

Referral Form

TO: TASC

FROM:

RE:

Referral Date: _____

Client Name: _____

SSN: _____ DOB: _____ Sex: _____

Age: _____ Race: _____

Docket #: _____

Charge: _____

Class: _____ Level: _____

Sentence: _____

Court Review Date (if any): _____

Note: Please attach a copy of the Probation Judgment.

**** SOP allows for only two (2) screening appointments. Consult with supervisor prior to scheduling a third.****

5. What are your current legal charges & docket #s?

Felonies: _____

Misdemeanors: _____

6. County of conviction? _____

7. Crime Type _____ (Current & Most Serious)

1-Violent Felony 2-Property Felony 3-Drug Felony 4-Other Felony 5-Violent Misdemeanor 6-Property
Misdemeanor 7- Drug Misdemeanor 8-Other Misdemeanor

8. Have you recently violated probation? Yes No If yes, describe _____

9. Have you ever been convicted of a DWI? Yes No If yes, conviction date(s): _____

10. Did you take the breathalyzer? Yes No If yes, results _____. If no, did you refuse? Yes No

11. Did you have a DWI assessment? Yes No If yes, where? _____

12. List any pending charges & court dates: _____

13. Have you previously been a TASC client? Yes No If yes, describe _____

Section 3

1. Are you currently under a doctor's care? Yes No

If yes, what for: _____

2. List any current health problems/medications/disabilities/limitations: _____

3. Do you drink alcohol or use drugs? Yes No

4. Are you currently in drug or alcohol treatment? Yes No

5. Have you ever been to drug/alcohol treatment (include education, counseling, hospitalizations)? Yes No

6. If yes, where: Have you noticed that you are able to drink more alcohol/use more drugs as time passes, or that you do not get as intoxicated or high as you use to? Yes No

7. Do you ever feel sick, nervous, or irritable if you do not drink alcohol/use drugs for a while?
 Yes No

8. How many times in the past month have you drank more alcohol/used more drugs than you had intended to? _____ times How many times in the past year? _____ times

9. Do you ever drink alcohol or use other drugs to stop feeling bad? Yes No

10. Have you ever decided to cut down or stop drinking alcohol/using drugs? Yes No
How long did it last? _____

11. How much time during the average week do you spend getting alcohol/drugs, using them, or getting over them (hangovers)? Circle one: **too much time** **a lot of time** **very little time** **none**

12. Have people close to you complained about you drinking alcohol/using drugs or asked you to quit or cut down? Yes No

13. Have you stopped being around certain people because they did not like you drinking alcohol/using drugs? Yes No
14. Has a doctor, nurse or other healthcare professional ever advised you to stop drinking alcohol/using drugs? Yes No
15. How many times have you gotten in trouble with work, school, or the law when you have been drinking alcohol/using drugs? ____ work ____ school ____ law
16. How many times have you been physically hurt when drinking alcohol/using drugs? ____ times
17. What drug was related to your arrest? _____

Drug Code	Age you first used	Date you last used	Route of use	Amount?	Frequency?
Alcohol					
Cocaine, Crack • (snort, smoke, inject)					
Marijuana					
Stimulants • (speed, uppers, etc.)					
Opiates • (heroin, dilaudid, cocaine)					
Sedatives • (Barbiturates, fiorinal, etc.)					
Tranquilizers • (Xanax, valium, etc.)					
Inhalants • (Nitrous oxide, gas, locker)					
Hallucinogens • (LSD, PCP, XTC, etc.)					
Over The Counter					
Methadone					
Other					

PRIMARY _____ SECONDARY _____ TERTIARY _____

Section 4

1. Do you think you have a drug problem? Yes No
2. Do you think you have an alcohol problem? Yes No
3. Do you think you need substance abuse treatment? Yes No
4. If TASC recommends substance abuse services, are you willing to participate in treatment and TASC services? Yes No

