|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | **Client Status Change Report** | | | | | | | 1. CSO NAME | |
| 2. ASSESSMENT ENTITY (INCLUDING COUNTY) | | | | | | | 3.  Initial  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:**  **ABD / HEN**  **TANF**  **SSI**  **PWA**  **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 |
| 5. COMMENTS | | | | | | | | | | |
|  | | | | | | | | | | |
| 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 |
| 5. COMMENTS | | | | | | | | | | |
| **C. Assessment Center Closing File** | | | | | | | | | | |
| 1. CLOSURE DATE | 2. CLOSURE REASON (CHECK ONE BOX ONLY)  Client died  Incarcerated  Rules violation/non-compliance  Completed treatment  Moved  Transferred to different facility  Funds exhausted  No contact/abort  Withdrew against program advice  Inappropriate admission  Not amenable to treatment  Withdrew with program advice | | | | | | | | | |
| **D. Comments** | | | | | | | | | | |
|  | | | | | | | | | | |
| **E. Assessment Counselor** | | | | | | | | | | |
| 1. NAME | | | | | | 2. TELEPHONE NUMBER  **(     )** | | | | |