Client Name:

Continuing Care Profile

Date of Birth:_____

County/Jurisdiction_____ Case No(s)_____

Judge _____

Treating Agency _____ Form Completed By_____

Date of Admission _____ Anticipated Discharge Date_____

Insurance Type _____ Discharge Date_____

Income/SSI_____ Other Benefits_____

Criminal Justice Agency [ ] MD P&P [ ] MD Juv. Services Agent_____

Agent Phone_____ Agent Notified Y / N

CJ Agency Location_____ Date of Notification _____

Address_____ City_____

State _____ Zip_____

Appointment w/ Agent (Date) _____

Living Situation

Living Arrangement _____ Start Date_____

Agency _____

Address_____ City_____

State_____ Zip _____

Contact _____ Phone_____

Employment/Vocational Training/Education

Employment

Employment/Vocational Status _____

Company/Agency _____

Address_____ City _____

State_____ Zip _____

Phone_____ Contact _____

Verified Y / N Start Date _____

Termination Date_____

Education/Vocational Training

Education Service Type_____ School_____

Address_____ City_____

State_____ Zip_____

Start Date_____

Substance Abuse/Mental Health Services

Service Category	Service Type	Agency	First Appointment

Service (Additional Information)

Medications

Medication	Dosage	Pharmacy	Phone

Medication (Additional Information)

Community Partners

Name	Phone	Relationship

Community Partner (Additional Information)