NEW YORK STATE | Office of Addiction Services and Supports

# CONTINUING CARE
## Per Service Report

*Provider Number

Provider Name

*Program Number

Program Name

*Provider Client ID

*Sex (at birth) ☐ Male ☐ Female

*Birth Date

*Last Name 2 Char

*Last 4 SSN

*Service Date

*Misuse of substance since last contact

- ☐ Yes
- ☐ No

*Frequency of Use in last 30 days

- ☐ No use in last 30 days
- ☐ 1-3 times last 30 days
- ☐ 1-2 times per week
- ☐ 3-6 times per week
- ☐ Daily

*Disposition

- ☐ Continuing Care
- ☐ Refer to Active Treatment

*Service (Check all that apply):

- ☐ Individual Counseling Brief (G0396/90832)
- ☐ Individual Counseling Normative (G0397/90834)
- ☐ Group Counseling Normative (H0005/90853)
- ☐ Peer Advocate Service (H0038)
- ☐ Medication Administration Observation (H0033)
- ☐ Medication Management (99211-99215)
- ☐ Addiction Medication Induction/Withdrawal (H0014)

* REQUIRED FIELD