New Day, Inc.
Four Dances Residential Co-Occurring Treatment
(Intensive Care- Adolescent ASAM Level III.5)

ADMISSION PACKET

New Day, Inc.
Four Dances Residential Co-Occurring Treatment
(Intensive Care- Adolescent ASAM Level III.5)
1111 Coburn Road
Billings, MT 59101

Referral Information

Participant's Legal Name _____ Date of Possible Admission _____

S.S.N. _____ Gender: M_____ F_____ Date of Birth _____

Current Residence _____ Address _____

City _____ State _____ Zip _____ Phone _____

Last School Attended _____ Address _____

City _____ State _____ Zip _____ Phone _____

Legal Guardian/Custodian _____ Relationship to Participant _____

Please circle one: Temporary Permanent Joint

Guardian Address _____ City _____ State _____ Zip _____
(If guardianship is other than parent, provide court documentation.)

Tribal Counselor _____ Agency _____

Address _____ City _____ State _____ Phone _____

Current Medications (if any): _____
_____

Prescribing Psychiatrist _____ Phone _____

Allergies: _____ Allergies Action Plan: _____

Name of Person Completing this Form _____ Phone _____

Also, please include the following information for admission packet completion:
Participant's court status (if applicable).
Copy of participant's birth certificate, Medicaid card, Insurance card, Prescription/Pharmacy card.
Documentation of current custody/legal guardianship of participant.
Cumulative health records and medical history including immunization records & prescription eyewear.
Most recent psychiatric evaluation, biopsychosocial assessment, chemical dependency assessment & other pertinent clinical reports.
Educational records.

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Participant Information

Name _____ Date of Placement _____

Date of Birth _____ Birthplace _____

Gender _____ Religious Preference _____

Tribe _____ Enrollment # _____

Complexion _____ Weight _____

Legal Guardian of Youth _____

Address _____ Phone # _____

Social Security # _____

Payment Source (Indian Health Service, Board of Tribal Health, Tribal Drug Court)

_____

Other Source _____

Name of Last School Attended _____ Grade _____

Father's Name _____ Mother's Name _____

Address _____ Address _____

_____ _____

Home Phone _____ Home Phone _____

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Participant Information Sheet Continued

Placement Agency/ Referral Source: (Tribal Alcohol Program, Tribal/ BIA Social Services, Tribal Drug Court, HIS Behavioral Health) _____

_____

Address _____

Referral Source Contract Person Name _____

Phone _____

Significant Others _____

Address _____

Phone _____

Additional Information (Contact Restrictions, etc.) _____

_____

_____

_____

Completed by _____ Date _____

New Day, Inc.
Four Dances Residential Co-Occurring Treatment

Contact Sheet

Resident _____ Date of Arrival _____

Placing Agency _____ Case Manager _____

Probation Officer _____

Resident may have passes with the following:

	Name	Relationship	Address	Phone
1.				
2.				
3.				
4.				
5.				

Resident may have phone contact with the following:

	Name	Relationship	Address	Phone
1.				
2.				
3.				
4.				
5.				

*Anyone who is not on the list will not be allowed contact with the resident.

New Day, Inc.
Four Dances Residential Co-Occurring Treatment

Placement Agreement
(guardian)

Name of Participant: _____

Youth who are referred to New Day, Inc., for possible placement are those having difficulty in their home, school and/or community. Any youth who is referred will be considered for placement at New Day, Inc. The goal of New Day, Inc. is to offer youth a program of service and care to meet their individual needs. If a youth is accepted, efforts will be made to help the youth learn social, academic, self-maintenance and similar skills to aid the youth in a better adjustment with family, teachers, peers, and members of the community. Efforts are made to return the youth to a community placement as soon as possible. Exact plans depend on the youth's needs and family situation.

With this understanding, I have decided that the problems of my child are serious enough to warrant placement of my child at New Day, Inc. I understand my child will be considered for residence in the New Day, Inc., home environment program. I agree to the terms contained in this Placement Agreement as set forth herein.

