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|------------------------------|----------------|-------|
| Resident Name (Last, First): | Age: | Date: |
| Social Security #: | Case/ PACTS #: | |
| | | |

DISPOSITION AT ENTRY

Employed _____ Yes _____ No
 Criminal History _____

Pre-Trial, Parole, Probation, etc. _____

FUNCTIONAL ASSESSMENT

| Category | Functional Impairment | | | |
|------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | None | Mild | Moderate | Severe |
| Family Relations | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Job/School | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Financial | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Physical Health | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Legal | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Friends/Social | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Risk Assessment (Check those which apply.)

History of Violence Convictions Arrests Other, Explain _____

History of Sex Offense Convictions Arrests Other, Explain _____

Substance Use/ Abuse Active Remission Discussion _____

Additional Services Requested/ Authorized (Check below all that apply, must have authorization.)

- | | |
|--|--|
| <input type="checkbox"/> 1010 Urine Collection <input type="checkbox"/> 2011 Intake Assessment & Report <input type="checkbox"/> 2020 Group Counseling (Free - 3 Groups/ week) <input type="checkbox"/> 2080 Intensive Outpatient Counseling (Substance Abuse) <input type="checkbox"/> 6030 Family Counseling (Mental Health) | <input type="checkbox"/> 1011 Presumptive Urine Testing (Free -1/month) <input type="checkbox"/> 2010 Individual Counseling (Substance Abuse) <input type="checkbox"/> 2030 Family Counseling (Substance Abuse) <input type="checkbox"/> 6010 Individual Counseling (Mental Health) |
|--|--|

Statement of Need: _____

Recommended Length of Stay : 0-6 months 6-12 months More than 12 months

Referral Source:

Name: _____ Agency: _____

Address: _____

Phone: _____ Email _____