

**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 <u>one</u> ) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____		Client Type: <input type="checkbox"/> Gambler <input type="checkbox"/> Family member	
How did this person get your phone number or other contact information?		#Urgent Care hours this month: _____	_____
		#Urgent Care hours prior months: _____	_____
<b>GAMBLER'S STAGE OF CHANGE</b>		<b>BBGS Score:</b>	
<input type="checkbox"/> PRE-CONTEMPLATION			
<input type="checkbox"/> CONTEMPLATION			
<input type="checkbox"/> PREPARATION			
<input type="checkbox"/> ACTION			

<b>METHOD FOR PROVIDING THIS SERVICE</b>	<b>WHO ASKED FOR THIS SERVICE</b>
<input type="checkbox"/> In Person	<input type="checkbox"/> Gambler
<input type="checkbox"/> Telephone	<input type="checkbox"/> Spouse
<input type="checkbox"/> Telehealth	<input type="checkbox"/> 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: \_\_\_\_\_