Intake Information Checklist

- ☐ Telephone number provided
- ☐ Emergency Contact Information
- ☐ Referral Source
- ☐ Physician name
- ☐ Completed Life Improvement Form (adult) or Columbia Impairment Scales (child)
- ☐ Completed DSM-5 Cross-Cutting Measure
- ☐ All current medical and medication information (including allergies)
- ☐ Proof of income
- ☐ Household income information (including spouse income)
- ☐ Insurance information or Medical Card
- ☐ Signature on **ALL** required forms

Just a reminder...

- If you feel uncomfortable answering any questions on the Health Risk Assessment, please feel free to leave them blank and we will discuss them at your appointment.
- If you need assistance filling out any of the required paperwork, please let us know and we can make arrangements to assist you.
- Call your insurance provider to determine benefits, copayments, or need for prior approval
- For children age 12 and under, only parents are needed for the first intake session.
- Please give 24-hour notice if you need to cancel, or reschedule. Call us if you are running late.
- **DO NOT DATE** any paperwork, it will be taken care of during the actual intake.
- Fill out **ALL** forms completely; if you are unsure about any form talk with a staff person

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age:** ____ **Sex:** ☐ **Male** ☐ **Female** **Date:**_____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child...	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child ...						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

ILLINOIS DEPARTMENT OF Healthcare and Family Services

☐ Initial
☐ Update
☐ Re-assessment

Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS)

1. GENERAL INFORMATION

Client First and Last Name:	Date of Birth:	RIN:	Gender:	Referral Source:	Date First Contact:

Phone Number:	Primary Language:	Interpreter Services: ☐ None required ☐ American Sign Language ☐ TDD/TYY ☐ Spoken Language: ____ ☐ Other: ____

Address:	City:	State:	Zip Code:	County:

US Citizen: ☐ Yes ☐ No

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic ☐ Hawaiian Native/Other Pacific Islander ☐ Multi-Race ☐ White ☐ Other: ____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Insurance Coverage and Company: ☐ N/A

Household Size:

Household Income:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partnership ☐ Widowed

Guardianship Status: ☐ Own guardian ☐ Biological Parent ☐ Adoptive Parent ☐ Youth in Care ☐ Other court appointed ☐ Other: ____

Employment Status: ☐ Self-employed ☐ Student ☐ Homemaker ☐ Military ☐ Retired ☐ Unable to work ☐ Employed full-time ☐ Employed part-time ☐ Unemployed

Living Arrangement: ☐ Lives alone ☐ Independent Living ☐ Lives with parent(s), relative(s), or guardian(s) ☐ State operated facility (mental health/dev. disability) ☐ Jail or correctional facility ☐ Residential/Institutional Setting (residential, nursing home, shelter) ☐ Community integrated living arrangement (CILA) ☐ Foster Care ☐ Homeless ☐ Other: ____

Education Level: (last completed) ☐ Never attended ☐ Pre-K/Kindergarten ☐ Grade 1 – 3 ☐ Grade 4 – 5 ☐ Grade 6 – 8 ☐ Grade 9 – 12 ☐ H.S. diploma/GED ☐ Some college ☐ Associate's degree ☐ Trade/technical training ☐ Professional certificate ☐ Bachelor's degree ☐ Master's/Doctoral degree

Parent, Guardian, or Significant Other Info.

First and Last Name: ____ Relationship to Client: ☐ Parent ☐ Guardian ☐ Significant Other Phone Number: ____

Address: ____ City: ____ State: ____ Zip Code: ____ County: ____

Emergency Contact Information

First and Last Name: ____ Relationship to Client: ____ Phone Number: ____

Address: ____ City: ____ State: ____ Zip Code: ____

Members of Family Constellation

Name	Age	Relation to Client	Living in Home
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Established Supports	Agency	Contact Name	Phone	Email
Physician				
School/Daycare				
Counselor/Therapist				
Child Welfare Worker				
ISC/PAS Agent				
Probation Officer				
Other: ____				
Other: ____				
Other: ____				