I understand that at the discretion of New Day, Inc., in accordance with the treatment plan, my child will be able to spend holidays and vacation time with me if applicable. I agree that I am responsible for my child during such periods and will notify the staff of New Day, Inc., immediately if any evidence of difficulty should appear. For example, if my child runs away or becomes physically abusive or is arrested, I agree to contact New Day, Inc. immediately to inform it of such happenings. I also agree to return my child "on time" in accordance with plans made with New Day, Inc.

I give my permission to New Day, Inc. to use physical restraints in the event that it is necessary for safety and to protect the health of my child, New Day, Inc. staff, visitors and others. It is understood that physical restraint in this context means holding the arms of my child to prevent injury to my child or other people. I understand that New Day, Inc. does not have legal authorization to restrain residents from leaving. Should my child leave the New Day, Inc. property unauthorized, I hold New Day, Inc. harmless of legal responsibility for any accident, injury, or crime incurred by my child or as a result of my child's actions off of New Day, Inc. property.

I further give my permission to New Day, Inc. to notify the Yellowstone County Sheriff's Department, the appropriate tribal law enforcement agencies, the referral agencies, and myself, if my child should leave or run away.

I understand that the New Day, Inc. program includes physical activities such as basketball, volleyball, horseback riding and similar vigorous activities. I understand that my child will be given proper instruction in both the use of equipment and safety procedures associated with any physical activity and will not be allowed to participate in the program until he/she has demonstrated competency in the activity. I further understand that I must give separate written authorization prior to my child being able to participate in the New Day, Inc. Riding Program and Sweat Lodge Activity. I understand that my child will be under staff supervision at all times while he/she is given proper instruction, as well as when participating in the physical activities. Unless my child has some physical limitations that make it medically unwise to participate if he/she so desires, I authorize such participation. I also will allow him/her to travel with teams and similar groups for such participation.

I understand that New Day, Inc. has a farm/ranch work program. I understand that while my child is at New Day, Inc. he/she may at one time or another operate equipment such as lawn mowers, weed eaters, or other yard tools as well as be involved in occasional cleaning of horse stalls and corrals and feeding horses as part of his/her

independent living skills, which is part of the New Day, Inc. program. I understand that my child will be given proper instruction in both the use of equipment and safety procedures associated with their use and that he/she will not be allowed to operate such equipment until he/she has demonstrated competency in the operation of such equipment and machinery. I understand that while being given the proper instruction and safety training procedures, my child will remain under constant staff supervision when operating equipment and tools and while working around the horse corrals and areas.

I understand that, given the difficulties my child is experiencing, placement at New Day, Inc. is the most appropriate and least restrictive placement.

Finally, I agree that if for any reason New Day, Inc. determines it is necessary to discharge my child from its care, I agree to accept my child back into my home and assume all responsibility for his or her care. I further agree to any arrangements made by New Day, Inc. to transfer my child back into my care, and to pay New Day, Inc., for all costs it incurs to transport my child back into my care.

Participant Name _____

**Parent/Guardian Signature_____ Date_____

New Day, Inc. Staff Signature_____ Date _____

(Youth signature obtained on Placement Agreement in Youth Handbook *(electronic file- Section 2-Handbook)*).

New Day, Inc
PROGRAM RELEASES

Name of Participant _____

HORSE PROGRAM

I give permission for my child to participate in the New Day, Inc. Horse Riding Program. I understand that my child will participate in a therapeutic riding program that is goal oriented to reach youth potential through the use of horsemanship. Youth will attend and satisfactorily complete 4 hours of orientation training on horsemanship, before being allowed to ride the horses. The orientation will include the proper use of safety equipment and knowledge of the appropriate basic safety skills necessary. An experienced horse person will facilitate the presentation.

