|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| DEPARTMENT OF HEALTH AND FAMILY SERVICES Division of Care and Treatment Services  F-25904 (01/2017) | | STATE OF WISCONSIN | | | | |
| **ADMISSION TO CASELOAD – REVOCATION** Completion of this form is required by the Conditional Release Program. Information will be used to determine client profile, quality assurance, recidivism rates and alternatives to recidivism. | | | | | | |
| Name – Client (Last, First MI) | Name – Regional Provider | | | | | |
| Diagnosis: | | | | | | |
| Name – Case Manager (Last, First MI) | Name – Court | | | | | |
| Name – Parole Agent (Last, First MI) | Name – Judge (Last, First MI) | | | | | |
| Name – Defense Attorney (Last, First MI) | Name – District Attorney (Last, First MI) | | | | | |
| List treatment / support persons involved in client’s care ( i.e. therapist / counselor, vocational rehabilitation, group home contact etc.) and average number of contacts with each listed 30 days prior to revocation. | | | | | | |
| Name (Last, First MI) | Title | | | | | No. of Contacts |
|  |  | | | | |  |
|  |  | | | | |  |
|  |  | | | | |  |
|  |  | | | | |  |
|  |  | | | | |  |
| List support persons who impact on the client’s life (i.e., parents, significant friends, partner, mentor, spouse, children) | | | | | | |
| Name (Last, First MI) | Relationship | | | | | |
|  |  | | | | | |
|  |  | | | | | |
|  |  | | | | | |
|  |  | | | | | |
|  |  | | | | | |
| Reason for return to institution care | | | | | | |
| Treatment History (briefly list facility / provider beginning and end dates) | | | | | | |
| Facility / Provider | | | | Begin Date | End Date | |
|  | | | |  |  | |
|  | | | |  |  | |
|  | | | |  |  | |
| Release Origin  MMHI  WMHI  Direct Court  Maximum  Medium  Medium  Minimum  Minimum | Employment Status  Sheltered  Competitive  Part Time  Full Time | | Length of time at MHI prior to conditional release | | | |
| Length of time on conditional release prior to revocation | | | |
| How does the client spend his / her day? (general / typical day – activities, contacts, etc.) | | | | | | |
| Adjustment to Treatment | | | | | | |
| Significant Life Events (Recent, and / or dates of past events that may impact on mental health | | | | | | |
| Attachments (Check if attached)  Demographics – Regional Provider Face Sheet  Criminal History (CIB)  Current Individual Service Plan  Client’s perception of reasons for revocation  Statement of Probable Cause | | | | | | |