TASC Staff Signature & Title

Date

TASC Assessment

Client Name: _____ Record Number: _____

Section I: Legal Status & CJS History

1. List & describe past & present arrests, including DWIs (offense, dates, disposition): _____

2. Age at first arrest _____

3. How many times have you been charged with the following?

a) Disorderly conduct, vagrancy, public intoxication..... _____

b) Driving while impaired _____

4. How many arrests resulted in a conviction? _____

5. What was the most serious conviction: _____

6. Any record of assault/violence? Yes No

If so, specify _____

7. How many times have you received the following sentence:

a) Supervised Probation _____

b) Prison _____

c) Jail..... _____

d) Other (DP, diversion, un-sup prob, etc.)..... _____

8. Has your probation, parole or post-release supervision ever been revoked? Yes No

If yes, why _____

9. Have you ever been incarcerated? Yes No

If yes, how many times, what were the offenses & lengths of custody? _____

10. Are any offenses related to your use of drugs or alcohol? Yes No

If yes, specify _____

11. Does substance abuse increase your criminal behavior? Yes No

If yes, specify _____

12. Was treatment ever ordered as a condition of probation/parole? Yes No Prior TASC

a) If yes, describe treatment episodes: _____

b) If yes, did treatment effect criminal behavior? Yes No

• If yes, describe how _____

13. Are you now or have you ever been involved in legal problems concerning a partner, family member or child? Yes No

If yes, describe _____

Section II: Education & Employment Status

1. Highest grade completed: _____

a) Have you earned your GED? Yes No

b) Do you have difficulty reading or writing? Yes No

2. Do you have a profession, trade, or skill? Yes No

If yes, explain: _____

3. Do you have a valid driver's license? Yes No

4. Do you have an automobile for use? Yes No

5. How many months have you been employed in the past year? _____ months

6. If you are currently working, to your knowledge, do your co-workers use drugs or alcohol? Yes No

If yes, do you use with your co-workers? Yes No

7. Briefly describe your work history (employer, position, length of employment, why separated): _____

8. What is your monthly gross income? _____

9. What is the major source of this income? _____ (If Public Aid/SSI, list type and amount in comments.)

1 - wages/salary
2 - public assistance

3 - retirement/pension
4 - disability

5 - other

10. What social service agencies are you involved with (SSI, VA, Health Department, etc.), include contact name & #? _____

Section III: Family and Social Relationships

1. Do you live with anyone who uses alcohol or illegal drugs? Yes No

2. Have you ever had a partner who abused drugs or alcohol? Yes No

If yes, please describe _____

3. Do you live with anyone that has had legal problems due to criminal behavior? Yes No

If yes, describe the past and present legal problems due to criminal behavior of this person _____

4. With whom do you spend most of your free time? _____
1-Family 2-Friends 3-Associates 4-Alone

5. How many close friends/associates do you have? _____

a) How many of your close friends/associates use alcohol or other drugs? _____

b) How many of your close friends/associates are involved in the Criminal Justice System? _____

6. Do you participate in pro-social recreational activities (hobbies, sports, etc.)? Yes No

If yes, how many times per week? _____

7. What is your spiritual orientation? _____

8. Do you attend religious services? Yes No

9. Are you involved with a gang? Yes No

If yes, explain: _____

Children:

10. How many children do you have? _____

What are their names & ages? _____

How many live with you/Are in your custody? _____

11. Do you think your drug/alcohol use has affected your children? Yes No

If yes, explain _____

12. What kind of support system do you have (friends, family, pastor)? _____

13. Have you ever or do you currently participate in recovery support groups? Yes No

If yes, past or current frequency? _____

Do you have a currently sponsor? Yes No

14. Have any of your relatives had what you would call a significant drinking, drug use or psychological problem? A problem that did or should have led to treatment? Yes No

If yes, who & describe circumstances: _____

15. Are any of your family or closest friends in recovery? Yes No

If yes, who _____

16. Have you ever been physically, sexually or emotionally abused? Yes No

If yes, did you receive any counseling (explain): _____

17. Do you have any siblings? Yes No

If yes, include names & ages _____

18. Describe you family relationships growing up and how they may differ presently: _____

19. Have you experienced any recent losses or major life changes (loss of loved one, job change, etc.) Yes No

If yes, explain: _____

Section IV: Drug and Alcohol Use

A. Drug History (update from screening)

Drug Code	Age you first used	Date you last used	Route of use	Amount?	Frequency?
Alcohol					
Cocaine, Crack • (snort, smoke, inject)					
Marijuana					
Stimulants • (speed, uppers, etc.)					
Opiates • (heroin, dilaudid, cocaine)					
Sedatives • (Barbiturates, fiorinal)					
Tranquilizers • (Xanax, valium, etc.)					
Inhalants • (Nitrous oxide, gas, locker room)					
Hallucinogens • (LSD, PCP, XTC)					
Over The Counter					
Methadone					
Other					