Parent/Guardian Signature _____ Date _____

SWEAT LODGE ACTIVITY

I give permission for my child to participate in the New Day, Inc. Home Sweat Lodge Activity. I understand that my child will participate in an outdoor adventure activity that is therapeutically designed to reach the youth's spiritual, mental, and physical potential through the use of the sweat lodge ceremony. Due to the possibility of excessive sweating causing adverse interaction with medications they might be taking, I understand that my youth's participation in the sweat lodge activity must be approved by a physician. I further understand that if my youth has a known heart disease, or is taking Benzodiazepines (Xanaxa, Valium) they will not be allowed to participate in the sweat lodge activity. An experienced seat lodge leader will facilitate the activity.

Parent/Guardian Signature _____ Date _____

MEDIA RELEASE

I authorize New Day, Inc to use photographs, digital images, or videotapes of my child for, among other things, public relations, school activities, advertisements, website, and fundraising activities. I further understand that I may deny use of my child's image and name in some or all of these activities by submitting a written withdrawal of permission to: New Day, Inc., P.O. Box 30282 Billings, MT 59107. The withdrawal of permission must be received within 30 calendar days of admission.

Parent/Guardian Signature _____ Date _____

RECREATION ACTIVITIES RELEASE

I give permission for my child to participate in recreational activities at New Day, Inc. The activities are designed therapeutically to challenge youth physically and mentally. Recreation activities will also teach youth life skills and how to work as a team. I understand that if my child is not capable of certain activities that he/she will not be forced to participate. An experienced recreation staff will facilitate the activities and requirements.

Parent/Guardian Signature _____ Date _____

New Day, Inc.
Four Dances Residential Co-Occurring Treatment

Authorization for Release of Student Records

Name of Participant _____

Previous School _____ All public schools attended _____
Address: _____ Address _____
_____ _____
_____ _____
(Phone) (Fax) (Phone) (Fax)

Re: _____
(Student)
_____
(Birth Date) (Grade)

I, _____ the parent/guardian of the above named student, hereby authorize the release of any and all of his/her educational records.

I acknowledge notification of this transfer of records as required by the Family Education Rights and Privacy Act of 1974. I understand that the student and/or I have a right to receive a copy at our own expense, if requested, and have an opportunity for a hearing to challenge the content of the records. I understand that the information transferred will be treated in a confidential manner and interpreted as necessary by competent school personnel. They will not be transmitted to a third party without my consent.

Parent /Guardian _____ Address _____
City _____ State ____ Zip _____ Phone _____ Date _____
Relationship to Student _____

New Day, Inc.
Four Dances Residential Co-Occurring Treatment

Authorization for Disclosure of Confidential Health Care Information

The undersigned hereby authorizes _____ to disclose certain confidential health care information concerning _____ (participant) to: _____

You are authorized to disclose all documents and files in your possession, including, but not limited to, admitting reports, discharge reports, summaries, progress reports, office records, hospital records, diagnostic test results, billing records, notes, correspondence, or any other documents relating to the treatment or evaluation of _____ (participant).

This Authorization shall be valid for thirty (30) months from the date recorded on this Authorization unless otherwise specified or revoked. The undersigned understands that this Authorization may be revoked at any time, upon written notification to _____, except to the extent that action has been taken in reliance thereon.

The undersigned understands that this Authorization may include disclose of ALCOHOL AND DRUG ABUSE records which are protected by virtue of the provisions of Federal Regulations (42 C.F.R. Part 2)

The undersigned makes this Authorization upon the promise that all disclosures of any alcohol and drug abuse records made pursuant to this Authorization shall be accompanied by the following notice:

NOTE: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulation (42 C.F.R. Part 2) prohibits you from making any 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 release of the information is NOT sufficient for this purpose.
The undersigned hereby acknowledges that he/she read, is familiar with, and fully understands the terms and conditions of this Authorization.

Photocopies of this signed Authorization shall be treated as executed originals.
Print Participant's Name _____
Signature of Participant _____
Parent/Guardian Signature _____
Date of Signing _____

Witness Signature _____

A copy of this document is to be delivered to the participant.

