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ILLINOIS PETITIONER TREATMENT VERIFICATION

Office of the
Secretary of State
DEPARTMENT OF
ADMINISTRATIVE HEARINGS

Additional forms may be obtained at
www.cyberdriveillinois.com

The rules of the Secretary of State's Department of Administrative Hearings require a petitioner to document completion of any recommended treatment or provide a treatment waiver as recommended in the Treatment Needs Assessment (TNA). This form may be completed and submitted for this purpose. If more space is needed, attach additional sheets.

Copies of the following documents must be attached to this form:
1) Individualized Treatment Plan **2) Discharge Summary** **3) Continuing Care Plan**
4) Continuing Care Status Report **5) Continuing Care Summary Report or Treatment Waiver**

PETITIONER INFORMATION:

Name: (Last, First, Middle)		Illinois Driver's License Number:	
Address: (Street/City/State/ZIP)			
Sex: ☐ M ☐ F	Date of Birth: / /	Home Telephone Number: ( )	Work Telephone Number: ( )

1. Referral Source: _____

2. Admission Date: _____ Discharge Date: _____
(Primary treatment only; not follow-up/aftercare)

3. Admission Diagnosis: _____

_____

Discharge Diagnosis: _____

_____

OR

TNA Date: _____ Diagnosis: _____

_____

4. Treatment Modality:
   - ☐ Outpatient counseling..... Number of hours completed: _____
   - ☐ Intensive outpatient counseling..... Number of hours completed: _____
   - ☐ Inpatient..... Number of days in inpatient treatment: _____
   - ☐ Individual therapy
   - ☐ Group therapy

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5. Prognosis after completing treatment and/or TNA. Must include a discussion of what the petitioner appears to have gained from treatment and whether it has substantially reduced the potential for future alcohol/drug-related problems.

6. Continuing Care Status:
   - ☐ Petitioner has completed continuing care (summary report required).
   - ☐ Petitioner is currently involved in a continuing care plan (status report required).
   - ☐ Petitioner has completed a continuing care plan.
   - ☐ Petitioner has not initiated continuing care.
   - ☐ Continuing care waived (rationale required).
   - ☐ Petitioner has initiated but failed to complete a continuing care plan for the following reason:

7. Rationale for: a) any modification in the number of treatment hours or change in treatment modality as recommended by the petitioner's last evaluation; b) treatment waiver; or c) additional treatment recommendations as a result of the TNA.

If a petitioner classified as "High Risk" has been determined to be "Non-Dependent," a detailed explanation by the treatment provider as to why "dependency" was ruled out must be submitted on a separate document.

I certify that I have accurately reported the data collected and required to complete the treatment verification. I also have attached copies of the petitioner's Individualized Treatment Plan, Discharge Summary, Continuing Care Plan, Continuing Care Status Report, and Continuing Care Summary Report or TNA.

Provider's Name: (type or print)	
Provider's Signature:	Date:
Provider's Title:	Telephone Number:
Program Name:	Accreditation/License Number:
Address: (Street/City/State/ZIP)	