PRIMARY *SECONDARY* *TERTIARY*

Drug History Notes: _____

1. How long was your last period of voluntary abstinence from this major substance? ____ months
2. When did abstinence end? ___/___/___
3. How many times have you:
 - a) had alcohol delirium trimmers (D.T.'s)____
 - b) overdosed on drugs ____
4. How many times in your life have you been treated for:
 - a) Alcohol Abuse ____
 - b) Drug Abuse ____
 - c) List all treatment episodes (include dates, modality, facility name, length of stay, discharge status)

5. How many of these were detox only?
Alcohol _____ Drugs _____
6. How much money would you say you spent on substances in last 30 days?
Alcohol \$_____ Drugs \$_____
7. What drug do you usually relapse on? _____

8. What triggers relapse for you? _____

9. Does significant alcohol/drug use pre-date significant criminal activity? Yes No

Explain _____

10. Does alcohol/drug use appear to be related to increased criminal activity? Yes No

Explain _____

11. Does treatment appear to be likely to reduce the level of criminal activity? Yes No

Explain _____

B. DSM-IV Criteria

1. **Tolerance:** Have you ever needed more alcohol or other drugs to get high or found that the same amount did not get you as high as you used to?
Describe: _____

2. **Withdrawal:** Have you ever had withdrawal problems from alcohol or other drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or have you used alcohol or other drugs to stop being sick or avoid withdrawal problems?
Describe: _____

3. **Increasing Amounts:** Have you ever used alcohol or other drugs in larger amounts more often or for a longer time than you meant to?
Describe: _____

4. **Desire to Cut Down:** Have you ever wanted to cut down or stop using alcohol or other drugs, but been unable to?
Describe: _____

5. **Time Devoted to Using/Seeking Substances:** Do you spend a great deal of time getting alcohol or other drugs or using alcohol or other drugs or recovering from the effects?
Describe: _____

6. **Salience of Drug Use:** Has your use of alcohol or other drugs caused you to give up, reduce, or have problems at important activities at work, school home, or social events?
Describe: _____
7. **Use despite medical/psychological consequences:** Have you kept using alcohol or other drugs even after you knew it was causing or adding to medical or emotional problem you were having?
Describe: _____

8. **Abuse:** Have you used alcohol or other drugs in situations where it made the situation unsafe or dangerous for you, such as when driving a car, using a machine, or where you might get forced into sex or hurt?
Describe: _____
9. **Abuse:** Has your alcohol or other drug use caused you to have (repeated) problems with the law?
Describe: _____
10. **Abuse:** Have you kept using drugs even after you knew it could get you into fights or other kinds of legal trouble?
Describe: _____

Notes/Comments: _____

Section V: Medical Status

1. Do you have medical benefits (including access to the Veterans Administration)? Yes No

If yes, indicate provider of benefits & provider #: _____

4. List any current health problems/disabilities/limitations: _____

5. List any medications you currently take:

Medication Name	Reason Prescribed	Dosage
1.		
2.		
3.		
4.		
5.		

