NEBRASKA GAMBLER ASSISTANCE PROGRAM
GAP-3 URGENT CARE DETAIL

2021-2022
CONTRACT YEAR

NAME OF CONTRACTOR: _____

DATE(S) OF SERVICES BILLED:

CLIENT DOB:	_____	RESIDENCE OF CLIENT:	YOUR ID FOR THIS CLIENT:	
Client Gender (Check one)	☐ Male ☐ Female ☐ Other _____		Client Type:	☐ Gambler ☐ Family member
How did this person get your phone number or other contact information?			#Urgent Care hours this month:	
			#Urgent Care hours prior months:	

GAMBLER'S STAGE OF CHANGE	**BBGS Score:**
☐ PRE-CONTEMPLATION	
☐ CONTEMPLATION	
☐ PREPARATION	
☐ ACTION	

METHOD FOR PROVIDING THIS SERVICE	**WHO ASKED FOR THIS SERVICE**
☐ In Person	☐ Gambler
☐ Telephone	☐ Spouse
☐ Telehealth	☐ Family member

NATURE OF THE PROBLEMS					
Suicide ideation/Gestures?	☐ Yes	☐ No	Risk of criminal action?	☐ Yes	☐ No
Financial?	☐ Yes	☐ No	Bankruptcy/Foreclosure?	☐ Yes	☐ No
Family/Marriage at risk?	☐ Yes	☐ No	Danger to others?	☐ Yes	☐ No
Employment at risk?	☐ Yes	☐ No	In danger from others?	☐ Yes	☐ No

RESOLUTION OF THE CONSUMER'S NEEDS					
Referral to emergency services?	☐ Yes	☐ No	GAP services explained?	☐ Yes	☐ No
Referral to medical care?	☐ Yes	☐ No	Referred to other GAP counselor?	☐ Yes	☐ No
Will talk again another time?	☐ Yes	☐ No	Wait for client to call?	☐ Yes	☐ No
Counselor will call to check in?	☐ Yes	☐ No	Appointment for assessment?	☐ Yes	☐ No

URGENT CARE FORM REVIEWED BY COUNSELOR FOR COMPLETENESS:

Signature: _____ Date: _____