STATE OF CONNECTICUT
Department of Mental Health and Addiction Services
SUPPORTED RECOVERY HOUSING SERVICES

SUPPORTED RECOVERY HOUSING SERVICES (SRHS) DOCUMENTATION INSTRUCTIONS

To complete the case management requirement for Supported Recovery Housing Services, providers must maintain hard-copy service documentation files for each client they serve. DMHAS and /or ABH® will review these completed forms to verify the provision of case management services.

The goals of SRHS case management services are to: utilize a person-centered, strength-based approach and promote the active participation of the client in stating preferences and making decisions that support recovery skills, foster independent living, promote community integration and increase the length of overall health and recovery while decreasing the risk of relapse.

SRHS case management assistance should support the client in securing basic needs, housing, employment, entitlements, transportation, and treatment services. On-site services should include referrals to DSS entitlements, the Behavioral Health Recovery Program (BHRP) or Access to Recovery III, vocational/educational opportunities, housing subsidies, medical or other treatment appointments, energy assistance, food stamps and other potential sources of income and community recovery supports.

Case Management supports are not meant to be provided in a group setting.

LIST OF SAMPLE FORMS

- Client Service Agreement
- Consent to Disclosure and Re-disclosure of Confidential Information and Records (ROI)
- SRHS House Rules
- Grievance Procedure
- Intake Assessment Form
- Recovery Plan
- Job Readiness Form
- Progress Notes (sample only)
- Discharge
- Sign In Sheet
- Treatment Verification Form (BHRP only)

• CLIENT SERVICE AGREEMENT

PURPOSE OF FORM: Helps set very clear expectations for the client of what they will receive from the SRHS provider.

WHAT IS ON THE FORM: In clear and simple terms, the provider should describe services offered at the supported recovery house.

WHEN THE FORM SHOULD BE COMPLETED: At intake - before the individual moves into the house. The client should sign, indicating that he or she has read and understands the rules of the house.

• RELEASE OF INFORMATION (ROI)

PURPOSE OF FORM: Protects the client's personal health information (PHI) and allows the client to specify under which circumstances and which parties have temporary permission to discuss their health information. Please note that it is illegal to discuss a client's services without an ROI - even with the best intentions.

WHAT IS ON THE FORM: The form explains a client's rights where their health information is concerned and explains that by completing the form, they are giving the specified parties permission to discuss PHI for the purposes of providing quality services. Please put the name of your house on line #2 and the name of any clinical/treatment provider on line #3.

WHEN THE FORM SHOULD BE COMPLETED: At intake. Additionally, if the form expires before services are completed. The form should be completed again to extend through the end of services. Providers may recommend that clients make the form valid for 180 days.

• SRHS HOUSE RULES

PURPOSE OF FORM: Clearly outlines the rules associated with SRHS.

WHAT IS ON THE FORM: A comprehensive list of house rules, including clearly defined consequences explaining what may happen should the client violate these rules.

WHEN THE FORM SHOULD BE COMPLETED: The form should be reviewed item by item at intake. The client should sign indicating he or she has read and understands the rules of the house.

- **CLIENT RIGHTS AND GRIEVANCE PROCEDURE FORM**

PURPOSE OF FORM: Explains the client's rights including right to file a complaint without the risk of losing services solely for filing the complaint.

WHAT IS ON THE FORM: Explanation of client rights and how to file a grievance.

WHEN THE FORM SHOULD BE COMPLETED: At intake.

- **INTAKE ASSESSMENT FORM**

PURPOSE OF FORM: Obtains information about the client, helping to better provide and coordinate services. This form can include the client's history of use, needs, and strengths as well as record basic demographics and contact information. The intake form contains all of the mandatory data fields required by the DMHAS DDAP system. These fields are identified by a number in parenthesis that corresponds to the data element in the DDAP standard file format.

WHAT IS ON THE FORM: Sections for demographics, Husky status, legal status, entitlement and benefits, family and other supports.

WHEN THE FORM SHOULD BE COMPLETED: At intake or at the first case management meeting.

- **RECOVERY PLAN**

PURPOSE OF FORM: Documents the short-term goals the client will work toward while in the SRHS house.

WHAT IS ON THE FORM: Goals agreed upon by client and case manager, the expected date or timeframe over which both parties expect the goals to be met, and specific measurable action steps necessary to reach goals. This form is based on issues identified in the intake assessment.

