8-507

AFTERCARE PLAN

*This form is due, 60 days prior to discharge, to Justice Services @ BHA Justice Services at mdh.bhajstxproviders@maryland.gov*

CONSUMER INFORMATION

|  |  |  |
| --- | --- | --- |
| NAME: | DOB: | AGE: |
| RACE: | GENDER: | SID #: |

COURT INFORMATION

|  |  |  |
| --- | --- | --- |
| COURT: | JUDGE: | NEXT HEARING DATE: |
| CASE #: | CASE #: | CASE #: |
| LEGAL STATUS: | | |

**SOMATIC HEALTH INFORMATION**

|  |  |
| --- | --- |
| CONDITION(S): | MEDICATION(S): |
| ALLERGIES: | |

**MEDICATION-ASSISTED TREATMENT INFORMATION**

|  |  |
| --- | --- |
| MEDICATION: | PROVIDER: |

**RESIDENTIAL PROVIDER INFORMATION**

|  |  |
| --- | --- |
| PROGRAM NAME: | |
| ADDRESS: | PHONE: |
| ASAM LEVEL OF CARE: | ADMISSION DATE: |

**AFTERCARE PLAN CHECKLIST**

**Treatment Provider(s)**

Provider Name:       Address:       Phone:       Provider Type: Addictions Counselor

Provider Name:       Address:       Phone:       Provider Type: Mental Health Therapist

Provider Name:       Address:       Phone:       Provider Type: Psychiatrist

Provider Name:       Address:       Phone:       Provider Type: Primary Care Physician

**Housing**

Provider Name:       Address:       Phone:       Provider Type:

Consumer Address:       Phone:       Housing Type:

**Employment**

Employer:       Address:       Phone:       Job/Position:

**Educational/Vocational Training**

Program:       Address:       Phone:       Program Type:

**ADDITIONAL INFORMATION**

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| --- |
|  |

Counselor Signature Date

Supervisor Signature Date