The Commonwealth of Massachusetts

Executive Office of Health and Human Services

Department of Public Health

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**SARP Report: Individual Therapist/Treatment Provider**

### *Please complete and return this Report as stipulated in the Consent Agreement for SARP Participation (CASP). This report may be faxed to (617)887-8786. Please attach additional sheets as necessary.*

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| --- | --- | --- |
| SARP Participant Name: |  | |
| Therapy Session Frequency: | | Weekly  Bi-weekly Monthly  PRN |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Dates of Attendance** | | | | **Missed Sessions** | | | |
|  |  |  |  | **Date(s)** | **Reason(s)** | **Session Rescheduled** | **Date Completed** |
|  |  |  |  |  |  | Yes No |  |
|  |  |  |  |  |  | Yes No |  |
|  |  |  |  |  |  | Yes No |  |
|  |  |  |  |  |  | Yes No |  |
|  |  |  |  |  |  | Yes No |  |

1.Are you familiar with the Participant’s Consent Agreement for SARP Participation? Yes No

2.Is the participant making satisfactory progress? Yes No

3.Have there been any breaks in abstinence since the last quarterly report? Yes No

4.Have you been informed of any SARP non-compliance matters? Yes No

5.Is there anything you with to speak with SARP staff about? Yes No

Comments section for questions 1-4:

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What are the Participant’s treatment goals and objective, and educational needs?

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If it applies, please share treatment plan recommendations:

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Additional Comment Space

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Do you have recommendations that the participant:

1. Reduces the amount of therapy sessions per month? Yes No
2. Reduces the amount of group meetings per week? Yes No
3. Return to nursing practice? Yes No

\*If yes to any of the questions above, please send or fax a letter of recommendation citing the request and rationale on letterhead that is signed and date. The recommendation may be faxed to **(617)887-8786.** Please note the following:

* Therapy shall not be reduced to less than an “as needed/ PRN” basis.

Please refrain from giving this quarterly report and letters of recommendation to the participant to submit to SARP staff. The SARP anticipates all reports being sent directly to the SARP by the individual completing the report/letter(s).

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Therapist Name: | |  | | | | Lic. Type and #: | | |  | |
| # Years working w/ participant: | | |  | | | Years of practice: | | |  | |
| Do you hold a substance use disorder counseling license/cert? | | | | | No  LADCI-II CADCI-II Other: | | | | | |
| Agency Name or Independent Practice: | | | |  | | | | Phone: | |  |
| Address: |  | | | | | | | | | |
|  | | | | | | | | | | |
| Signature | | | | | | | Date Signed | | | |

Form Revised: 3/13/23