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**

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| --- |
| 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