WHEN THE FORM SHOULD BE COMPLETED: At the first case management meeting with client and reviewed at each subsequent meeting.

- **JOB READINESS**

PURPOSE OF FORM: Tracks employment searches and other work readiness steps taken by the client. This form is required of all clients when applying for their second month of SRHS. Case managers may find this form useful for tracking employment searches or other employment readiness activities for those clients who have a goal of finding employment.

WHAT IS ON THE FORM: Space for the client to indicate places they have applied for employment, dates of interviews, contact people at the agencies, etc.

WHEN THE FORM SHOULD BE COMPLETED: Ongoing. In order to receive a second 30 days of SRHS, the form will need to be submitted. The form should also be reviewed at case management meetings.

- **PROGRESS NOTES**

PURPOSE OF FORM: Records case management services. Notes should track the client's progress toward achieving goals, document the case manager's work on behalf of the client, and summarize the client's recovery status.

WHAT IS ON THE FORM: The form is available electronically in the web-based ATR and BHRP systems. Form is client specific and includes the date and time of the session, a brief summary of the client's status and steps taken towards his or her recovery goals.

WHEN THE FORM SHOULD BE COMPLETED: At least weekly, and after every meeting with the client. Notes must be documented electronically within 60 days of the intervention. All notes must be documented in the web-based ATR or BHRP systems.

- **DISCHARGE SUMMARY**

PURPOSE OF FORM: Summarizes the client's progress on goals, next steps (including any referrals), and recovery status at the time of discharge. A brief Discharge Summary should be completed when each client completes services successfully or leaves services prematurely.

WHAT IS ON THE FORM: Reason for discharge, employment status and living situation at the time of discharge, any service referrals.

WHEN THE FORM SHOULD BE COMPLETED: Directly before or directly after discharge, depending upon the circumstances.

- **SIGN IN SHEET**

PURPOSE OF FORM: Records that a client is in the house and /or attending house meetings.

WHAT IS ON THE FORM: Space for a client to sign in to verify that they are in the house or that they attended a house meeting.

WHEN THE FORM SHOULD BE COMPLETED: Each day the client is in the house or attends a house meeting.

- **TREATMENT VERIFICATION FORM**

PURPOSE OF FORM: A required part of the request for housing under BHRP.

WHAT IS ON THE FORM: Information related to clients participation and engagement in treatment.

WHEN THE FORM SHOULD BE COMPLETED: For each BHRP request. Form is not required for ATR request.

STATE OF CONNECTICUT
Department of Mental Health and Addiction Services
SUPPORTED RECOVERY HOUSING SERVICES

CLIENT SERVICE AGREEMENT

I understand that an approval for SUPPORTED RECOVERY HOUSING SERVICES (SRHS) will mean:

- I will have a clean, safe, drug and alcohol-free living environment.
- There will be staff/workers who:
  - are available 8 hours a day to assist with recovery planning and available on call 24 hours a day for urgent situations;
  - understand the principles of recovery and are respectful of my recovery;
  - are competent and are able to address or help me address my unique needs;
  - will be positive role models; and
  - will not discriminate against me based on my age, race, color, ethnicity, gender, national origin, sexual orientation, religion, mental/physical disability or political affiliation.
- My case manager will help me accomplish the following, based on my needs:
  - obtain basic needs such as food, personal care, clothing and transportation;
  - connect me to treatment;
  - connect me to local self-help and support groups like NA/AA or church meetings;
  - obtain employment;
  - complete benefit or entitlement applications; and
  - talk about relapse prevention and stressful situations.
- I understand I will need to:
  - meet with the case manager every week to make a short-term recovery plan and do my best to meet the goals I set for myself;
  - not break the rules and regulations of the house;
  - not endanger the recovery of the people who share the house with me;
  - try to resolve any issues I have through my case manager; and
  - submit to alcohol or drug screenings as requested;
  - Obtain a signed *Treatment Verification Form* from my treatment provider (BHRP only).
- With an approval through the Behavioral Health Recovery Program (BHRP) or Access to Recovery III program, $500 per month will be paid on my behalf to the housing provider and I will not be charged any additional fees for housing or case management services.
- The maximum period that I may receive BHRP or ATR III payment for SRHS is 30 days, with the possibility of a second month extension. The time period may be reduced based on my previous use of the BHRP or ATR III programs.