Health Risk Assessment Date: _____ Client #_____

18. General Information				
First Name:	Last Name:		Date of Birth:	Gender:
Height: ____Ft. ____In.	Weight: _____ lbs	Primary Care Doctor's Name:	Date of last Physical:	Date of last flu shot:

19 Medication(s)

Are you currently taking any psychotropic medications(antidepressants, antianxiety, mood stabilizer, etc.): ☐ Yes ☐ no
If Yes, do you regularly receive lab work ☐ Yes ☐ no ☐ not required ☐ Unknown
List **current** and **previous** medications below, **including over the counter medications**.

Medication	Prescriber	Dosage	Date Started	Date Ended	Medication Issues

What pharmacy do you use? Pharmacy phone#

20. Health Status

a. How would you rate your physical health:
☐Excellent ☐Good ☐Fair ☐Poor
b. How many snack foods or drinks (e.g. chips, cookies, candy, soda) do you usually consume in a day?
☐0-1 ☐2-3 ☐more than 4
c. How many servings of fruits and vegetables do you eat in a day? ☐0-1 ☐2-3 ☐more than 4
d. Do you engage in physical activity? ☐ Yes ☐ no
If **YES**, how often?_____
e. Do you use any form of tobacco? ☐ Yes ☐ no
f. Do you drink alcohol? ☐ Yes ☐ no
If **YES**, how often and how much?:
g. Have you ever fainted or passed out? ☐ Yes ☐ no
If **YES**describe:_____
h. Do you have any allergies? ☐ Yes ☐ no
If **YES**, list: _____
i. Have you fallen in the past 12 months? ☐ Yes ☐ no
j. Do you want help to quit smoking? ☐ Yes ☐ no

Health Concerns: Do you have any current health concerns? ☐ Yes ☐ no If **YES**, describe below

_____
_____
_____

General Illness: Do you have the tendency to any illnesses ☐ Yes ☐ no If **YES**, describe below

_____
_____
_____

Breathing issues: Do you have any trouble breathing?
☐ Yes ☐ no (if **NO,** skip to the next section)
a. What are the breathing issues related to? Check all that apply.
☐Physical activity ☐Weather extremes
☐Other: _____
b. Do you take medication for breathing issues?
☐ Yes ☐ no

Cognitive (**skip if you are under age 50**)
a. Have you ever had a significant head injury?
☐ Yes ☐ no If **YES**, when?_____
b. Do you have difficulty remembering or recalling events?
☐ Yes ☐ no

Client#_____

Blood Sugar and Diabetes: a. Do you urinate more frequently than appears normal? ☐ Yes ☐ no b. Do you seem to have an increased thirst, compared to other in your same age range? ☐ Yes ☐ no c. Do you have any special dietary instructions related to your blood sugar? ☐ Yes ☐ no d. Do you take any medication to control your blood sugar? ☐ Yes ☐ no	Chronic Pain: Do you experience chronic pain or complain of pain frequently? ☐ Yes ☐ no (If **NO**, skip to the next section) a. Have you ever taken or been prescribe medication for pain? ☐ Yes ☐ no b. Describe the location and intensity of your pain below.
Sexual Risk Behaviors: Are you sexually active? ☐ Yes ☐ no (if **NO**, skip to the next section) a. Do you use any protection against sexually transmitted diseases/infections (STD's, STI's)? ☐ Yes ☐ Sometimes ☐ no b. When were you last tested for STD's/STI's?_____ c . Have you ever been diagnosed with an STD/STI or HIV? ☐ Yes ☐ no If **YES**, list the diagnosis and the age it occurred. _____ _____ _____	Female Reproductive Health: (If **MALE**, or if **female and not had first period**, skip to next section) a. Do you see a women's health provider? ☐ Yes-date of last visit: _____ ☐ No-Referral needed b. Are you experiencing any issues related to your menstrual cycle or menopause? ☐Yes ☐No If **YES,** describe. _____ _____ c. Are you currently or have you ever been pregnant? ☐Yes-currently ☐ Yes-previously ☐ No If **YES**, describe the status or the outcome of the pregnancy. _____ _____