New Day, Inc.
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Authorization to Use and Disclose Health Information

Name: _____ Date of Birth: _____
Maiden or Other Name: _____

To: _____
Print Name Print Address

My health information may be disclosed under this authorization as marked:

- I authorize disclosure of the following types of individually identifiable health information maintained by you to New Day, Inc. Four Dances Residential Program.
- I authorize New Day, Inc. Four Dances Residential Program to disclose to you the following types of individually-identifiable health information.

Health information that may be used and disclosed through this authorization is as follows:

_____ Intake History/ Admission Information
_____ Psychological Testing
_____ Progress Notes/ Report
_____ Chemical Dependency Assessment Summary
_____ ACT Evaluation/ Recommendation Report
_____ Medication Records
_____ Psych/ Social Information
_____ Treatment Plans
_____ Discharge Summary
_____ Other (provide specific description of the information): _____
_____

Specific purpose for the use or disclosure: _____

1. I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment.
2. I understand that information released by me may be subject to re-disclosure, and the information may no longer be protected by federal laws governing privacy of health information. However, if this disclosure consists of information about a client involved in chemical dependency services the following applies:

PROHIBITION OF REDISCLOSURE: 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 federal 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.

3. I understand that I may revoke this authorization in writing at any time. I understand that I must submit a written notice of revocation to the Administrator of New Day, Inc. I understand that the revocation will not apply to information that has been released in response to this authorization prior to my written notice.
4. I understand that my records may be transmitted by fax.
5. This consent will expire one hundred days (100) from the date this authorization is signed.
6. I have received a copy of this authorization.

_____ _____
Client Signature Date Witness Signature Date

_____
Parent or Personal Representative Signature Date

Description of Personal Representative's authority to act for the client: _____
New Day, Inc. Four Dances Residential Program Staff accepting authorization: _____

New Day, Inc.
Four Dances Residential Co-Occurring Treatment

Your Rights Regarding Your Health Information

1. Communications: You can request that our facility communicate with your about participants health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of our health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of the participant's health information to only certain individuals involved in the participant's care or the payment of the participant's care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat the participant.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about the participant, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to New Day, Inc.
4. You may ask us to amend the participant's health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to New Day, Inc. You must provide us with a reason that supports your request for amendment.
5. Right to copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, please contact New Day, Inc.
6. Right to file a complaint. If you believe the privacy rights of the participant have been violated, you may file a complaint with our facility or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice contact New Day, Inc. All complaints must be submitted in writing. The participant will not be penalized for you filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our facility will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.
   If you have any questions regarding this notice or out health information privacy policies, please contact New Day, Inc.

I hereby acknowledge that I have been presented with a copy of New Day, Inc. Notice of Privacy Practices.

Parent/Guardian Signature _____

Name of participant _____ Date_____

New Day, Inc.
Four Dances Residential Co-Occurring Treatment

Notice of Privacy

Name of Participant: _____

This notice describes how health information about the participant may be used and disclosed, and how the participant can get access to the participant's health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to the participant's privacy:
Our facility is dedicated to maintaining the privacy the participant's health information. We are required by law to maintain the confidentiality of the participant's health information:

Use and disclosure of the participant's health information in certain special circumstances:
The following circumstances may require us to use or disclose the participant's health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to the participants health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If the participant is a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if the participant is an inmate or under the custody of law enforcement official.
8. For Workers Compensation and similar programs.

Parent/ Guardian Signature _____

Date Received _____

New Day, Inc.
Four Dances Residential Co-Occurring Treatment
(Intensive Care- Adolescent ASAM Level III.5)

Authorization for Treatment & Examinations

The undersigned hereby authorize New Day, Inc. Four Dances Residential Program, Billings, MT (hereinafter referred to as Four Dances) to provide an enrollment biopsychosocial assessment, mental health assessment, psychiatric assessment (if deemed necessary) and routine medical care and treatment to _____ (patient) as the Four Dances staff consider to be necessary and as established pursuant to an existing treatment plan. We/I also give consent for continued testing as appropriate and pertinent for my child which may include psychological, academic, and/or physical testing.

