

CLIENT NAME _____
 CLIENT ID# _____
 PROGRAM/RU _____
 DATE OF BIRTH _____

Recovery Resources Individual Service Plan/Individual Treatment Plan

Describe specific needs/problems based on diagnostic assessment, referral information, and client-generated information:

Describe strengths, assets, supports, and how these will be utilized in achieving treatment goals:

List Recovery Resources services to be provided and, for each service listed, include start date, end date, name of staff providing each service and frequency of the service. There must be at least one corresponding goal for each service listed.

Start Date	End Date	Service	Staff Providing Service	Frequency of Service
				x
				x
				x
				x
				x
				x
				x
				x

Involvement with Other Agencies

Start Date	End Date	Agency	Service Provided	Name/ Title of Responsible Staff

06/02

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Confidentiality 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 is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or any other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute.

Recovery Resources
Goal Sheet

Client Name _____
Client # _____
Date _____
Date of Birth _____

Adult Level IA: Non- Intensive Outpatient Treatment Intensive Outpatient Treatment

Adult Level IB: Non- Intensive Outpatient Treatment Intensive Outpatient Treatment

- 1. Goal Number _____
- 2. Current Need/Problem Statement _____
- 3. Treatment Goal _____

Therapeutic Objectives/Measurable Steps	Expected Date of Achievement/Duration	Date of Achievement	If not achieved by EDA, Specify
A.			
B.			
C.			
D.			

Client's Signature _____ Date _____
 Provider's Signature/Credentials _____ Date _____

Supervisor's Signature/Credentials _____ Date _____
 Physician/Psychologist's Sign./Cred. _____ Date _____

Other Signature/Relationship to CIL _____ Date _____
 Other Signature/Relationship to CIL _____ Date _____

Check One: Goals Achieved Goals Continued On New Goal Sheet Goals Discontinued

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CLIENT NAME _____
CLIENT ID# _____
PROGRAM/RU _____
DATE _____

Recovery Resources Individual Service Plan/Individual Treatment Plan Review and Summary

Each goal must be addressed. Please summarize progress or lack of progress toward goals in ISP/ITP at any change in level of care or every 90 days. Include any significant factors that may have been influential, any changes in service providers as well as any changes to be made to the ISP/ITP. Indicate whether goals have been achieved, retained, or discontinued. This summary must be signed and dated by the client, significant other (if applicable), worker, supervisor and psychiatrist/psychologist. On a progress note document the client's participation in this review process and his or her consent to the treatment being provided.

General Summary

Review of Goal # _____

Review of Goal # _____

Please Indicate If Review Is Continued On Reverse: YES NO

Client's Signature _____ Date _____
Provider's Signature/Credentials _____ Date _____

Supervisor's Signature/Credentials _____ Date _____
Physician/Psychologist's Sign./Cred. _____ Date _____

Other Signature/Relationship to Clt. _____ Date _____
Other Signature/Relationship to Clt. _____ Date _____

RECOVERY RESOURCES

AUTHORIZATION TO DISCLOSE INFORMATION

Name of Client: _____ Date of Birth: _____

The following programs are authorized to disclose receive exchange information as noted below.

Program Authorized to Make Disclosure (Name and Address)

Authorized Individual/Organization to Whom Disclosure is Made (Name and Address)

Purpose of Disclosure: to coordinate treatment, to gather assessment information for treatment planning, to gather information for ongoing treatment, other purposes (specify) _____

Type of Information to be Disclosed: progress notes, diagnostic assessment information, progress in treatment, lab results, attendance, HIV/AIDS testing or status, diagnosis, information on mental illness and/ or treatment, other information (specify) _____

Amount of Information to be Disclosed: information covering the previous three months, information covering the most recent admission, other amount of information (specify) _____

Client Signature & Date

Signature & Date of Staff or Witness

Parent or Guardian Signature

Date

AOD, This authorization expires (specify event, date and/or condition) _____
MH, This authorization expires in 180 days of service _____

Revocation:

This authorization is subject to revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it, drug and /or alcohol clients can revoke consent either verbally or in writing.

This authorization was revoked on: _____
Date & Time

Client Signature

Witness Signature & Date

Prohibition against Re-Disclosure: This information has been disclosed to you from records protected by Federal confidentiality rules. 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 C.F.R., 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 information to criminally investigate or prosecute any alcohol or drug abuse client. (These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.)

