MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION
SUBSTANCE ABUSE TREATMENT PROGRAMS
DRUG CONVICTION EXCEPTION VERIFICATION

INSTRUCTIONS:
Contact your current or previous treatment provider to complete the form. Do not contact Probation or Parole for completion of this form. If you are unable to obtain verification from a previous treatment provider, you may have another treatment provider complete an assessment to determine that you do not require substance abuse treatment.

NAME: _____ DCN: _____

SOCIAL SECURITY NUMBER: _____ DOB: _____

INSTRUCTIONS FOR TREATMENT PROVIDERS:
Please mark yes or no where appropriate regarding the above-named person's substance abuse treatment program status, sign and date the form, and provide name and address of treatment provider. Or, provide a copy of a certificate of completion. You may request the individual presenting the form to complete any authorization for release of information that your entity requires.

Is the above person currently successfully participating in a substance abuse treatment program approved by the Division of Alcohol and Drug Abuse? Treatment Center Name: _____ Start Date: _____	☐ Yes ☐ No
Is the above person currently enrolled in a substance abuse treatment program approved by the Division of Alcohol and Drug Abuse but on a waiting list? Treatment Center Name: _____ Date of Enrollment: _____	☐ Yes ☐ No
Has the above person successfully completed a substance abuse program approved by the Division of Alcohol and Drug Abuse? Treatment Center Name: _____ Completion Date: _____	☐ Yes ☐ No
Has a certified treatment provider from Division of Alcohol and Drug Abuse determined the above person does not need substance abuse treatment? Treatment Center Name: _____ Determination Date: _____	☐ Yes ☐ No

I certify that I have given true, accurate, and complete statements to the best of my knowledge. If signing electronically, I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature.

Authorized Signature: _____ Date: _____

Printed Name and Title: _____

Name of Treatment Provider: _____

Return Information – the provider or participant may return this form:

Upload your document: Visit mydssupload.mo.gov to upload a copy of your document.

Mail to: Family Support Division
PO BOX 2700
Jefferson City, MO 65102

Fax to: 573-526-9400

IM-369 (4/2025)

SAVE PRINT RESET