I, _____ (*Your Name*), have read and understand everything written above and agree to fully participate in SUPPORTED RECOVERY HOUSING SERVICES.

_____

Client Signature Date

STATE OF CONNECTICUT
Department of Mental Health and Addiction Services
SUPPORTED RECOVERY HOUSING SERVICES

CONSENT TO DISCLOSURE AND RE-DISCLOSURE OF CONFIDENTIAL INFORMATION AND RECORDS

RELEASE OF INFORMATION

I, _____, DOB: _____,
(Name of Participant) (Date of Birth)

EMS#: _____, SS#: _____ as a
(EMS Number) (Social Security Number)

participant in the DMHAS Behavioral Health Recovery Program (BHRP) or the Access To Recovery (ATR) III Program, understand my support services will be coordinated through DMHAS and the DMHAS designated Administrative Service Organization (ASO). I authorize the following individuals and organizations to release and exchange information to each other for the purpose of processing BHRP and ATR III requests:

1. The DMHAS Administrative Service Organization; and

2. _____

3. _____

This information may include: my name, address, age, gender, Social Security number, clinical assessment, progress in care, the type and outcome of mental health and addiction services I have received/am currently receiving, BHRP or ATR III support history and such other information as is necessary to provide effective coordination of the treatment and services I receive.

The purpose of the disclosure authorized herein is to facilitate the provision of BHRP or ATR III recovery supports.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and Chapter 899 of the Connecticut General Statues, and cannot be disclosed without my written consent unless otherwise provided for in the regulations or statutes. I have received a summary of the federal law protecting this information and a statement of the intended use of this information. I understand that the federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient, and I understand that the rules prohibiting re-disclosure to third parties without my written consent will be strictly adhered to. I also understand that I may revoke this release at any time except to the extent that action has been taken in reliance on it. Unless revoked by me, this consent shall expire upon completion of this application, or:

_____
[Specific date, event or condition upon which this consent expires, only if different from above]

Date:_____ _____
(Signature of Participant)

SRHS HOUSE RULES

Please sign the document to indicate your full understanding and agreement to follow these house rules. Please note that each housing provider may have additional rules that are required.

1. Alcohol and Drugs
    a. Absolutely no alcohol or drug use by any client, staff or visitor of the house on or off the premises. Law enforcement officials will be notified if there is illegal drug use in the house by any client or visitor. Any client possessing or using alcohol or drugs will be immediately discharged.
    b. House staff have the right to request clients to provide a urine sample or other drug test, including random testing. If a client fails to submit to any testing, the client will be immediately discharged.
2. Guests and Visitors
    a. There are no guests/ visitors allowed in the house without the consent of the house staff. Guests/visitors are only allowed in common areas and are not permitted to stay overnight.
3. Smoking
    a. Smoking will only be allowed in designated areas.
4. Health and Medications
    a. Please inform staff of any and all medical conditions.
    b. All clients are responsible for the safety and administration of any medications they may have. All medications must be documented with house staff at intake.
5. Clients should immediately begin job searching. Job searching should be considered a 'full time' activity and residents should be looking for work several (e.g. six hours) hours each day. Employment is a mandatory criteria for ongoing housing supports.
6. Clients should begin actively seeking a sponsor immediately, and should obtain one within 30 days of admission.
7. During the period that clients housing is being paid through the BHRP or ATR, clients must meet weekly with a case manager (see client service agreement for additional details on case management services).
8. Complaints
    a. All clients are encouraged to use the written grievance procedure should they have a disagreement. There is a grievance procedure posted at each SRHS house.
9. Behavior and Personal Relationships
    a. Sexual relationships between any clients in the house (including the staff) are not acceptable.
    b. Clients are not allowed to borrow money from other clients or staff.
    c. Stealing of anything will result in immediate discharge.
    d. No threatening, violence, or acts of dishonesty.
10. Curfew and Check-in
    a. Clients must sign in at house meetings and at other required times.
    b. Clients must adhere to the curfew set by the housing provider.
11. Limit the use of internet and phone services (if available) to 15-minutes.
12. Any outstanding warrants must be documented at intake and addressed within 30 days of admission.
13. In the case of an emergency, call 911 immediately and then notify staff.
14. Mandatory Meetings:
    a. The minimum mandatory meetings will be:
        i. 1 weekly housing meeting
        ii. 5 self-help meetings per week during the first 30 days
        iii. 3 self-help meetings per week during the second 30 days

iv. weekly meeting with the case manager

b. Other mandatory meetings may be set by the housing provider.