The nature, purpose, and benefits of these routine treatments, the possible alternate methods to these treatments, any risks involved, and any possible side effects or complications arising from them will be explained to the undersigned and the patient prior to their use. Non-routine care and treatment or medications will not be administered to the patient without the undersigned and/or patient's informed consent.

The undersigned hereby consent to the rendering of such emergency medical treatment as may be necessary in the event of a medical emergency either while on an expedition, while completing a challenge activity or while at Four Dances facility. The Four Dances staff will make every reasonable effort to notify the undersigned in advance of such treatment, unless doing so creates a life-threatening situation. Should more comprehensible emergency medical treatment be necessary, the undersigned consent to the transfer of the patient to a local general hospital facility for medical treatment.

_____	_____	_____
(Participant Name)	(Parent/Guardian)	(Agency Representative)
_____	_____	_____
(Date)	(Date)	(Date)
_____	_____	_____
(Address)	(Address)	(Address)
_____	_____	_____
(City, State, Zip)	(City, State, Zip)	(City, State, Zip)

_____
(Witness)

New Day, Inc.
Four Dances Residential Co-Occurring Treatment

Medication Authorization Consent

I, _____ authorize _____
(name of program)
to dispense to _____ the following medications, as prescribed by
(name of participant)
a State licensed psychiatrist: _____
_____
_____

Specific purpose for the medication use: _____
Potential benefits for the medication: _____
Potential risks for the medication: _____
Potential alternatives for the medication: _____

This form addresses medications at time of participant's admission, in addition to any medication changes/additions/deletions that are made by a licensed physician during participant's stay at Four Dances. I understand and have been informed of the potential benefits, risks, and alternatives for the current prescribed medication. I will be notified by phone, writing, or in person of any medication changes/additions/deletions that are made by a licensed physician during participant's stay at Four Dances in addition to the potential benefits, risks, and alternatives for the prescribed medication. I also understand that I may revoke this authorization with a written request. This consent also gives approval for the self-administration of over-the-counter medications to the participant pending the complaint of a nonurgent medical issue. Prior to dispensing any over-the-counter medications, the participant's physician will be consulted regarding potential adverse reactions or interactions with prescribed medications.

The above participant is allergic to the following: _____

Executed this _____ day of _____, 20_____.

_____ _____
(Signature of Guardian or Authorized Representative) (Signature of Witness)

_____ _____
(Signature of Participant) (Participant Date of Birth)

New Day, Inc.
Four Dances Residential Co-Occurring Treatment

Physical Examination

(Completed by appropriate licensed practitioner
if they don't provide own form.)

Participant Name: _____ Date of Birth: _____

Known Allergies: _____ Social Security #: _____

Doctor Name: _____ Participant's Current Age: _____

Doctor Address: _____ Participant's Current Weight: _____

Doctor Phone Number: _____ Participant's Current Height: _____

Participant's Current Medications: _____
_____
_____
_____

Date of Physical Exam (completed prior to enrollment, but no earlier than 30 days before admission):
_____

Results of Examination: (Please attach pages if more space is needed.)

1. Overall Physical Condition: _____
   _____
   _____
   _____
2. Physical Problems that would limit physical activity: _____
   _____
   _____
   _____
3. Special Care needed: _____
   _____
   _____
   _____
4. History of communicable diseases and serious illnesses or operations: _____
   _____
   _____
   _____
5. Identification of any known drug reactions and allergies: _____
   _____
   _____
   _____
6. Identification of medications taken during the six months prior to exam and a description of any possible special needs due to the use of medication in an outdoor high impact environment: _____
   _____
   _____
   _____

7. Special Dietary Requirements: _____
_____
_____
_____

8. Hereditary Health Issues that may affect the participant: _____
_____
_____
_____

9. If a participant is in a risk group for circulatory or auto-immune syndrome disorder, written approval must be included on this exam form by the practitioner: _____
Practitioner Signature

10. Does participant have any prior outdoor experience? Yes ___ No ___
11. Does the physical health and well-being of this participant appear well enough to participate in athletic activities including horse back riding, rappelling, scuba diving, mountaineering, Sweat Lodge Ceremonies (where excessive sweating may occur), strenuous exercise, and activities that may occur in altitudes over 5000 with exposure to cold and hot temperatures? Yes ___ No ___
If yes, include practitioner signature: _____
Practitioner Signature

12. Please approve over-the-counter medications that will most likely not have adverse interactions to this participant: (check) ___ non-alcoholic cough syrup/drops, ___ antacids, ___ Tylenol/Ibuprofen, ___ other: _____

13. Attach participant's immunization record that includes evidence of Hepatitis A series and/or Hepatitis B series if deemed necessary.
14. Attach current TB test results.