6. Do you have any communicable diseases such as TB, STD? Yes No

If yes, diagnosis: _____

If yes, are you currently under treatment? Yes No

7. Have you ever had what you would call a significant problem with any of the following?

- | | Yes | No | |
|----------------------------------|--------------------------|--------------------------|----------------------------------|
| 8. Lung Problems | <input type="checkbox"/> | <input type="checkbox"/> | If yes, when? ___/___ month/year |
| 9. Fainting Spells | <input type="checkbox"/> | <input type="checkbox"/> | If yes, when? ___/___ month/year |
| 10. Convulsions..... | <input type="checkbox"/> | <input type="checkbox"/> | If yes, when? ___/___ month/year |
| 11. Strokes..... | <input type="checkbox"/> | <input type="checkbox"/> | If yes, when? ___/___ month/year |
| 12. Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | If yes, when? ___/___ month/year |
| 13. Heart Disease..... | <input type="checkbox"/> | <input type="checkbox"/> | If yes, when? ___/___ month/year |
| 14. Epilepsy..... | <input type="checkbox"/> | <input type="checkbox"/> | If yes, when? ___/___ month/year |
| 15. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | If yes, when? ___/___ month/year |
| 16. Cancer..... | <input type="checkbox"/> | <input type="checkbox"/> | If yes, when? ___/___ month/year |
| 17. High/Low Blood Pressure..... | <input type="checkbox"/> | <input type="checkbox"/> | If yes, when? ___/___ month/year |
| 18. Arthritis..... | <input type="checkbox"/> | <input type="checkbox"/> | If yes, when? ___/___ month/year |
| 19. Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | If yes, when? ___/___ month/year |
| 20. Pancreatitis..... | <input type="checkbox"/> | <input type="checkbox"/> | If yes, when? ___/___ month/year |
| 21. Cirrhosis | <input type="checkbox"/> | <input type="checkbox"/> | If yes, when? ___/___ month/year |
| 22. Gonorrhea | <input type="checkbox"/> | <input type="checkbox"/> | If yes, when? ___/___ month/year |
| 23. Herpes..... | <input type="checkbox"/> | <input type="checkbox"/> | If yes, when? ___/___ month/year |
| 24. Other STD | <input type="checkbox"/> | <input type="checkbox"/> | If yes, when? ___/___ month/year |

25. **Women:** Are you pregnant? Yes No

If yes, approximate due date ___/___/___

If yes, last menstruation date ___/___/___

26. Are there any other medical history issues that may be important in your treatment? Yes No

If yes, specify _____

27. Do you have any chronic medical problems that continue to interfere with your life that we have not covered yet?

Yes No

If yes, explain _____

28. Was the brief risk intervention (BRI) completed? Yes No

Section VI: Psychiatric Status

1. How many times have you been treated for any psychological or emotional problems?

On an inpatient basis _____ On an outpatient basis _____

If yes, when, where and what were the circumstances: _____

2. Have you ever received a pension for a psychiatric disability? Yes No

3. **Have you had a significant period that was not a direct result of drug/alcohol use, in which you: (check those that apply).**

a) Experienced serious depression..... Yes... No If yes, when _____

b) Experienced serious anxiety or tension Yes... No If yes, when _____

c) Experienced hallucinations..... Yes... No If yes, when _____

d) Experienced trouble understanding, concentrating or remembering Yes... No If yes, when _____

e) Experienced trouble controlling violent behavior Yes... No If yes, when _____

f) Experienced serious thoughts of suicide/homicide..... Yes... No If yes, when _____

g) Attempted suicide Yes... No If yes, when _____

i) If you ever attempted or considered suicide, when and why did you? _____

ii) Were alcohol or drugs being used during the suicide attempt/consideration? Yes No

iii) Are you considering suicide now? Yes No

iv) Do you have a plan? Yes No

4. Have you ever been prescribed medication for any psychological/emotional problems? Yes No

5. Describe the feeling that you most often experience _____

6. When do you experience feelings of guilt? _____

INTERVIEWER'S IMPRESSIONS

7. Is client obviously depressed/withdrawn? Yes No

8. Obviously hostile? Yes No

9. Obviously anxious/nervous? Yes No

10. Having trouble with reality testing, thought disorders, paranoid thinking? Yes No

11. Having trouble comprehending, concentrating, remembering? Yes No

12. Having suicidal thoughts? Yes No

13. Does the client need to seek a psychiatric consultation? Yes No

DIAGNOSIS(ES):	TYPE: Principal (P) Both Principal & Primary (B) Primary (R) Additional (A)
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Axis	Code	Type	Description

Comments: _____

Section VII: Summary

DSM IV Summary (Three or more checks across any row, excluding the abuse column, indicates dependence for that substance)

	Drug (name, not code)	Tolerance	Withdrawal	Increasing amounts	Desire to cut down	Time devoted to using/seeking substances	Saliency of drug use	Use despite med/psych consequence	Any abuse criteria
Primary		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Secondary		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tertiary		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Make clinical determination if use is likely to have caused or exacerbated medical or psychological condition
 Yes No
- Diagnostic Impression _____ _/ _/ _/ • / _/ _/
- Physiological Dependence Yes No
- Course: _____