15. Overnight Absences:
    a. Absences from the house without permission from staff, are not allowed.
    b. Clients may obtain permission for overnight absences based on the individual house rules.
16. House Chores
    a. Each client must complete chores as described by the housing provider and must keep his/her personal areas clean and orderly. This includes, but is not limited to, the kitchen, bathroom and bedroom.
    b. Clients must periodically help with major chores, such as spring and fall cleanup, major house cleaning, painting, moving furniture, etc.
    c. Room checks may be done by staff at any time.
17. Cars
    a. Any motor vehicle on the property must be registered and insured, and each SRHS participant is limited to one motor vehicle.
    b. All drivers must have valid driver's licenses.
    c. Cars must be in working condition.
18. Departure and Discharge
    a. All clients will be discharged from SRHS after 60 days.
    b. Staff will help clients to secure more permanent housing, based upon their recovery plan.
19. Personal belongings
    a. I agree to accept full responsibility for any personal property. I have been advised to not bring any item of sentimental or significant monetary value into the house because of risk of loss or theft.
    b. I agree to hold the SRHS staff harmless from any and all losses I may have, from theft or otherwise. I understand that my belongings are not insured unless I obtain my own insurance policy at my own cost.
    c. Upon leaving the house for any reason whatsoever, I will immediately remove my personal belongings. All personal belongings left behind after three (3) days, will be donated without compensation.

I, _____, agree to follow all rules.

Client Signature _____ Date _____

Staff Signature _____ Date _____

VIOLATION OF ANY RULE MAY RESULT IN IMMEDIATE DISCHARGE FROM HOUSE.

CLIENT RIGHTS AND GRIEVANCE PROCEDURE

CLIENT RIGHTS

All services at _____ (SRHS Provider Name) are voluntary. Even after accepting services, clients have a right to terminate services at any time. Applicants for services will have equal access and can expect to be treated with respect regardless of their gender, race/color/national origin, age, sexual orientation, or physical/mental disability.

GRIEVANCE PROCEDURE

If you do not think you are being afforded your rights, or believe you have been treated unfairly, you should file a grievance with the SRHS provider's designated staff member, per the posted grievance policy. A grievance may be filed verbally or in writing and should contain, at a minimum, a full description of the event, the date it occurred, the persons involved, and a reasonable expected outcome. If you do not feel that your grievance is being handled appropriately, you may contact the SRHS supervisor, owner or director. If you are not satisfied with the outcome of the grievance at the SRHS provider, you may contact Behavioral Health Recovery Program (BHRP) at (800) 658-4472 or Access to Recovery (ATR) III at (866) 580-3922. **You are required to try to resolve your grievance at the SRHS level before calling BHRP or ATR III.**

You should not be threatened, penalized or have your services negatively affected or otherwise be retaliated against because you filed a grievance.

Client Signature: _____ Date: _____

STATE OF CONNECTICUT
Department of Mental Health and Addiction Services
SUPPORTED RECOVERY HOUSING SERVICES

INTAKE ASSESSMENT

Demographics

Name(8-10): _____ Phone: ( ) _____- _____

Previous address: _____ City_____ Zip _____

Date of Assessment (53): ___/___/___ Social Security (4) #: _____-_____-_____ Date of birth (6): ___/_____/_____

Gender (12): Male❑ Female❑ If female, pregnant (39): Yes ❑ No ❑ Smoker (40): Yes ❑ No ❑

Veteran Status (28): Yes ❑ No ❑ Dates of Military Services (29-30) ____/____/____ through ____/____/_____

Marital Status (27): Married ❑ Civil Union ❑ Divorced ❑ Separated ❑ Widowed ❑ Never Married ❑
Other:_____

Race (13): Native American ❑ Asian ❑ African American ❑
Native Hawaiian ❑ White / Caucasian ❑

Ethnicity (18): Hispanic – Other ❑ Non-Hispanic ❑ Hispanic-Puerto Rican ❑
Hispanic - Mexican❑ Hispanic-Cuban ❑ Unknown ❑

