## RAFT Diversion Program: SUD Assessment Summary Form

**Date of Assessment:       (M/D/YYYY)**

|  |  |
| --- | --- |
| **AUTHORIZED TREATMENT PROVIDER** | **COMMUNITY CORRECTIONS / COURT SERVICES AGENCY / DA** |
| Treatment Provider Name: | District: |
| Street Address: | Street Address: |
| City / State / Zip: | City / State / Zip: |
| Assessor Name:  Phone No.:  Email.: | ISO  CSO  DA Name:  Phone No.:  Email.: |
| Assessor Signature: | |
| SASSI Completed by:  Above  CSO/Supervisor (name): | |

Safeguarding of Client Information. The information contained on this form is confidential and not to be used or disclosed by any party, for any purpose that is not connected directly to the Court’s assignment of sentence or the case management responsibilities assigned by law to Supervising Agency or by court order. Treatment providers are required to maintain confidentiality consistent with the requirements of their state license.

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **OFFENDER PROFILE** | | | | | | | | | | | |
| Conviction Name (**First, MI, Last**): | | | | | | | | ATHENA # (if available): | | KBI No.: | |
| Date of Birth:(MM/DD/YYYY) | | | | County of Diversion: | | | TOADS Legacy KDOC # (if available): | | Court Case No: | | |
| **SASSI Probability:** | | | **SASSI Profile Scores:** | | | | | | | | |
| High:  Low: | | | | | | |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | FVA | FVOD | SYM | OAT | SAT | DEF | SAM | FAM | COR | RX | |  |  |  |  |  |  |  |  |  |  |   **NOTE:** Summary Score Page -   * If RAP is above 2, DEF is above 8, score may be invalid. * If score is invalid or low and treatment is recommended, please address in comments. | | | | | |
| Was Mental Health Screen administered?  Yes  No | | | | | | Mental Health Comments: | | | | | |
| Referred for additional services?  Yes  No | | | | | |
| Clinical History Comments: (attach additional page(s) as necessary) | | | | | | | | | | | |
| **ASSESSOR RECOMMENDATIONS**: **Identify BOTH initial and ALL anticipated treatment components and modalities as reflected by ASAM criteria that apply for the continuum of care as identified in the narrative summary:** | | | | | | | | | | | |
| **Initial** Treatment Modality | **Anticipated** Treatment component | | | Modality | | | | | |
|  |  | | | NONE (If NONE please attach explanation) | | | | | |
|  |  | | | Social Detoxification | | | | | |
|  |  | | | Therapeutic Community (**Jo Co only**) | | | | | |
|  |  | | | Intermediate Residential | | | | | |
|  |  | | | Reintegration | | | | | |
|  |  | | | Intensive Outpatient | | | | | |
|  |  | | | Outpatient – Individual | | | | | |
|  |  | | | Outpatient – Group | | | | | |
|  |  | | | Outpatient – Family | | | | | |
|  |  | | | Peer Mentorship **(NOT a stand-alone service)** | | | | | |
|  |  | | | Relapse Prevention/Continuing Care | | | | | |
|  |  | | | Drug Abuse Education (**FUNDED by Offender**) | | | | | |

**\*Treatment Provider and Supervising Agency to retain copy for record keeping and auditing purposes.**