CONDITIONAL RELEASE REPORT

Any violation of the Conditional Release, psychiatric decompensation, or use of alcohol, illegal substances, or prescription medication not prescribed to the patient shall be reported to the Superior Court ***immediately.***

REPORT FOR THE MONTH OF ________________________ **YEAR** ______________

DATE *(MM/YYYY)* ________________________

DEMOGRAPHICS		
Name:	AHCCCS ID#	
Date of Birth:	Current Psychiatric Diagnosis: Phone:	
Crime:		
Sentence:	Sentence Expiration: ZIP Code:	
Patient Address: Monthly payment or rent: How long?		
Residence phone:	Personal Phone: ZIP Code:	
Type of Placement: Monthly payment or rent: How long?		
ASH Admission Date:	Last ASH Discharge Date:	Number ASH Admissions:

CONTACTS		
Primary Behavioral Health Provider Agency: How long?		
County:	Phone:	Fax:
Full Provider Address: State: ZIP Code:		
Contractor Care Manager:	Email:	Phone:
Treatment Supervisor (include credentials):	Email:	Phone:
Case Manager:	Email:	Phone:
Member Attorney:	Email:	Phone:

COMPLIANCE WITH THE STANDARD CONDITIONS OF RELEASE		
Answer all questions and provide explanatory comments for each section when potential concern is indicated. ***All Non-Compliant responses require comment.***	Compliant	Non-Compliant
1. Cooperating with all treatment recommendations	☐	☐
2. Keeping all required appointments	☐	☐
3. Providing personal and employer contact information to the Superior Court	☐	☐
4. Not violating any local/state/federal law	☐	☐
5. Not using/possessing drugs, alcohol or toxic vapors	☐	☐
6. Not leaving residence for more than 24 hours without the approval of the treating psychiatrist	☐	☐
7. Not leaving residence for more than 72 hours or left the state of Arizona without the approval of the Superior Court	☐	☐
8. Not changing his/her residence without the approval of the Superior Court	☐	☐
9. Not possessing weapons	☐	☐
10. Adhering to restrictions on contacting victims	☐	☐
Click here to enter text.		

PSYCHIATRIC PRESENTATION		
Provide a narrative summary of the patient's psychiatric presentation. Click here to enter text.		
	YES	NO
Has there been any crisis or signs of decompensation since the last monthly report?	☐	☐
Has there been any need of outreach interventions to maintain the patient in treatment?	☐	☐
Has the patient presented any signs **or** made any statements of Danger to Self (DTS)/Danger to Others (DTO)?	☐	☐
If yes to any of the above questions, provide the date and copy of correspondence to confirm the Superior Court, ASH, and AHCCCS were immediately notified __/__/____		
Click here to enter text.		

ANSWER ALL QUESTIONS AND PROVIDE EXPLANATORY COMMENTS FOR EACH SECTION WHEN POTENTIAL CONCERNS ARE INDICATED		
INDIVIDUALIZED CONDITIONS OF RELEASE		
List the Specific Conditions of Release Click here to enter text.		
	YES	NO
1. Has the patient complied with ALL residence conditions outlined in the approved CR Plan?	☐	☐
2. Has the patient's residence contacted the clinical team with any concerns?	☐	☐
3. Has the treatment team spoken with staff/family members at the residence? Indicate N/A if this is not a requirement of the individual's CR plan.	☐	☐
Click here to enter text.		

PSYCHIATRIC TREATMENT AND MONITORING		
	YES	NO
1. Has the patient complied with ALL psychiatric treatment conditions outlined in the approved CRP?	☐	☐
2. Dates of psychiatric visits this month.		
Click here to enter text.		

MEDICATION AND MONITORING		
List all current medications including dosage and frequency. Click here to enter text.		
	YES	NO
1. Have there been any problems obtaining psychotropic medications for the patient?	☐	☐
2. Have there been any changes in medication since the last report?	☐	☐
3. Does the patient take medication independently? If so, how is medication adherence and medication supply monitored? Document in the comments section below.	☐	☐
Click here to enter text.		

OUTPATIENT PROVIDER		
	YES	NO
Has the patient complied with ALL Outpatient Provider conditions outlined in the approved CR Plan?	☐	☐
Click here to enter text.		

CASE MANAGEMENT		
	YES	NO
1. Has the patient complied with ALL case management conditions outlined in the approved CR Plan?	☐	☐
2. Dates of provider case management contact this month. Click here to enter text.		

