; or b) The client continues to display significant depression, with thoughts of self-harm, but is making progress in achieving treatment objectives; or c) The client is being held pending transfer within 72 hours to an acute psychiatric inpatient service; or d) The client manifests continued recurrent impulsive behavior (angry outbursts, withdrawal from social contacts, violation of program expectations), which is slowing, but is not preventing progress in treatment; or e) The client manifests continued risk of severe self-defeating behaviors, such as running away, return to victimization or a return to illegal drug activities; however, he/she is making progress in achieving treatment objectives.			
Dimension 4: Treatment Acceptance/Resistance	The client recognizes that he/she has an alcohol/other drug problem and is responding to treatment but has not demonstrated behaviors indicative of the problem-solving or social skills necessary to cope with the problem.			
Dimension 5: Relapse/Continued Use Potential	The client's status in this dimension is characterized by one of the following: a) The client exhibits moderate intensification of addiction-symptoms (such as difficulty postponing gratification and related drug seeking behaviors) which would jeopardize his or her ability to respond to treatment in a less intensive level of care; or b) The client recognizes relapse triggers or dysfunctional behaviors that previously have undermined sobriety but demonstrated minimal			

	understanding of his/her self-defeating responses to such triggers or use of such dysfunctional behavior; however, the client is progressing in treatment; or c) The client recognizes relapse triggers or dysfunctional behaviors that previously have undermined sobriety but does not demonstrate the skills necessary to interrupt such behaviors and apply the alternative coping skills needed to maintain ongoing abstinence.		
Dimension 6: Recovery Environment	The client's status in this dimension is characterized by one of the following: a) Problem aspects of the client's social and interpersonal environment are responding to treatment but are not sufficiently resolved to support recovery. Thus, the client is not ready for discharge or transfer to a less intensive level of care; or b) The client's social or interpersonal environment has not changed or has deteriorated, and the client needs additional treatment to learn to cope with the current situation or to take steps to secure an alternative environment.		
Counselor Name: _____ **Counselor Signature/Credential: _____**		**Date:** **_____**	

Recommendations/Notes:	

ASAM LEVEL III: DISCHARGE & TRANSFER

Dimensions	Client Name: _____	Date: _____	
Instructions:	Circle all items in each dimension that apply to the client's situation. Place a check in the "yes" or "no" box that indicates validation or lack of validation for placement into this level of care.	YES	NO
ASAM Requirements	Meets diagnostic criteria in one of Dimensions 1-6.		
Dimension 1: Alcohol Intoxication and/or Withdrawal Potential	The client's status in this dimension is characterized by one of the following: a) Client is free from intoxication or withdrawal symptoms/risks; or b) The client exhibits sym ptoms of severe intoxication and/or withdrawal which cannot be safely managed at this level of care.		
Dimension 2: Biomedical Conditions and Complications	The client's status in this dimension is characterized by one of the following: a) The client's biomedical conditions, if any, have diminished or stabilized to the extent they can be managed through outpatient appointments at a less intensive level of care, and the client does not meet any of the continued stay criteria in this or another dimension that indicates the need for further treatment; or b) The client has a biomedical condition that is interfering with addiction treatment that requires treatment in another setting.		
Dimension 3: Emotional/Behavioral Conditions and Complications	The client's status in this dimension is characterized by one of the following: a) The client's emotional/behavioral problems have diminished in severity to such an extent that regular monitoring of the behavior is no longer necessary, and the client does not meet any of the continued stay criteria for further treatment at Level III; or b) The client has a psychiatric, emotional or behavioral condition that is interfering with addiction treatment and that should be addressed in another setting; or c) The client has been unable to benefit from treatment due to the inability to function at least at the 11-year old age level.		
Dimension 4: Treatment Acceptance/Resistance	The client's status in this dimension is characterized by one of the following: a) The client's awareness and acceptance of his or her addiction problem and commitment to the definitive treatment is sufficient to expect treatment compliance at a less intensive level of care, as evidenced by the following: 1) The client recognizes the severity of his/her substance abuse problem; 2) The client has an understanding of his/her self-defeating relationship with substances; 3) The client is applying skills necessary to maintain recovery by accessing appropriate community supports or by continuing treatment in a less intensive level of care; and 4) The client does not meet any of the continued stay criteria for Level III; or b) The client consistently has failed to achieve essential treatment plan objectives despite revisions to the treatment plan and advice concerning the consequences of continued alcohol/other drug use, to such an extent that further progress is not likely to occur.		

Dimension 5: Relapse/Continued Use Potential	The client's status in this dimension is characterized by one of the following: a) The client is capable of following a specific and complete post-treatment recovery plan. The client's therapeutic gains in addressing craving and relapse issues have been integrated into the client's daily behavior to support an ongoing care program at a less intensive level of care, and the client does not meet continued stay criteria indicating the need for further treatment at Level III; or b) The client is not committed to continuing care and has achieved maximum benefit from all attempts to have him or her accept the need for continuing care and relapse prevention.		
Dimension 6: Recovery Environment	The client's status in this dimension is characterized by one of the following: a) Problem aspects of the client's social and interpersonal environment are responding to treatment and the environment is sufficiently supportive of recovery to allow discharge or transfer to a less intensive level of care, and the client does not meet any of the continued stay criteria that indicate the need for further treatment at this level of care; or b) The client's social or interpersonal environment has not changed or has deteriorated, but the client has learned skills adequate to cope with the current situation or has secured and alternative environment, and the client does not meet any of the Level III continued stay criteria that indicates the need for further treatment at this level of care; or c) The client's social support system remains non-supportive or has deteriorated and the client is having difficulty coping with the environment and is at substantial risk of reactivating his/her addiction. An alternative environment is not feasible. An alternative environment has been identified but the parent(s)/guardian(s) or family does not accept the recommendation.		
Counselor Name: _____ **Counselor Signature/Credential: _____**		**Date:** **_____**	
Recommendations/notes:			