Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Behavioral Health Is Essential to Health • Prevention Works • Treatment Is Effective • People Recover

Assisted Outpatient Treatment Program

May 16-17, 2017 – Las Vegas, NV
June 1-2, 2017 – Rockville, MD
June 28-29, 2017 – Detroit, MI

This form can be filled out, saved, and e-mailed back using Adobe Acrobat Reader or Adobe Acrobat Pro. If you are having trouble filling out and saving the form, please download and use the free Acrobat Reader from https://get.adobe.com/reader/otherversions/

REGISTRATION FORM

SUBMIT COMPLETED FORM BY April 7, 2017 TO aotregistration@affirmasolutions.com
ALL PAGES MUST BE FILLED OUT

Please enter 1st, 2nd and 3rd choice:

May 16-17, 2017 – Las Vegas, NV
June 1-2, 2017 – Rockville, MD
June 28-29, 2017 – Detroit, MI

FIRST NAME: **LAST NAME:**

CREDENTIALS: **TITLE:**

ORGANIZATION NAME:

ADDRESS:

CITY: **STATE (TWO LETTER CODE):** **ZIP CODE:**

EMAIL:

PHONE: **ALTERNATE PHONE (MOBILE):**

Provide the contact information for up to four additional attending AOT Team members (Please try to include at least one judicial member):

Team Member 1

FIRST NAME: **LAST NAME:**

CREDENTIALS: **TITLE:**

ORGANIZATION NAME:

ADDRESS:

CITY: **STATE (TWO LETTER CODE):** **ZIP CODE:**

EMAIL:

PHONE: **ALTERNATE PHONE (MOBILE):**

Team Member 2

FIRST NAME: **LAST NAME:**

CREDENTIALS: **TITLE:**

ORGANIZATION NAME:

ADDRESS:

CITY: **STATE (TWO LETTER CODE):** **ZIP CODE:**

EMAIL:

PHONE: **ALTERNATE PHONE (MOBILE):**

Team Member 3

FIRST NAME: **LAST NAME:**

CREDENTIALS: **TITLE:**

ORGANIZATION NAME:

ADDRESS:

CITY: **STATE (TWO LETTER CODE):** **ZIP CODE:**

EMAIL:

PHONE: **ALTERNATE PHONE (MOBILE):**

Team Member 4

FIRST NAME: **LAST NAME:**

CREDENTIALS: **TITLE:**

ORGANIZATION NAME:

ADDRESS:

CITY: **STATE (TWO LETTER CODE):** **ZIP CODE:**

EMAIL:

PHONE: **ALTERNATE PHONE (MOBILE):**

Please submit the completed form to aotregistration@affirmasolutions.com

For assistance, please contact Courtney Casey at ccasey@affirmasolutions.com or (240) 708-2381

READINESS ASSESSMENT

Please describe why your team believes an AOT Program is needed in your jurisdiction. Include a brief description of the nature of the problem, including service gaps:

Please describe any current or past efforts to develop and implement an AOT Program in your jurisdiction:

Please submit the completed form to aotregistration@affirmasolutions.com

For assistance, please contact Courtney Casey at ccasey@affirmasolutions.com or (240) 708-2381

Please describe any existing/established use of AOT in your jurisdiction:

For each team member, please provide a brief description of his or her role in outpatient treatment efforts or the civil commitment process:

Please describe what your team hopes to achieve from this training, and how it will further your current goals:

Please submit the completed form to aotregistration@affirmasolutions.com

For assistance, please contact Courtney Casey at ccasey@affirmasolutions.com or (240) 708-2381