



California Access to Recovery Effort

(CARE)

Form 15

RECOVERY SUPPORT SERVICES SCREENING AND ASSESSMENT TOOL

Name: _____	Home Phone: _____
Address: _____	SSN: _____
_____	DOB: _____

RECOVERY SUPPORT SERVICES SCREENING TOOL

Instructions: This screening tool is to be used to determine whether a client meets the criteria for receiving CARE recovery support services without receiving CARE treatment services. The screening must be completed by a certified alcohol or drug counselor approved by ADP to conduct CARE assessments. The individual must meet either criteria one or criteria two to be eligible for recovery support services only.

Criteria One

1. Has the individual completed a treatment program for alcohol or drug abuse within the last six months? ___Yes ___No (If the answer is no, client does not meet criteria one. Continue to question #3.)
2. Has the individual been alcohol and drug free for at least 2 months since discharge from treatment? ___Yes ___No (If the answer is no, STOP. The client is not eligible for recovery support services only.)

Criteria Two

3. Has the individual ever been diagnosed with a substance use disorder? ___ Yes ___ No (If the answer is no, STOP. The client is not eligible for recovery support services only.)
4. Is the individual currently using alcohol or drugs? ___ Yes ___ No. (If the answer is yes, STOP, the client is not eligible for recovery support services only.)
5. When was the last time the individual used alcohol or drugs? _____. (If the answer is more than 6 months ago, STOP. The client is not eligible for CARE.)

RECOVERY SUPPORT SERVICES ASSESSMENT TOOL

Instructions: If the individual meets either eligibility criteria one or criteria two, the client should be asked to complete the remainder of the form. The assessment provider must review the client's answers to identify needed recovery support services. A "yes" answer to question #4, #5, #6, #7, #24, or #26 requires the provider to get further clarification and act on the information immediately, if necessary (the youth is homeless, has no food, is being abused or otherwise harmed, or needs immediate medical attention).

FAMILY/ HOME / SAFETY	YES	NO	N/A
1. Do you get along well with your parents or other family members?			
2. Do you feel loved and respected by your family?			
3. Do any of your family members have problems with alcohol or drugs?			
4. Is there anyone in your family who you are afraid of or intimidated by? ♦			
5. Have you ever run away from home because you were afraid? ♦			
6. Are you homeless? Are you in need of shelter? ♦			
7. Is anyone in your neighborhood threatening you or harming you? ♦			
8. Do you have any children?			
DAILY LIVING	YES	NO	NA
9. Are you able to care for yourself and your hygiene (bathing, showering, brushing teeth)?			
10. Can you prepare a meal yourself?			
11. Do you have difficulty planning ahead and making choices?			
12. Is budgeting or managing money a problem for you?			
13. Do you have difficulty resolving conflicts nonviolently?			
14. Is transportation a problem for you?			

♦ Requires clarification and immediate provider action as appropriate.

VOCATIONAL/OCCUPATIONAL	YES	NO	NA
15. Do you attend school or work daily?			
16. Do you get along with your teachers or employers?			
17. Do you have constructive things to do after school (music, theatre, arts, clubs, sports)?			
18. Do you have trouble with reading or math?			
19. Do you need help with schoolwork or homework?			
20. Are you interested in preparing for college?			
21. Would you like to get a job or a different job?			
22. Would you like help with English as Second Language (ESL) or GED (General Education Diploma)?			
23. Would you like help with job seeking skills (resume, interviewing, filling an application)?			
24. Do you have health issues that need attention? ♦			
25. Do you get regular medical and dental care?			
26. Do you have enough food to eat? ♦			
27. Do you eat a balanced diet that includes fruits and vegetables daily?			
28. Do you have opportunities for regular exercise and physical recreation?			
SOCIAL SUPPORT	YES	NO	NA
29. Do you have a caring, supportive adult that you can talk to when you need help?			
30. Do you have friends that you spend time with?			
31. Are you or your friends considered gang members?			
32. Do you wish you had more opportunities for participating in groups, clubs, hobbies, social gatherings?			
33. Do you feel valued for who you are?			
34. Do you have opportunities to help out in your community?			

♦ Requires clarification and immediate provider action as appropriate.

SPIRITUAL/CULTURAL	YES	NO	NA
35. Are spiritual/religious activities important to you?			
36. Would you like to attend spiritual/religious activities?			
37. Do you wish you had someone to listen/speak to you about spiritual needs or wish you had spiritual support?			
38. Are you interested in learning more about your culture or participating in cultural activities?			
SUBSTANCE ABUSE	YES	NO	NA
39. Would you be interested in a support group to help you not use alcohol or drugs?			
41. Would you like to learn more about how to cope with a friend or family member's substance use?			