CONSUMER PROTECTION ASSOCIATION
3030 Euclid Avenue LL4
Cleveland, Ohio 44115
216/472-0286
FAX: 216/472-0290

REQUEST FOR CLIENT FUNDS

Client Name _____ SSN _____
 Amount of request \$ _____ Request Date _____ Date needed _____
 Purpose: _____
 Pick up _____ Mail _____ Address: _____
 Case Manager _____
 Agency _____ Phone #: _____ ext _____

COMMENTS

 Client Signature _____ Date: _____

 Case Manager Signature _____ Date: _____

THE COMPLETED FORM MAY BE FAXED TO 216/472-0290 OR BROUGHT TO THE AGENCY. PLEASE ALLOW THREE (3) BUSINESS DAYS FOR ROUTINE REQUESTS. IN ORDER TO EXPEDITE PROCESSING OF A REQUEST NEEDED IN LESS THAN 3 BUSINESS DAYS, THE REQUEST MUST ALSO BE CALLED IN (216/472-0286).

CPA MAY NOT BE ABLE TO RESPOND TO SAME DAY REQUESTS.

FOR CONSUMER PROTECTION ASSOCIATION USE ONLY

Date request received: _____
 Date request completed: _____ Check # _____
 CPA staff signature: _____ Date: _____

MENTAL HEALTH AND SAMI GROUP TREATMENT REFERRAL

Client Name: _____ Referral Date: _____
Social Security Number: _____ Date of birth: _____

Client's next review date and time: _____ (must be included)

Record Number: _____ RU: _____

Address: _____ Zip Code: _____

Referring Person: _____ Referring Program: _____

Phone Number: _____

Age: _____ Probation or Parole? Yes No : Name & Number: _____

CIAI Complete: yes no Date of active CIAI: _____

Date of last Diagnostic Assessment: _____ (if this is an outside agency referring, please include last assessment and last doctors notes with referral).

Prior treatment and dates: _____

Is client familiar with the concept of recovery utilizing the 12 step model: _____

Has client ever attended 12 step meetings before/if yes, when: _____

In relation to how client would best be served in a group setting, please identify:
Client's strengths: _____

What are you looking for client to address in treatment? _____

Client's challenges: _____

Marital Status: _____ Does client have children? _____ How many? _____
Are children living with client? _____ If not, where are they living? _____

Diagnosis: Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____ (current)

Please fill in diagnosis completely

Release date from jail or treatment : _____

Circumstances leading to jail or treatment: _____

Meds: _____ Med compliant: _____ yes _____ no

Describe any active psychosis: _____

SI/HI in last 90 days: _____ yes _____ no if yes, please explain : _____

Last drug/alcohol use: _____ What drug/alcohol was used: _____

If above info regarding drug/alcohol was answered, please answer the question below

To what degree does client acknowledge / accept the notion of dual recovery? (drugs,alcohol/mental illness):

Cognitive Impairment: (blunt trauma, brain injury) _____

Living Situation: (who are they living with/ where are they living): _____

Is client interested in having family involved in treatment: _____

What other community services is client receiving: _____

Is client on Medicaid : _____ yes _____ no SSI: _____ yes _____ no How much per month? \$ _____

- *disability Medicaid does not pay for group treatment programs*

REVISED TRACKING SHEET FOR OUTCOMES SURVEYS

CLIENT INFORMATION

LNAME

FNAME

ID#

SSN

DOB YEAR OF BIRTH
 MONTH OF BIRTH
 DAY OF BIRTH

COUNTY OF RESIDENCE CUYAHOGA
 OTHER: _____

ADMISSION DATE YEAR MONTH DAY

DSM IV DIAGNOSIS .(PRIMARY)
 .(SECONDARY)

SURVEY TYPE CONSUMER ADULT A
 PROVIDER ADULT A
 CONSUMER ADULT B(COUNSELING ONLY)

 CLIENT REFUSED TO PARTICIPATE

ADMINISTRATION INITIAL
 6 MONTHS
 ANNUAL
 TERMINATION

PRIMARY WORKER'S NAME

DATE OF SURVEY ADMINISTRATION
YEAR MONTH DAY



Ohio Mental Health Consumer Outcomes System Adult Consumer Form A

A

Today's Date _____/_____/_____

Name _____

Date of Birth _____/_____/_____

Gender (check one): Male Female

Agency Use Only

Client's Medical Record Number:

We are very interested in how you are doing, and how our services may or may not be helping you. Please answer all of the questions below, then give the questionnaire to your case manager or another staff person at the mental health agency.

Part 1
Below are some questions about how satisfied you are with various aspects of your life in <i>the past 6 months</i> . For each question, checkmark <input checked="" type="checkbox"/> the answer that best describes how you feel.