The following must be completed prior to admission if deemed necessary by the examining practitioner.

(Attach results if any of the following are completed.)

1. Complete Blood Count (CBC), Urinalysis, and Electrolyte Screen.
2. Hepatitis Series.
3. Pregnancy Test for females.
4. Detoxification.

Practitioner's signature indicating approval for participation in the New Day, Inc. Four Dances Program based on the results of this examination. It appears the participant's current needs will be addressed at the program.

_____ _____

Practitioner Signature Date

New Day, Inc.
Substance Abuse Treatment
CD Biopsychosocial Evaluation

Client Name: _____
Date of Birth: _____
Date of Evaluation: _____
Evaluator: _____

Status/Precipitating Factors:

Medical History:

Family History:

Legal History:

School History:

Chemical Use History:

Alcohol:

Marijuana:

Other Drugs:

ASAM CRITERIA

Client participation in a chemical dependency evaluation interview utilizing the ASAM Criteria for placement recommendation.

Dimension	Please refer to ASAMCRITERIA.ORG for further description	Severity Rating 0-4 0- Non-issue- stable 1 – Mild discomfort 2 – Moderate risk/ Difficult can cope yet difficult 3– Serious difficulties/ Impairment difficulty understanding or coping 4– Severe difficulty, imminent danger/risk	Level of care: Low or Moderate General Guidelines: All "Lows"= Level 1 One "Moderate" = Level 2 Two or more "Moderate" = Level 3
Dim 1: Acute intoxication and or withdrawal potential	**What substance/s are of greatest concern? Last use? Other substances used? Method of use? History of withdrawal? History of seizures? Risk of current withdrawal? Diagnoses?**	Severity Rating	Level of Care
Dim 2: Biomedical Conditions and Complications	**How is their health? Any acute/chronic medical problems? Ability to access (health) care for those medical issues? Immunizations? HIV/STI/pregnancy risk? Nutrition?**		

Dim 3: Emotional Behavioral or cognitive conditions and complications	**History of any mental health concerns? Any current mental health Symptoms? Do they have a diagnosis & by whom? Psychotropic medications? Past history of Mental Health treatment? History of suicide or harm to others? How functional are they?**		
Dim 4: Readiness to change	**Individuals (patients) thoughts about being here? Long term plan for substance use? Thoughts about overall situation and plan to address? What does the patient think that they need? What is the patient willing to do? What is important to the patient? Internal vs. external motivation to change?**		
Dim 5: Relapse, continued use, or continued problem potential	**How long can the patient stay substance free? How are they able to stay sober/clean? What skills does the patient have? Can the patient stay substance free if they so desire? Does the patient have prior successes in recovery?**		
Dim 6: Recovery environment	**Who is in the patient's life? What is important to the patient? Is there any legal/child welfare involvement? (current) family issues? Patients education level?** **Concerns/issues related to parenting? Type of support and from whom does the patient have? How is the patient connected to the community, culture, etc.? What is the patients current housing? Employment? Financial Situation?**		

TESTING ADMINISTERED

___ MAST
___ AADIS
___ SASSI
Cross Reference:

Test Results/ Diagnostic Impression (DSM V Criteria):

Evaluation Recommendation:

Level of Care & services to address all issues including mental health:

Continued Care Plan. Discharge criteria is based upon the ASAM PPC in all six (6 dimensions to justify the move to a less restrictive treatment environment documenting needed services for continued care in the community setting with the necessary arrangements for these services.