AFTERCARE COMPLETION FORM

Please submit this form, either with your typed or printed responses, to the Multiple Offender Program (MOP) either,

1.) Upon completion of aftercare treatment; or,
2.) When the course of treatment has been terminated before a low-risk assessment has been made. Please provide a reason for termination.

Approved providers in New Hampshire MUST hold the credential of:
- MLADC or LADC
- Psychologist with a certificate from the APA (American Psychological Association) for the treatment of alcohol and other psychoactive substance abuse disorders.
- A person working towards licensure as a NH M/LADC, and who has passed the examination required by the New Hampshire Board of Licensed Alcohol and Drug Abuse Professionals (administered June 30th, 2008 and after), working towards licensure, under the direct supervision of an MLADC or LADC.
- There will be NO EXCEPTIONS.

Approved providers outside of New Hampshire:
- Must have the equivalent credentials as determined by IC&RC. If you require clarification PLEASE contact us at (603) 271-4936 and request the Aftercare Department.
- There will be NO EXCEPTIONS.

In the state of Massachusetts, ONLY CADAC’s are approved to provide DWI Aftercare Treatment for New Hampshire DWI clients. Please call if further clarification is needed.

In order to consider this client for completion of the Multiple Offender Program, if you are an MLADC or an LADC we MUST have a current copy of your license on file. If you are a psychologist providing services, we MUST have a current copy of your APA certificate. We will NOT review any paperwork until we have a copy of your current (valid) license, as well as the MOP Release of Information (Form B), both filled out accurately and COMPLETELY. If an area is not applicable, please write N/A. Both the copy of your license, and the Release Of Information must be on file at MOP in order to process paperwork.
Be sure to answer ALL applicable questions on this form, as failure to do so will result in delays. If not applicable, please write in N/A.

Client’s Name: ______________________________ Date of Birth: __________________

Client’s Current Address (include zip code): ____________________________________

Client’s Telephone #: _________________________ Last 4 of Client’s SS__________

Dates of MOP attendance: __________________ to _____________________________

1. Providers’ review of the following paperwork is REQUIRED before MOP considers submission of aftercare paperwork for completion. By checking the following off, you are verifying that you have, in fact, reviewed the information.

* MOP Client Evaluation and Referral Recommendations Form □□ YES □□ NO
* The Aftercare Requirements Statement □□ YES □□ NO
* MOP 60-Day Court-Ordered Aftercare Requirement Form □□ YES □□ NO
* The Consent for the Release of Confidential Information □□ YES □□ NO

2. TYPE OF SERVICE:

   Outpatient
   Were the outpatient session’s individual, group or both? (Please circle the appropriate answer). If both individual and group sessions were included in your treatment plan, please provide identification of either group sessions (G), or individual sessions (I) when noting the individual dates of service. (See * “Session” section, below). EXAMPLE: 1/7/09 (G); 1/14/09 (G); 1/28/09 (I).
   If client has experienced any significant life events since MOP, please document on a separate piece of paper, attaching the sheet to this form, and note any impact on this client’s use of alcohol and/or other drugs. Please provide independent verification if the client has been abstinent from alcohol and/or other drugs. (If diagnostic tests/assessments were used to provide independent verification, please attach results to this form along with your clinical impression of results).

   OR

   Second Opinion Evaluation (minimum of 3 contact hours, no more than 5 contact hours)
   A second opinion evaluation is warranted if you have determined that the client has reached an acceptable level of risk (low risk) sooner than the time period that was recommended by MOP. Please provide your clinical rationale, in an attached updated substance abuse history, describing why you don’t think the client would benefit from the amount of time recommended by MOP (as noted in the client’s Evaluation and Referral Recommendations from MOP). The updated substance abuse evaluation need not be more than two pages, however, document any significant changes in the client’s life history since the client’s MOP evaluation, along with your treatment plan/prognosis. Please provide independent verification if the client has been abstinent from alcohol and/or other drugs. (If diagnostic tests/assessments were used
to provide independent verification, please attach the results to this form, along with your clinical impression).

**Sessions**  
Total number of sessions: ______________________ Length of session: ______________

Provide all dates of service and explain any gaps of service over 3 months:
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

3. **Self Help Involvement:**

   - If yes, note which recognized self-help group(s) this client attended, or continues to attend, as well as how often, and his or her level of involvement.
   - If no recognized self-help groups were included in the treatment plan, please explain your clinical rationale for not requiring attendance and/or explain what other support system this client is utilizing on a separate sheet of paper.

4. Please note all alcohol and/or illicit drug diagnosis/diagnoses: Please include course specifiers for clarity._____________________________________________________
_______________________________________________________________________
_______________________________________________________________________

If your diagnosis/diagnoses do not agree with the preliminary diagnosis/diagnoses noted in the MOP evaluation, please provide your clinical rationale to explain any discrepancy.
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Has the client continued to drink during the course of treatment? If yes, please provide the frequency and quantity of use. Please indicate date(s) when this client last drank and/or used illicit drugs:
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

In your opinion, does this client have an accurate assessment of their relationship to alcohol/illicit drug use? **YES** **NO**

Please explain:
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
5. Risk Assessment:

Low/ acceptable Level of Risk to recidivate
Remains at Risk

Briefly Explain your Rationale: ____________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

6. Is this client on medication presently? YES NO

If this **client is on medication** that could adversely affect his or her ability to drive safely, or has a medical condition that could negatively impact his or her ability to drive safely, you are required to provide a letter from the client’s healthcare provider, on letterhead. The letter, **signed and dated by the physician**, must state, “I attest that the above medication(s), when taken as prescribed, will not hinder or impair my patient from safely operating a motor vehicle.” Should a health care provider not wish to send a letter attesting to this, the client will be required to attend a Medical Risk Hearing at the Department of Safety, NH DMV, to determine whether or not the medication(s), or medical condition, will adversely affect his or her ability to safely operate a motor vehicle.

If this **client was on medication while at MOP** that could adversely affect his or her ability to drive safely, but is **not now**, provide details on a separate sheet of paper. **Failure to do so will result in delays.**

Provider’s Name______________________________________________________

Provider’s Signature__________________________________________________

Agency________________________________________________________________

Address (please include zip code)________________________________________
_____________________________________________________________________

Telephone #_________________Hours provider can be reached__________

Today’s Date________________________________________________________

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