01 - Early full remission	05 - On agonist therapy
02 - Early partial remission	06 - In a controlled environment
03 - Sustained full remission	07 - Client actively using
04 - Sustained partial remission	08 - Never met criteria

1. Focus of Concern for ASAM Level of Care and Service Planning

Dimension	Level of Concern
1. withdrawal/intoxication risk	0 1 2 3 4 5 6 7 8 9
2. biomedical complications	0 1 2 3 4 5 6 7 8 9
3. emotional/behavioral issues	0 1 2 3 4 5 6 7 8 9
4. acceptance/resistance	0 1 2 3 4 5 6 7 8 9
5. relapse potential	0 1 2 3 4 5 6 7 8 9
6. environment	0 1 2 3 4 5 6 7 8 9

2. Focus of Concern for ASAM Level of Care and Service Planning

Dimension	Level of Concern									
1. withdrawal/intoxication risk	0	1	2	3	4	5	6	7	8	9
2. biomedical complications	0	1	2	3	4	5	6	7	8	9
3. emotional/behavioral issues	0	1	2	3	4	5	6	7	8	9
4. acceptance/resistance	0	1	2	3	4	5	6	7	8	9
5. relapse potential	0	1	2	3	4	5	6	7	8	9
6. environment	0	1	2	3	4	5	6	7	8	9

3. Comparison of Focus of Concern and Level of Care (or see LOC Crosswalk)

Dimension	.5-9	I.1-9	II.1-9	III.1-2	III.3-4	III.5-6	III.7+	IV
1. withdrawal	0	0-3	3-5	0-1	3-5	3-5	6-7	8-9
2. medical	0-1	0-3	0-5	0-2	0-2	0-5	6-7	8-9
3. emotional	0-1	0-2	2-4	0-2	2-6	5-7	7-8	9
4. resistance	0-2	2-3	3-5	2-4	5-7	7-8	8-9	*
5. relapse	0-3	2-4	4-6	2-4	5-7	6-8	8-9	*
6. environment	0-3	1-4	3-5	4-6	5-7	6-8	8-9	*

*: Note that dimensions four, five and six cannot qualify a person for Level IV services.

Current ASAM Level of Care: _____ explain if not consistent with chart above

Are you willing to participate in treatment recommended by TASC? Yes No

Recommended Care Management Level (from CCMC) _____

Primary Service Recommend: _____

- | | |
|--|---------------------------------------|
| 1-TASC Assessment Only | 11- Care Mgmt & Residential Treatment |
| 2-Care Mgmt Only (includes urinalysis) | 12- Care Mgmt & Therapeutic Community |
| 3-Care Mgmt & DES | 13-Young Adult Offender Initiative |
| 4-Care Mgmt & Dealers Group | 14-Pre-trial Services |
| 5-Care Mgmt & CBI | 15-Jail Program |
| 6-Care Mgmt & Mental Health Services | 16-Drug Tx Court |
| 7-Care Mgmt & pre-tx/orientation | 17-Juvenile Care Mgmt Services |
| 8- Care Mgmt & Outpatient | 18-DRC Care Mgmt Services |
| 9- Care Mgmt & Intensive Outpatient | 19-Other (please describe) _____ |
| 10- Care Mgmt & Day Treatment | |

Referred to (facility): _____

If known: Treatment Intake Date ___/___/___ and Time ___:___

Next scheduled TASC appointment:

TASC Care Manager Signature: _____ Date: _____

Screening/Assessment Report

DATE:

TO:

RE:

Pursuant to your referral, TASC conducted a screening/assessment on the above-named client.

He/she is **ineligible** for TASC services as evidenced by the following reason(s):

- No indication of a current substance abuse related service need.
- Failed to attend scheduled appointment(s) on _____.
- Unwilling to participate in TASC services.
- Other _____

It is recommended that he/she continue to be tested for drug and/or alcohol use. Should he/she test positive for any controlled substance he/she should be referred to TASC immediately for further assessment.