CONTRACTOR MONITORING		
	YES	NO
Has the patient complied with ALL Contractor monitoring conditions outlined in the CR Plan?	☐	☐
Date and type/location of Contractor Care Manager outreach with the member during the month (face to face, teleconference, provider office, etc.):		
Date on which the Contractor attended staffing for the member during the month:		

EMPLOYMENT/EDUCATION/VOLUNTEERING		
	YES	NO
1. Is the patient volunteering, employed or attending school?	☐	☐
2. If yes, please provide the name and address and hours per week spent on volunteering/employment/education.		
Click here to enter text.		

COMMUNITY MEETINGS		
	YES	NO
1. Has the patient complied with ALL community meeting(s) conditions outlined in the approved CR Plan?	☐	☐
2. Dates of community meetings this month.		
Click here to enter text.		

SUBSTANCE USE TESTING (ATTACH THE SUBSTANCE TESTING LABORATORY RECORDS)		
	YES	NO
1. Has the patient complied with ALL random, unannounced substance testing conditions outlined in the approved CR Plan?	☐	☐
2. Date(s) of substance testing this month		
3. Was any drug screen positive this month?	☐	☐
If yes, provide the date and copy of correspondence to confirm the Superior Court, ASH, and AHCCCS were immediately notified __/__/____		
Click here to enter text.		

THERAPEUTIC INTERVENTIONS		
	YES	NO
1. Has the patient complied with ALL therapeutic intervention conditions outlined in the approved CR Plan?	☐	☐
2. Dates of therapy and other therapeutic interventions this month:		
Click here to enter text.		

VICTIM CONTACT		
Enter contact restrictions. Click here to enter text.	YES	NO
Has the patient complied with ALL victim contact restrictions outlined in the approved CR Plan?	☐	☐
Click here to enter text.		

REPORTER INFORMATION:	
Name of Provider Case Manager Completing Report:	Date:
Title Provider Case Manager:	
1. I have included copies of monthly prescriber treatment note and results of required lab testing, where applicable, 2. I have verified the member's attendance in treatment requirements not solely on the report of the member, 3. I have reported all non-compliance with the CR Plan, all significant incident(s) and/ or change(s) in mental health status to the Superior Court and ASH. I have attached a copy of these notifications to confirm reporting was completed and 4. I have verified that all services were provided to the client as required in the court order/treatment plan, or I have explained in this report why services were not provided.	
By Signing I am attesting the above to be true: Provider Case Manager Signature:	Date:

Name of Treatment Supervisor	Date:
☐ I am the member's treatment supervisor. I have reviewed the monthly monitoring report. The member is in compliance with their conditional release plan and supervised treatment plan. I have notified the Superior Court and ASH of any changes in the member's condition and submitted this monthly monitoring report to all parties as required by statute. ☐ I am the member's treatment supervisor. I have reviewed the monthly monitoring report. The member is **not** in compliance with their conditional release plan and/or supervised treatment plan. I have notified the Superior Court and ASH of non-compliance and/or any changes in this member's condition. I have submitted this monthly monitoring report to all parties as required by statute.	
By Signing I am attesting the above to be true: Treatment Supervisor (Treating Psychiatrist or Psychologist):	Date:

Name of Contractor Care Manager:	Date:
☐ I have completed a review of the administrative and clinical activities, services, and reporting for this member as reported by the outpatient provider. I have verified that all services were provided to the client as outlined in the conditional release plan and supervised treatment plan. The member is in compliance with their conditional release plan and supervised treatment plan as ordered by the court. I have verified all reporting and notification requirements have been completed by the outpatient provider. ☐ I have completed a review of the administrative and clinical activities, services, and reporting for this member as reported by the outpatient provider. Services were **NOT** provided to the client as outlined in the conditional release plan and supervised treatment plan. I have verified all reporting and notification requirements have been completed by the outpatient provider as guided by statute. I have taken immediate action to address service gaps with the outpatient provider and treatment team. ☐ I have completed a review of the administrative and clinical activities, services, and reporting for this member as reported by the outpatient provider. The member is **NOT** in compliance with their conditional release plan and supervised treatment plan as ordered by the court. I have verified all reporting and notification requirements have been completed by the outpatient provider as guided by statute.	
By Signing I am attesting the above to be true: Contractor Care Manager Signature:	Date:

CONTRACTOR CARE MANAGER SUBMIT TO THE AHCCCS DELIVERABLES PORTAL BY THE 5TH OF THE MONTH
❑ **Completed report**
❑ **Confirmation of submission of monthly report copies as required in the member's conditional release plan**
❑ **Confirmation of outpatient providers notification of any violation of conditional release, psychiatric decompensation, or use of alcohol, illegal substances, or prescription medication not prescribed to the patient to the Superior Court and ASH**
❑ **Confirmation of provider submission of information requested or required by the Superior Court, ASH, or Parties as guided by statute**