Reset

# ILLINOIS PETITIONER TREATMENT VERIFICATION

**Office of the Secretary of State**
**DEPARTMENT OF ADMINISTRATIVE HEARINGS**

Additional forms may be obtained at www.**ilsos**.gov

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 ☐ X | 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) | |