He/she is **eligible** for TASC services and as a result of screening/assessment it is recommended that he/she participate in the following:

- Urinalysis/TASC Care Management
- Drug Education School
- Regular Outpatient
- Intensive Outpatient
- Day Treatment
- Residential/Inpatient
- Therapeutic Community
- Mental Health Assessment
- Aftercare/Continuing Care
- Other: _____

TASC Care Manager

cc: Client File

Information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). Federal Rules prohibit you from any re-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 general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules do not restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

TASC is authorized by the State of North Carolina to perform screening, assessment, and care management services for offenders

TASC CONSENT FORM

CRIMINAL JUSTICE SYSTEM CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Record Number: _____

I, _____, hereby authorize TASC to disclose to, receive from, and communicate with the following person(s) or agency(ies); in written, verbal and/or electronic format:

- North Carolina Court Officials _____
- North Carolina Department of Correction, _____
- North Carolina District Attorney's Office _____
- North Carolina Public Defender's Office _____
- Other _____
- Other _____

I understand that my participation is a condition of at least one of the following: my release from confinement; the disposition of a criminal proceeding against me; the execution of a sentence imposed upon me; or the suspension of a sentence imposed upon me.

The purpose of and need for the disclosure is to inform the criminal justice agency(ies) listed above of my attendance and progress. The extent of the information to be disclosed is my diagnosis, information about my attendance or lack of attendance, cooperation, prognosis, urinalysis results, evaluation results, admission and discharge dates, status summaries and _____

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, Part 2 of Title 42 of the Code of Federal Regulations, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: _____

Executed this date: _____ Client Signature: _____

Witnessed by: _____ Guardian/Legal Rep. Signature: _____
(as required)

Facsimiles provide valid forms of consent

TASC CONSENT FORM

CRIMINAL JUSTICE SYSTEM CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Record Number: _____

By signing this form, I, _____, am aware of the following:

1. I will notify TASC within 72 hours of the following changes: address, phone, employment, education, health conditions (i.e. pregnant), attorney representation, re-arrests, or new court dates.
2. I am responsible for:
 - Observing all local, state and federal statutes.
 - Attending any required court appearances.
 - Attending all counseling appointments unless excused in advance by the counselor.
 - Providing TASC with the information necessary to facilitate court and treatment activities.
 - Participating in the development of his/her service plan.
 - Observing all rules and regulations of the treatment program to which I am assigned.
 - Cooperating with TASC services and satisfactorily completing his/her service plan.
3. TASC will be responsible for:
 - Having a TASC Representative and/or TASC Progress Report at any required court proceedings and presenting assessment findings with status in treatment and TASC.
 - Identifying my treatment needs and referral to the appropriate treatment provider.
 - Supplying me and the treatment facility with the information necessary to complete the intake process at the treatment facility.
 - Reporting verified treatment intake, progress in treatment and termination from treatment to appropriate CJS personnel or other referral source.
4. TASC reserves the right to seize and dispose of any urine specimens that I provide fraudulently or any illicit drugs, alcohol, or drug paraphernalia.
5. I also understand that Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records protects my rights to confidentiality.

I have received a copy of this contract and I understand and agree to fulfill the responsibilities that it assigns to me until my termination from TASC services. The TASC fees, payment policies and procedures have been thoroughly explained to me and I agree to comply. I also understand that failure to adhere will result in termination from TASC. This unsuccessful termination will be reported to the appropriate CJS personnel.

Executed this date: _____ Client Signature: _____

Witnessed by: _____ Guardian/Legal Rep. Signature: _____
(as required)

CONFIDENTIAL CLIENT INFORMATION

ANY UNAUTHORIZED DISCLOSURE IS A NORTH CAROLINA AND FEDERAL OFFENSE

Success Criteria

- I understand that in order to successfully complete TASC I must either satisfy my Service Plan or complete CJS Jurisdiction. At a minimum this is:
 - completion of all required treatment services;
 - maintain abstinence from mood altering chemicals for 90 days;
 - establish a legitimate source of income or full-time student status;
 - maintain a satisfactory and stable living environment;
 - pay all fees.

- I understand that TASC expects the following:
 - that I will not use drugs or alcohol;
 - that I will submit to urinalysis and breathalyzer testing as directed;
 - that I will comply with treatment rules and regulations;
 - that I will comply with my service plan;
 - that I will not miss two consecutive counseling sessions;
 - that I will attend all scheduled meetings with TASC including office monitoring appointments, case conferences and jeopardy meetings;
 - that I am cooperative with TASC and treatment personnel; and
 - that I refrain from criminal activity.

