PGS Service Extension Variance Request

Agency Name:

Counselor Name:

Clinical Supervisor Name:

Date of Request:

Client ID# (*Please do not include Private Health Information)***:**

Client Enrollment Date:

Date Range of Request (*Start and end dates of requested period of coverage):*

Check if retroactive request ☐

Primary Diagnosis (Check One):

Gambling Disorder ◯ **Relational Issue** ◯

Secondary Diagnosis (*Please provide diagnosis for any assessed co-occurring mental health or SUD's Disorders)***:**

Risk Factors (*check all that apply)*

☐ **High Risk of Relapse**	☐ **Housing Issues**
☐ **Recent Hospitalization**	☐ **Legal Issues**
☐ **High Suicide Risk**	☐ **Relational Issues**
☐ **Substance Use Disorders Issues**	☐ **Mental Health Issues**

Precipitating Factors Indicating

Further Treatment is Needed:
(Context for Risk Factors above)

Engagement

Number of No Shows/Cancellations in past three months:

Current Stage of Change: NOT COMPLETED (*Must Select Current SOC*)

Treatment Modalaties/Services in the past three months (*check all that apply):*

- ☐ **Individual Therapy**
- ☐ **Group Therapy**
- ☐ **Couples Family**
- ☐ **Family Therapy**
- ☐ **Mentor/Peer Services**
- ☐ **Other**

Treatment Completion (*Where is client at in moving towards completion of episode of treatment?)* *Best Practice is to start wellness plan draft early in treatment.*

- ☐ **Wellness Plan Completed.**
- ☐ **75% of short term treatment goals completed.**
- ☐ **Lacked engagement in problem gambling behaviors for at least [30] consecutive days.**

Continued Treatment

Treatment plan goals moving forward:

◯ **Three Months** ◯ **Six Months** ◯ **Nine Months** ◯ **Twelve Months**

Email (preferred) or FAX to Problem Gambling Treatment & Recovery Specialist: David Corse, LPC, ACS, CADCIII, CGACII.

david.corse@dhsoha.state.or.us **FAX: 503-378-8467**