CLIENT & SUPPORTIVE OTHER INFORMATION & RELEASE TO CONTACT FORM

Please report someone who you would ideally like to attend your FBT meetings. This person will be asked to assist you in providing support/rewards for completion of performance goals:

1) Name: _____
Relationship to you: □parent/caregiver (1); □ grandparent (2); □ other family member (3); □ spouse/intimate partner (4); □ coworker (5); □ friend (6).
Email Address: _____
Home Phone: (_____)_____Cell Phone: (_____)_____ Work Phone: (_____)_____
Your supportive other may participate in person, through video conferencing using a computer or by telephone.
Please list which of the following options are possible:
_____ In Person _____ Video Conferencing _____ Telephone Conferencing

Please report an additional person who could attend at least some of the FBT meetings with you:

2) Name: _____
Relationship to you: □parent/caregiver (1); □ grandparent (2); □ other family member (3); □ spouse/intimate partner (4); □ coworker (5); □ friend (6).
Email Address: _____
Home Phone: (_____)_____Cell Phone: (_____)_____ Work Phone: (_____)_____
Please list which of the following options are possible:
_____ In Person _____ Video Conferencing _____ Telephone Conferencing

If you DID NOT indicate a parent/spouse/intimate partner above, please report a parent/spouse/intimate partner who could participate in the FBT meetings with you:

3) Name: _____
Relationship to you: □parent/caregiver (1); □ grandparent (2); □ other family member (3);
Email Address: _____
Home Phone: (_____)_____Cell Phone: (_____)_____ Work Phone: (_____)_____
Please list which of the following options are possible:
_____ In Person _____ Video Conferencing _____ Telephone Conferencing

Please report an additional person who could attend at least some of the FBT meetings with you:

4) Name: _____
Relationship to you (client): □parent/caregiver (1); □ grandparent (2); □ other family member (3); □ spouse/intimate partner (4); □ coworker (5); □ friend (6); □ None (7).
Email Address: _____
Home Phone: (_____)_____Cell Phone: (_____)_____ Work Phone: (_____)_____
Please list which of the following options are possible:
_____ In Person _____ Video Conferencing _____ Telephone Conferencing

I hereby give permission for _____ to schedule intervention meetings and to review their role and expectations in being my supportive other. I also give permission to contact the above persons to review my participation in the program, including information relevant to my effort with goals. This authorization is good for one year.

Printed Name: _____ Signature: _____ Date: _____
Email Address: _____
Home Phone: (_____)_____Cell Phone: (_____)_____ Work Phone: (_____)_____

□ Attend meetings w/ Client and Provider through telephone, videoconferencing or live.

- Meetings target achieving Client's goals relevant to:
  - Avoiding problems due to substances and risk of HIV/STIs

SUPPORTIVE OTHER ACKNOWLEDGEMENT CHECKLIST
(Client & Supportive Other)

- Attend meetings w/ Client and Provider through telephone, videoconferencing or live.
  - Meetings target achieving Client's goals relevant to:
    - Optimum thoughts, feelings, and behaviors (personal accomplishments)
    - Optimum relationships with family and friends
    - Mental strength and stability
- Participation may vary, but SOs role will always be focused on supporting the Client in:
  - Goal attainment and completion of assignments
  - Communicating desired actions
  - Providing encouragement, rewards and support for goal attainment
  - Generating solutions
- Participation is completely voluntary, and SO may withdraw at any time.
- Confidentiality
  - Protects information that is reviewed during therapy in the event of attempted legal mandates to obtain information (e.g. judge, probation officer)
    - Exception: threats to harm self or others, child abuse or abuse of vulnerable population
- SO is responsible for ensuring personal privacy and privacy of Client.
  - Maintain all information that is reviewed in the meetings confidentially
  - When telephone calls ensure complete privacy of the location

The following information was reviewed with the supportive other (SO) and client prior to involvement in FBT meetings.

Name of Provider: _____ Date:_____