Jeopardy Criteria

- I understand that if I break any of the above mentioned rules I will be placed in Jeopardy Status with TASC and that all Jeopardies are reported to Criminal Justice System Personnel. I also understand that if I fail to follow through with the recommendations of this jeopardy status staffing, I will be terminated from TASC.

Termination Criteria

- I understand that I will be unsuccessfully terminated from TASC if I break any of the following rules:
 - I fail to attend two scheduled intake appointments to enter treatment;
 - I repeatedly violate TASC rules and regulations;
 - I am convicted of a violent offense;
 - I am convicted of a manufacture or trafficking offense;
 - I fail to contact TASC for 30 days;
 - I am repeatedly in non-compliance with my service plan;
 - I act or threaten violence against TASC or treatment staff or another client;
 - I possess a weapon in TASC or the treatment program sites;
 - I withdraw or refuse to participate in the treatment program of referral or recommended services;
 - I had possession of drugs/alcohol in TASC or in the treatment program sites;
 - I am convicted of a subsequent felony charge which precludes my continued participation in TASC;
 - I am incarcerated for 90 days or more.

Date

Client Initials

TASC Care Management Plan

Client:		Record Number:		Date:	
Diagnosis(es):			Type: Principal (P); Both Principal & Primary (B); Primary (R); Additional (A)		
Axis	Code	Type	Description		
Supports/Strengths					
Date			Date		
Preferences					
Date			Date		
Problems(s)/Need(s)					
Date			Date		

Client:	Record Number:
----------------	-----------------------

Date:

Goal	Service(s)/Intervention(s) (Including Frequency)	Responsible Person/Position

Target Date	Reviewed Date	Status Code	Justification for Continuation/Discontinuation of Goal

STATUS CODES: R=REVISED O=ONGOING A=ACHIEVED D=DISCONTINUED

COMPREHENSIVE CARE MANAGEMENT CRITERIA (CCMC) CHECKLIST

Client Name: _____ SSN: _____

	Date	Date	Date	Date	Date
Dimension 1: Risk/Connection					
A. Criminal history					
B. Recidivism Potential					
C. Substance Abuse/Criminal Justice Connection					
• Highest Level Checked	□	□	□	□	□
Dimension 2: Rehabilitation Potential					
A. Compliance with TASC Requirements					
B. Current Use and Potential for Return to Use					
• Highest Level Checked	□	□	□	□	□
Dimension 3: Recovery Environment					
A. Environmental Structure					
B. Support					
C. Stability					
D. Gang Influence					
• Highest Level Checked	□	□	□	□	□
Dimension 4: Serviceability					
A. Physical Health					
B. Mental Health					
C. Systems involvement					
D. Treatment Resources					
• Highest Level Checked	□	□	□	□	□
Current TASC Care Management Level	□	□	□	□	□

Discuss coordination of supervision: _____

General Instructions: Complete this checklist following initial assessment & review during each month thereafter. Record Dimension results from pages 2-5 in the appropriate columns above. ***If Level 1 criteria are met in any Dimension, the client is assigned to Level 1 Care Management.*** Otherwise the level of care management is determined by a preponderance of the findings. If the dimensions are evenly divided between Level 2 & Level 3, the client is to be placed in the higher care management level. (See TASC SOP for care management requirements.)

Adult CCMC CHECKLIST (Static Criteria)

DIMENSION 1: Social Risk & Connection between Substance Abuse and Criminal Justice *(Check all boxes that apply)*

	LEVEL 3 Minimum	LEVEL 2 Moderate	LEVEL 1 Maximum
A. Criminal history involves <u>harm to others</u> . If offense indicates injury or is aggravated, this meets criteria for harm. Information surfacing during interaction with client or Criminal Justice System which clearly indicates physical harm to victim is to be considered.	No Harm	One Prior	Current Offense or 2 +
B. Recidivism Potential	No Probation/ Parole/Post-Rise Revocations	1 Revocation	2+ Revocations
	17 years or older at 1st offense 50 years or older at 1st interview	1 prior failed TASC or TX episode	2+ prior failed TASC or TX episodes
C. Substance Abuse/Criminal Justice (CJ) Connection (see offense guide)	Level 3 Offenses and substance abuse prior to CJ involvement	Level 2 offenses and substance abuse prior to CJ involvement	Level 1 offenses or extensive CJ involvement unrelated to addiction

Mark the level for each section below. Highest level marked in a given section (A, B or C) dictates level of assignment for that section. If any section results in a Level 1 determination, the overall dimension will be designated Level 1. Otherwise, level assignment is determined by the results in at least two sections.