21. Developmental History--- Complete based on your early childhood experiences

a. Did your mother receive the appropriate prenatal care?
☐ Yes ☐ no ☐ Unknown
b. Were there any complications during your mother's pregnancy with you?
☐ Yes ☐ no ☐ Unknown
c. Was your birth normal or premature?
☐Normal ☐Premature ☐Unknown
d. Were you exposed to your mother's use of tobacco, alcohol, or street/prescription drugs during pregnancy with you?
☐ Yes—Describe.
_____
_____
_____
_____
_
☐ No ☐Unknown

e. Were there any unusual issues related to your mother's labor and delivery of you?☐ Yes—Describe.
_____
_____
_____
_
☐No ☐Unknown
f. What was your birth weight? ____lbs. _____oz.
g. When did you first crawl?____ Walk?_____ Talk?____
h. When did you begin to toilet train? _____
i. Do you have a biological parent or sibling that has developmental or behavioral problems?
☐ Yes ☐ no ☐ Unknown

22. Medical History

How many times have you been to the Emergency Room in the past 12 months?
☐0 ☐1time ☐2 times ☐3 times ☐4+times
What was the reason for the ER visit(s)? _____
_____
_____
_____
_____
_____

Client#_____

Have you ever been psychiatrically hospitalized? ☐ No ☐ Yes If **YES**, please list below.

Hospital Name	Location (City, State)	Dates Hospitalized	Reason(s)

List all medical/other hospitalizations you have experienced. ☐ N/A

Hospital Name	Location (City, State)	Dates Hospitalized	Reason(s)

List the names and specialties of the providers that are currently providing you treatment.

Provider Name	Specialty	Service(s) Provided

Do you have any vision problems?
☐ No ☐ Yes If **YES**,explain. _____
_____
_____

Do you have any hearing problems?
☐ No ☐ Yes If **YES**,explain. _____
_____
_____

Do you want MCCC to be in contact with your Physician(s)? ☐ No ☐ Yes If **YES**,explain._____
_____
_____

Have you used any complementary and integrative health approaches? Yes ☐ No ☐ If yes, which ones?

- ☐ Natural products (dietary supplements)
- ☐ Deep breathing strategies
- ☐ Yoga, Tai Chi, or Qi Gong
- ☐ Chiropractic or Osteopathic Manipulation
- ☐ Meditation
- ☐ Massage
- ☐ Special Diets
- ☐ Homeopathy
- ☐ Progressive Relaxation
- ☐ Guided Imagery
- ☐ Acupuncture
- ☐ Hypnotherapy
- ☐ Movement therapy
- ☐ Other:

ILLINOIS DEPARTMENT OF Healthcare and Family Services

Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS)

PERSONAL HEALTH SURVEY

The survey is voluntary and confidential. Your answers will help in understanding any health problems you may have. Please answer every question as best as you can.

CLIENT INFORMATION

First Name: _____ **Last Name:** _____

Date of Birth: _____ **Medicaid ID Number (RIN):** _____

Phone Number: _____ **Alternate Phone Number:** _____

Best Time to Call (day and time): _____

Person Completing Form: **Relationship to Client:**

HEALTH SURVEY (Please only answer the survey questions for the person listed above.)

1. Do you have any health problems that need to be taken care of quickly? ☐ Yes ☐ No

If **YES**, what is the health problem? Please explain below.

