

## AB 109 Client Intake and Progress Report Behavioral Health Care Services

*This report is to be used by mental health and substance use treatment providers to report to Alameda County Probation on the commencement of services by their AB109 clients and subsequent progress in treatment*

| Client Information  |  |                            |
|---|--|----------------------------|
| Probation Officer:  | Agency/Program (if applicable):  |                            |
| Client Name:  | Provider Contact:  |                            |
| Date of Birth:  | Phone number:  |                            |
| Date of Referral From ACCESS:   | Date of Intake:  | Date of First Appointment: |
| Program Information   |  |                            |
| Service Frequency:<br><input type="checkbox"/> Daily<br><input type="checkbox"/> Weekly (Specify days of expected attendance): <input type="checkbox"/> M <input type="checkbox"/> Tu <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F<br><input type="checkbox"/> Monthly<br>Type of Services: _____                              |  |                            |
| Client Participation (if treatment has begun)   |  |                            |
| Attendance:<br>Client missed appointment(s) on the following day(s): _____  |  |                            |
| Drug Testing – part of treatment program?<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | Date(s) of Positive Test (if applicable):<br>_____<br>Drugs detected (if applicable):<br>_____ |                            |
| Ancillary Services (if applicable)  |  |                            |
| Referrals Made to Ancillary Services (check all that apply): Housing <input type="checkbox"/> Employment <input type="checkbox"/> Benefits <input type="checkbox"/> Medical <input type="checkbox"/><br>Dental <input type="checkbox"/> Family Support <input type="checkbox"/> Legal <input type="checkbox"/> Other (describe) _____                               |  |                            |
| Client Progress   |  |                            |
| Treatment Progress: _____<br>_____  |  |                            |
| Discharge (if applicable)   |  |                            |
| Discharge Date:<br>Discharge Status (check one):<br><input type="checkbox"/> Completion<br><input type="checkbox"/> Left before completion w/satisfactory progress<br><input type="checkbox"/> Left before completion w/o satisfactory progress<br><input type="checkbox"/> Transfer to another program/provider<br><input type="checkbox"/> Other (describe) _____ |  |                            |

**Please FAX this form to the referring Probation Officer at (510) 795-2572 (Hayward) or (510) 268-2429 (Oakland)**

**Confidentiality Notice:** The information contained in this facsimile originated from client records of a substance abuse treatment or mental health agency that are protected by federal law (Federal Regulation 42 CFR, Part 2, and 45 CFR, Part 160, and/or the Health Insurance Portability and Accountability Act of 1996 (HIPAA)), with the consent of the named client. The authorized recipient of this information is prohibited from disclosing this information to any other party outside of the recipient agency. If you have received this fax in error, please notify the sender immediately by calling the phone number above to arrange for return of these documents.