How do you feel about:

1. The amount of friendship in your life?

- Terrible
- Mostly dissatisfied
- Equally satisfied/dissatisfied
- Mostly satisfied
- Very pleased

2. The amount of money you get?

- Terrible
- Mostly dissatisfied
- Equally satisfied/dissatisfied
- Mostly satisfied
- Very pleased

3. How comfortable and well-off you are financially?

- Terrible
- Mostly dissatisfied
- Equally satisfied/dissatisfied
- Mostly satisfied
- Very pleased

4. How much money you have to spend for fun?

- Terrible
- Mostly dissatisfied
- Equally satisfied/dissatisfied
- Mostly satisfied
- Very pleased

5. The amount of meaningful activity in your life (such as work, school, volunteer activity, leisure activity)?

- Terrible
- Mostly dissatisfied
- Equally satisfied/dissatisfied
- Mostly satisfied
- Very pleased

6. The amount of freedom you have?

- Terrible
- Mostly dissatisfied
- Equally satisfied/dissatisfied
- Mostly satisfied
- Very pleased

7. The way you and your family act toward each other?

- Terrible
- Mostly dissatisfied
- Equally satisfied/dissatisfied
- Mostly satisfied
- Very pleased
- Does not apply

Please turn to the next page →

8. Your personal safety?

- Terrible
- Mostly dissatisfied
- Equally satisfied/dissatisfied
- Mostly satisfied
- Very pleased

9. The neighborhood in which you live?

- Terrible
- Mostly dissatisfied
- Equally satisfied/dissatisfied
- Mostly satisfied
- Very pleased

10. Your housing/living arrangements?

- Terrible
- Mostly dissatisfied
- Equally satisfied/dissatisfied
- Mostly satisfied
- Very pleased

11. Your health in general?

- Terrible
- Mostly dissatisfied
- Equally satisfied/dissatisfied
- Mostly satisfied
- Very pleased

12. How often do you have the opportunity to spend time with people you really like?

- Never
- Seldom/rarely
- Sometimes
- Often
- Always

Part 2

These next few items ask you about your health and medications *within the past 6 months.*

13. How often does your physical condition interfere with your day-to-day functioning?

- Never
- Seldom/rarely
- Sometimes
- Often
- Always

14. Concerns about my medications (such as side effects, dosage, type of medication) are addressed:

- Never
- Seldom/rarely
- Sometimes
- Often
- Always
- Not applicable/no medications

The next two items deal with how you have been treated by other people.

15. I have been treated with dignity and respect at this agency.

- Never
- Seldom/rarely
- Sometimes
- Often
- Always

16. How often do you feel threatened by people's reactions to your mental health problems?

- Never
- Seldom/rarely
- Sometimes
- Often
- Always

Part 3

The following questions ask you about how much you were distressed or bothered by some things *during the last seven days.* Please mark the answer that best describes how you feel.

During the past 7 days, about how much were you distressed or bothered by:

17. Nervousness or shakiness inside

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

18. Being suddenly scared for no reason

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

19. Feeling fearful

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

20. Feeling tense or keyed up

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

21. Spells of terror or panic

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

22. Feeling so restless you couldn't sit still

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

23. Heavy feelings in arms or legs

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

24. Feeling afraid to go out of your home alone.

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

25. Feeling of worthlessness

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

26. Feeling lonely even when you are with people

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

27. Feeling weak in parts of your body

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

28. Feeling blue

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

29. Feeling lonely

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

30. Feeling no interest in things

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

31. Feeling afraid in open spaces or on the streets

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

32. How often can you tell when mental or emotional problems are about to occur?

- Never
 Seldom/rarely
 Sometimes
 Often
 Always

33. When you can tell, how often can you take care of the problems before they become worse?

- Never
 Seldom/rarely
 Sometimes
 Often
 Always

Part 4

Below are several statements relating to one's view about life and having to make decisions. Please check the response that is closest to how you feel about the statement. Check the word or words that best describes how you feel now.