_____

_____

_____

2. Do you have a primary care doctor? ☐ Yes ☐ No ☐ Don't Know

3. Do you need help making a doctor's appointment? ☐ Yes ☐ No

4. What health problems or medical conditions do you have or have you ever had had in the past? Check all that apply.

☐ Breathing problems, such as asthma, COPD, emphysema
☐ Bone or joint problems, such as arthritis, osteoporosis, or back pain
☐ Cancer
☐ Dementia
☐ Developmental Delay/Learning Disability
☐ Diabetes
☐ Hearing Problems
☐ Heart problems, such as chest pain, heart attacks, Congestive Heart Failure
☐ High Blood Pressure/Hypertension
☐ High Cholesterol
☐ HIV/AIDS
☐ Kidney Diseases/Bladder Problems
☐ Mental Health Problems
☐ Pregnancy
☐ Seizures/Epilepsy
☐ Stroke
☐ Substance Use Issues
☐ Vision Problems
☐ Other Health Problems (list): _____

_____

5. Do you need help with any of following activities? ☐ Not applicable

☐ Bathing/showering ☐ Brushing teeth ☐ Getting dressed ☐ Brushing hair
☐ Walking ☐ Climbing stairs ☐ Using the bathroom ☐ Getting to school/work
☐ Getting/making food ☐ Eating ☐ Managing medications ☐ Housework/chores

6. Are you current on your vaccinations? ☐ Yes ☐ No ☐ Don't Know

CLIENT EMERGENCY CARE CONSENT FORM

Clients Name: _____

Address: _____

Telephone: (H)_____(C)_____
Can we leave a message saying "Counseling Center" Yes or No

Emergency Contact: _____Relationship:_____
Telephone: (H)_____(C)_____
Can we leave a message saying "Counseling Center" Yes or No

Hospital Preference: _____
Physicians Name: _____ Phone #_____

Allergies: _____
Medications: _____
_____
Pharmacy: _____

Primary Insurance: _____
ID #_____Group #_____
Secondary Insurance: _____
ID#_____ Group#_____

In case of sickness, accident, or other emergency situations. I hereby give consent to Moultrie County Counseling Center to communicate the above information to the appropriate medical care providers as necessary. I understand that I may revoke this consent at any time. It has been explained to me that if I refuse to sign this consent, emergency care cannot be given.

Client/Parent/Guardian Signature: _____
Date

Signature of Person Gathering Information: _____
Date

CONSENT WITHHELD: _____Date_____

Client Generated Treatment Plan Goals Client #_____

Describe the problem(s) that led to you entering therapy.

1._____

2._____

3._____

4._____

Imagine that while you're sleeping, all of your problems are solved. When you wake up, how will you know that things are better? What specific changes do you notice?

1._____

2._____

3._____

4._____

5._____

What are three broad goals you would like to work on during therapy sessions?
Example: "Improve my relationship with my spouse."

1._____

2._____

3._____

For each of the goals you listed above, describe specifically how your life will be different once you've completed therapy.

Example: "My spouse and I would communicate about our problems. When we get angry at one another, we would know how to get through it without big fights."

1._____

2._____

3._____

Client:_____ Date:_____

Parent /Guardian: _____ Date:_____

Date _____

THE COLUMBIA IMPAIRMENT SCALE (C. I. S.)-- (Parent Version)

Please circle the number that you think best describes the child or youth's situation:

0 .....1.....2..... 3.....4 5

No problem Some problem very bad problem No t applicable/Don't know

In general, how much of a problem do you think [she/he] has with:	
1)...getting into trouble?	0 1 2 3 4 5
2)...getting along with/(you [her/his] mother/mother figure.	0 1 2 3 4 5
3)...getting along with/(you [her/his] father/father figure.	0 1 2 3 4 5
4)...feeling unhappy or sad?	0 1 2 3 4 5
How much of a problem would you say [she/he] has:	
5)...with [her/his] behavior at school? (or at [her/his]job)	0 1 2 3 4 5
6)...with having fun?	0 1 2 3 4 5
7)...getting along with adults other than (you and/or [her/his] mother/father)?	0 1 2 3 4 5
How much of a problem does [she/he] have:	
8)...with feeling nervous or afraid?	0 1 2 3 4 5
9)...getting along with [her/his] [sister(s)/brother(s)]?	0 1 2 3 4 5
10) ...getting along with other kids [her/his] age?	0 1 2 3 4 5
How much of a problem would you say [she/he] has:	
11)...getting involved in activities like sports or hobbies?	0 1 2 3 4 5
12)...with [her/his]school work (doing [her/his] job?	0 1 2 3 4 5
13)...with [her/his] behavior at home?	0 1 2 3 4 5

