|  |  |  |
| --- | --- | --- |
|  | **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**(     )** |