

Client Status Change Report

			1. CSO NAME
2. ASSESSMENT ENTITY (INCLUDING COUNTY)		3. <input type="checkbox"/> Initial <input type="checkbox"/> Update	4. DATE FORM COMPLETED
A. Identifying Information			
1. CLIENT NAME (LAST, FIRST, MI)		2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
4. ACES CLIENT NUMBER	5. CSO APPLICATION DATE	6. TREATMENT PRIORITY	7. ASSESSMENT DATE
B. Assistance Program Type: <input type="checkbox"/> Primary ADATSA <input type="checkbox"/> TANF <input type="checkbox"/> SSI <input type="checkbox"/> GAU <input type="checkbox"/> Other: _____			
1. BEGINNING DATE		2. ENDING DATE	3. MODALITY
4. AGENCY NAME	MAILING ADDRESS	CITY	ZIP CODE
5. COMMENTS			
1. BEGINNING DATE		2. ENDING DATE	3. MODALITY
4. AGENCY NAME	MAILING ADDRESS	CITY	ZIP CODE
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5. COMMENTS			
C. Assessment Center Closing File			
1. CLOSURE DATE	2. CLOSURE REASON (CHECK ONE BOX ONLY)		
	<input type="checkbox"/> Client died	<input type="checkbox"/> Incarcerated	<input type="checkbox"/> Rules violation/non-compliance
	<input type="checkbox"/> Completed treatment	<input type="checkbox"/> Moved	<input type="checkbox"/> Transferred to different facility
	<input type="checkbox"/> Funds exhausted	<input type="checkbox"/> No contact/abort	<input type="checkbox"/> Withdrew against program advice
	<input type="checkbox"/> Inappropriate admission	<input type="checkbox"/> Not amenable to treatment	<input type="checkbox"/> Withdrew with program advice
D. Comments			
E. Assessment Counselor			
1. NAME		2. TELEPHONE NUMBER ()	