

Nebraska Problem Gamblers Assistance Program

GAP-3 URGENT CARE DETAIL

2024–2025
Contract Year
Rev. May 2024

NAME OF CONTRACTOR:

DATE(S) OF SERVICES BILLED:

RESIDENCE OF CLIENT (CITY):

WHO ASKED FOR THIS SERVICE

- Gambler
- Spouse
- Family Member

METHOD FOR PROVIDING THIS SERVICE

- Person-to-Person
- Telephone
- Telehealth

GAMBLER'S STAGE OF CHANGE

- Pre-Contemplation
- Contemplation
- Preparation
- Action

CLIENT ID: **H** **I**

CLIENT DOB: _____ / _____ / _____

CLIENT GENDER (CHECK **ONE**):

Male Female Other: _____

Urgent Care hours this month: _____

Urgent Care hours prior months: _____

CLIENT TYPE: Gambler Family Member

RESULTS OF SCREENS

Gambler BBGS (1 positive):

Family Member GAM-ANON 20
(6 positive):

NATURE OF THE PROBLEMS

Suicide ideation/Gestures?	Risk of criminal action?
Financial?	Bankruptcy/Foreclosure?
Family/Marriage at risk?	Danger to others?
Employment at risk?	In danger from others?

RESOLUTION OF THE CONSUMER'S NEEDS

Referral to emergency services?	GAP services explained?
Referral to medical care?	Referred to other GAP counselor?
Will talk again another time?	Wait for client to call?
Counselor will call to check in?	Appointment for assessment?

URGENT CARE FORM REVIEWED BY COUNSELOR FOR COMPLETENESS:

Signature: _____

Date: ____ / ____ / ____