Offense Guide		A	B	C	Date
Level 3 Offense Types Impulsive and utilitarian or involving drug use or possession. Examples, <u>including</u> but <u>not limited to</u> : Purse-snatching, Drug Possession, DWI, Public Intoxication	Level 2 Offense Types Impulsive and non-utilitarian or calculated and utilitarian. Examples, <u>including but not limited to</u> : Battery, Criminal Damage, Joy Riding, Theft, Burglary, Robbery, Drug Sales, Forgery, Fraud, Prostitution				
Level 1 Offense Types Calculated and non-utilitarian. Examples, <u>including but not limited to</u> : Murder, Arson, Sex Offenses, Stalking					

TASC Progress Notes

Date:

Period of Time Report Covers:

Client Name:

TASC Care Manager:

Record Number:

Counselor/Provider Agency:

Referral Source:

Education/Service/Treatment Modality:

- | | |
|--|--|
| <input type="checkbox"/> Urinalysis/Care Management Only | <input type="checkbox"/> Therapeutic Community |
| <input type="checkbox"/> Drug Education School | <input type="checkbox"/> Methadone |
| <input type="checkbox"/> Regular Outpatient | <input type="checkbox"/> Mental Health (no SA) |
| <input type="checkbox"/> Intensive Outpatient | <input type="checkbox"/> Aftercare/Continuing Care |
| <input type="checkbox"/> Day Treatment | <input type="checkbox"/> Family Services |
| <input type="checkbox"/> Residential/Inpatient | <input type="checkbox"/> Other (please describe) |

Start Date:

Expected Completion Date:

Counseling Contacts:

Group Sessions Scheduled:	Individual Sessions Scheduled:
Group Sessions Attended:	Individual Sessions Attended:
Group Sessions Absent (Unexcused):	Individual Sessions Absent (Unexcused):

Treatment Counselor Comments:

TASC Contacts:

Urinalysis Results:

Scheduled:	Date:	Result:	Drug Type:
Attended:	Date:	Result:	Drug Type:
Absent (Unexcused):	Date:	Result:	Drug Type:

TASC Care Manager Comments:

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). Federal Rules prohibit you from making any re-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 general 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 client.

TASC is authorized by the State of North Carolina to perform screening, assessment, and care management services for offenders.

Successful Termination Letter

DATE:

TO:

RE:

This is to inform you that the above-named client **SUCCESSFULLY** completed TASC on _____.

In order to complete TASC successfully, the following was accomplished:

- Fulfilled the following TASC goals:
 - Successfully complete all recommended treatment.
 - Remain alcohol and drug free for at least 90 consecutive days prior to termination from TASC, includes relapse prevention plan.
 - Establish and maintain a legitimate source of income or full-time student status.
 - Establish and maintain a stable living environment.
 - Comply with agreed upon activities needed to support the recovery and rehabilitation process.
- Paid all required fees.

The following is a brief summary of the Service Plan activities which this individual completed: _____

TASC Care Manager

TASC Supervisor

cc: Client File

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Unsuccessful Termination Letter

DATE:

TO:

RE:

This is to inform you that the above-named client was **UNSUCCESSFULLY** terminated from TASC on _____. This individual has failed to complete his/her *Service Plan* and the requirements of TASC for the following reason(s):

- client reached the third and final jeopardy status;
- client was convicted on any subsequent felony charge, which precludes his/her continued participation in TASC services;
- client was not in contact with TASC for 30 calendar days;
- client acted violently or threatened violence against TASC staff, treatment staff or another client;
- client was repeatedly in non-compliance with his/her Service Plan;
- client was in possession of a weapon in TASC or the treatment program sites;
- client was in possession of drugs or alcohol in TASC or the treatment program sites
- client withdrew from TASC services
- client failed to pay required fees

The following is a brief summary of the events and activities leading to the unsuccessful termination: _____

TASC Care Manager

TASC Supervisor

cc: Client File

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). Federal Rules prohibit you from making any re-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 general 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 client.

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