State of Illinois
Department of Human Services

RESPONSIBILITY AND SERVICES PLAN
ALCOHOL/SUBSTANCE ABUSE SERVICES - JOB READINESS BARRIER REDUCTION

Customer Name:	Case Number:

☐ **783 ALCOHOL/SUBSTANCE ABUSE SERVICES - JOB READINESS BARRIER REDUCTION**

Provider:	Start Date:

ACTION STEPS

☐ Contact: _____ (Name) to schedule an appointment by: _____ (Date)	_____ Date Added
☐ Cooperate with the evaluation process.	_____ Date Added
☐ Follow through with recommended treatment.	_____ Date Added
☐ Report to treatment activities on time.	_____ Date Added
☐ Bring a copy of your treatment plan to your DHS caseworker.	_____ Date Added
☐ Attend support group or meeting at _____ (Name / Place) _____ (Time)	_____ Date Added
☐ Contact: _____ (Name) if unable to participate in treatment.	_____ Date Added
☐ Attend meetings with your caseworker and/or treatment provider as requested.	_____ Date Added
☐ Respond to letters sent by DHS or your treatment provider as requested.	_____ Date Added
☐ Provide any information your caseworker or treatment provider asks from you.	_____ Date Added
☐ Turn in verification of time you spent in this activity: _____ (How often or by date)	_____ Date Added
☐ Other: _____	_____ Date Added
☐ Other: _____	_____ Date Added