Date _____

THE COLUMBIA IMPAIRMENT SCALE (C. I. S.)-- (Youth Version)

Please circle the number that you think best describes the child or youth's situation:

0 .....1.....2..... 3.....4 5

No problem Some problem very bad problem No t applicable/Don't know

In general, how much of a problem do you think you have with:	
1)...getting into trouble?	0 1 2 3 4 5
2)...getting alcng with your mother/mother figure.	0 1 2 3 4 5
3)...getting alcng with your father/father figure.	0 1 2 3 4 5
4)...feeling unhappy or sad?	0 1 2 3 4 5
How much of a problem would you say you have:	
5)...with your behavior at school? (or at your job)	0 1 2 3 4 5
6)...with having fun?	0 1 2 3 4 5
7)...getting alcng with adults other than (your mother and/or your father)?	0 1 2 3 4 5
How much of a problem do you have:	
8)...with feeling nervous or afraid?	0 1 2 3 4 5
9)...getting alcng with your sister(s) and/or brother(s)?	0 1 2 3 4 5
10) ...getting along with other kids your age?	0 1 2 3 4 5
How much of a problem would you say you have:	
11)...getting involved in activities like sports or hobbies?	0 1 2 3 4 5
12)...with your school work (doing your job)?	0 1 2 3 4 5
13)...with your behavior at home?	0 1 2 3 4 5

Client Name: _____ Client # _____

Consent for Mental Health Screening & Assessment, Treatment, and Follow-up

Consent for Mental Health Screening & Assessment: During your first visit(s) to Moultrie County Counseling Center, you will be assessed for the need for behavioral health services. This screening and assessment may include a detailed intake interview to explore the reasons why you are seeking services. At the conclusion of the assessment phase you may be: Assigned to a counselor or therapist to begin treatment, Referred to another individual or agency that can better meet your needs, or Receive a recommendation that mental health services are not required at this time. If you begin treatment at Moultrie County Counseling Center, you will be assigned to one or more of the available treatment services as outlined in the enclosed Agency Brochure. You will be informed of our policies on billing and procedures for determining your fee.

Consent for Treatment: You are requesting treatment and you are attesting to the following:

The nature and purpose of treatment, the possible complications and/or the possible consequences have been fully explained to you. There is no guarantee or assurance given to you by anyone regarding the results of treatment. You have been informed that your records are privileged and will be kept absolutely confidential. You have also been informed in the Client's Rights and Responsibilities statement of the exceptions to this privilege. You understand your case may be discussed in clinical staff meetings attended by Agency personnel and that the secretarial and billing staff may be required to access your client record.

Consent for Follow-up: Throughout your treatment, your primary counselor/therapist will be measuring your progress. Our goal at Moultrie County Counseling Center is to assist you in reducing your symptoms and in increasing your leve of functioning. It is important to measure your progress not only while in treatment, but also after you have left the program.

You have read, or had explained to you, all of the above information. You are authorizing Moultrie County Counseling Center to contact you or your emergency contact as outlined on the Emergency Care Contact Form following your discharge from Moultrie County Counseling Center Services.

Your signature below gives Moultrie County Counseling Center permission to contact you or your emergency contact regarding treatment outcomes. Your signature also gives your consent to treatment for you, your minor child, or a person who is under your guardianship. Your signature authorizes consent to a mental health screening/assessment.