34. I can pretty much determine what will happen in my life.

- Strongly agree
 Agree
 Disagree
 Strongly disagree

35. People are limited only by what they think is possible.

- Strongly agree
 Agree
 Disagree
 Strongly disagree

36. People have more power if they join together as a group.

- Strongly agree
 Agree
 Disagree
 Strongly disagree

37. Getting angry about something never helps.

- Strongly agree
 Agree
 Disagree
 Strongly disagree

38. I have a positive attitude toward myself.

- Strongly agree
 Agree
 Disagree
 Strongly disagree

39. I am usually confident about the decisions I make.

- Strongly agree
 Agree
 Disagree
 Strongly disagree

40. People have no right to get angry just because they don't like something.

- Strongly agree
 Agree
 Disagree
 Strongly disagree

41. Most of the misfortunes in my life were due to bad luck.

- Strongly agree
 Agree
 Disagree
 Strongly disagree

42. I see myself as a capable person.

- Strongly agree
 Agree
 Disagree
 Strongly disagree

43. Making waves never gets you anywhere.

- Strongly agree
 Agree
 Disagree
 Strongly disagree

44. People working together can have an effect on their community.

- Strongly agree
- Agree
- Disagree
- Strongly disagree

45. I am often able to overcome barriers.

- Strongly agree
- Agree
- Disagree
- Strongly disagree

46. I am generally optimistic about the future.

- Strongly agree
- Agree
- Disagree
- Strongly disagree

47. When I make plans, I am almost certain to make them work.

- Strongly agree
- Agree
- Disagree
- Strongly disagree

48. Getting angry about something is often the first step toward changing it.

- Strongly agree
- Agree
- Disagree
- Strongly disagree

49. Usually I feel alone.

- Strongly agree
- Agree
- Disagree
- Strongly disagree

50. Experts are in the best position to decide what people should do or learn.

- Strongly agree
- Agree
- Disagree
- Strongly disagree

51. I am able to do things as well as most other people.

- Strongly agree
- Agree
- Disagree
- Strongly disagree

52. I generally accomplish what I set out to do.

- Strongly agree
- Agree
- Disagree
- Strongly disagree

53. People should try to live their lives the way they want to.

- Strongly agree
- Agree
- Disagree
- Strongly disagree

54. You can't fight city hall (authority).

- Strongly agree
- Agree
- Disagree
- Strongly disagree

55. I feel powerless most of the time.

- Strongly agree
- Agree
- Disagree
- Strongly disagree

56. When I am unsure about something, I usually go along with the rest of the group.

- Strongly agree
- Agree
- Disagree
- Strongly disagree

57. I feel I am a person of worth, at least on an equal basis with others.

- Strongly agree
- Agree
- Disagree
- Strongly disagree

58. People have a right to make their own decisions, even if they are bad ones.

- Strongly agree
- Agree
- Disagree
- Strongly disagree

59. I feel I have a number of good qualities.

- Strongly agree
- Agree
- Disagree
- Strongly disagree

60. Very often a problem can be solved by taking action.

- Strongly agree
- Agree
- Disagree
- Strongly disagree

61. Working with others in my community can help to change things for the better.

- Strongly agree
- Agree
- Disagree
- Strongly disagree

Part 5
Please tell us some things about yourself.

62. What was the last school grade you completed?

- | | |
|--|--|
| <input type="checkbox"/> Less than 1 st grade | <input type="checkbox"/> 10 th grade |
| <input type="checkbox"/> 1 st grade | <input type="checkbox"/> 11 th grade |
| <input type="checkbox"/> 2 nd grade | <input type="checkbox"/> High school diploma/GED |
| <input type="checkbox"/> 3 rd grade | <input type="checkbox"/> Trade/Tech school |
| <input type="checkbox"/> 4 th grade | <input type="checkbox"/> Some college |
| <input type="checkbox"/> 5 th grade | <input type="checkbox"/> 2 yr college/Associate degree |
| <input type="checkbox"/> 6 th grade | <input type="checkbox"/> 4 yr college/Undergraduate degree |
| <input type="checkbox"/> 7 th grade | <input type="checkbox"/> Graduate school courses |
| <input type="checkbox"/> 8 th grade | <input type="checkbox"/> Graduate degree |
| <input type="checkbox"/> 9 th grade | <input type="checkbox"/> Post-graduate studies |
| | <input type="checkbox"/> Further special studies |

63. Race (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Hispanic/Latino |
| <input type="checkbox"/> Native American/Pacific Islander | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Black/African-American | <input type="checkbox"/> Other _____ |

64. What is your marital status?

- Never married
- Married
- Separated
- Divorced
- Widowed
- Living together

65. What is your current living situation?

- Your own house/apartment
- Friend's home
- Relative's home
- Supervised group living
- Supervised apartment
- Boarding home
- Crisis residential
- Child foster care
- Adult foster care
- Intermediate care facility
- Skilled nursing facility
- Respite care
- MR intermediate care facility
- Licensed MR facility
- State MR institution
- State MH institution
- Hospital
- Correctional facility
- Homeless
- Rest home
- Other _____

66. What is your employment status?

- Employed full time
- Employed part time
- Sheltered employment
- Unemployed
- Homemaker
- Retired
- Disabled
- Inmate of institution

67. Are you in treatment because you want to be?

- Yes
- No

Please stop here. Thanks!!