_____ _____

Client (age 12 or older) Date

_____ _____

Parent/Guardian (if applicable) Date

_____ _____

Witness Signature Date

Created 8/2011

Please keep this document for your convenience

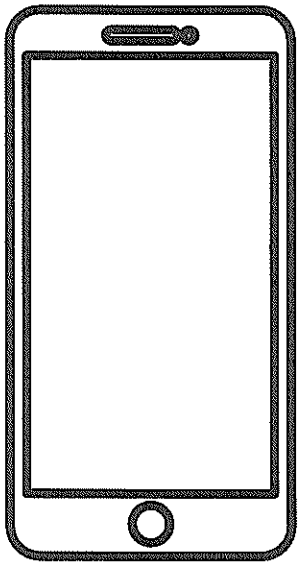
PROCEDURES FOR THE MOULTRIE COUNSELING CRISIS LINE

All calls made to the crisis line after 5:00 p.m. weekdays, all day Saturday, Sunday, and on official holidays will be forwarded to Moultrie County Counseling Center Staff member who is on call. Callers will hear a recorded message directing him/her to leave a message and a telephone number where he/she can be called. A person can expect to get a call back within 5 (five) minutes. There is also a backup number provided on the message if a call back is not received within that 5 (five) minutes. Blocked or Restricted numbers will not be answered unless there is a message left with the information needed. When leaving a message, please leave your name and complete telephone number. To aid us in returning your call, please keep your telephone line open so we can reach you.

MCCC CRISIS line number: 217-728-7611

We offer this service to assist you in contacting a staff member during a mental health emergency. We welcome you to use this service.

If you have any questions about the use of the crisis line or if any problems in the use of the crisis line occur, please let us know as soon as possible by calling our office at 217-728-4358 during regular business hours.



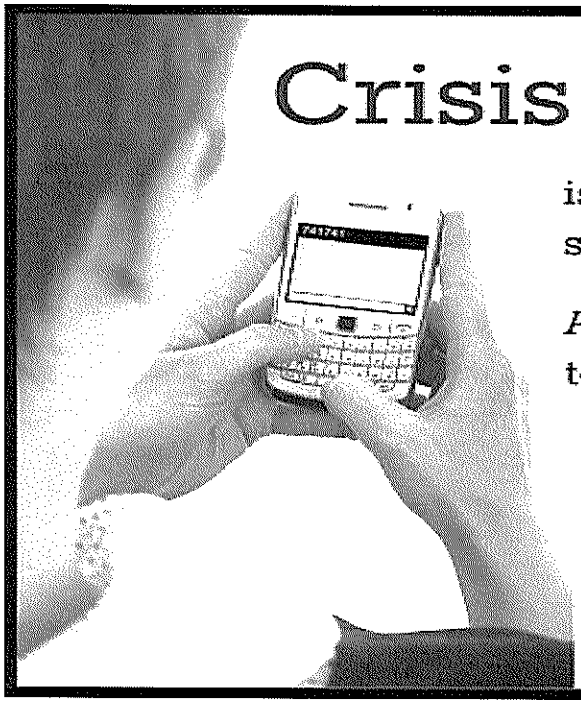
The Warm Line: Peer and Family Support by Telephone

The Illinois Mental Health Collaborative for Access and Choice is pleased to announce the Warm Line!

Sometimes what is needed most in difficult times is someone to talk to:
Someone who listens and understands.

The Warm Line is an opportunity in Illinois for persons with mental health and/or substance use challenges and their families to receive support by phone. Peer and Family Support Specialists are professionals who have experienced mental health and/or substance use recovery in their own lives. They have been trained in recovery support, mentoring, and advocacy and are ready to listen and support you. The warm line is not a crisis hotline, but is a source of support as you recover or help a family member to recover.

- **Call: 1 (866) 359-7953**
- **TTY: 1 (866) 880-4459**
- Hours of Operation: Monday through Saturday, 8am-8pm except holidays
- From the main menu, select option #2 for Consumers and Families Next, select option #5 for the Warm Line: Peer and Family Support by Phone.



Crisis Text Line

is a free, 24/7 emotional support for those in crisis.

Anyone can use this service by texting the number

741741

Texters remain anonymous.

For Ages 13 & up

Learn more: http://www.crisistextline.org/