Primary Language (19): _____ Religious/Spiritual Practice (21): _____

Emergency contact: _____ Phone: ( ) _____ - _____ Relationship: _____

Emergency contact address: _____

Legal Information/History

Pending Case(s): Yes ☐ No ☐ Previous Involvement with the Criminal Justice System: Yes ☐ No ☐

Currently on probation? Yes ☐ No ☐ Parole? Yes ☐ No ☐ Conservator? Yes ☐ No ☐

Number of arrest in last 30 days (62): _____

Criminal Justice Contact: _____ Telephone: _____**Health**

Status

	Currently Experiences or Uses	History Of	In Treatment For	Not Applicable
Psychiatric conditions				
Addiction disorders				
Medical Conditions				
Trauma/ Abuse				
Prescribed Medications				

Current problems: _____

Allergic reactions (Include Medication): _____

Current provider agency: _____ Admission date: _____

Current Doctor/Clinician/Worker: _____ Phone #: ( ) _____ - _____

Medications prescribed during current treatment: _____

Do you attend AA/NA? _____ YES _____ NO How many times in the last 30 days? (63)_____

When did you last use? _____

What is your longest period of sobriety or stability? _____

_____

Drug / Alcohol History

Drug Type(65)_____ Method(66)_____ Days used in last 30 Days (67) _____ Age at First Use (68) _____

Drug Type _____ Method_____ Days used in last 30 Days _____ Age at First Use _____

Drug Type _____ Method_____ Days used in last 30 Days _____ Age at First Use _____

Drug Type _____ Method_____ Days used in last 30 Days _____ Age at First Use _____

Drug Type_____ Method_____ Days used in last 30 Days _____ Age at First Use _____

Entitlements and Benefits

Principal Source of Income (58): None ❑ Public Assistance ❑ Retirement ❑ Salary ❑ Disability ❑ Unknown ❑ Other ❑

Number of Persons Dependent on Income (56): _____ Number of Minors Dependent on Income (57):_____

Medicaid Status: Active ☐ Not Active ☐ Pending☐ Spend-down ☐ EMS #: _____

Benefit Husky D ☐ Medicaid ☐ Social Security Disability (SSD) ☐ Supplemental Security Income (SSI) ☐

TANF ☐ Food Stamps ☐ Other (Specify) ☐ _____

Other State/Provider Agency Involvement

Are you currently working with another agency/case manager? (e.g. DCF, ABH ICM)? _____ Yes _____ No

If yes, what is the name of your worker: _____ Phone Number: ( ) _____ - _____

Referral Source

Who referred you to this house (38)? Self ❑ SA Provider ❑ MH Provider ❑ Probation / Parole ❑ DOC ❑ Other _____

Family and Supports

Social Supports (i.e. family, friends, etc) (64): Yes ❑ No ❑

How would you describe your current relationship with your family members? _____

_____

Do any of your immediate family members have service needs? If yes, please explain. _____

_____

Do you currently have a sponsor? No ☐ Yes ☐ Not sure ☐

Employment Status

Employment Status at intake (54): Employed FT ☐ Employed PT ☐ Unemployed (but looking for work) ☐

non-competitive/volunter work ☐ Not in labor force ☐ Other (Specify) ☐:_____

Highest Grade Completed(55): _____

Housing Status

Living situation immediately prior to SRHS:

Private Residence		Single Room Occupancy		Residential care / treatment		Board and Care		Hospital	
Prison/Jail		Homeless Shelter		Homeless (i.e. street)		Inpatient (i.e. SA/MH)			

Reason for leaving the last housing situation: _____

Have you been homeless within the last six months (60)? No ☐ Yes ☐

In the last 30 days, the number of days that you have been in a controlled environment (i.e. jail, hospital, group home, etc) (61)?

_____

Are you at risk of homelessness? No ☐ Yes ☐ Not sure ☐

In the Client's Own Words

I need help with the following:

Housing		Medical Care		Education		Hygiene		Cleaning	
Paying Rent/Utilities		Shopping & Meal Preparations		Mental Health Services		Substance Abuse Services		Health and Wellness Services	
Securing Benefits		Money/Debt Management		Opening a Bank Account		Taking Medication		Legal Assistance	

What do you think is your biggest or most challenging issue? _____

_____

Are you interested in maintaining a sober lifestyle? No ☐ Yes ☐ Not sure ☐

What are the relapse triggers you can recognize? _____

_____

What are your strengths? _____

_____

_____

What specific assistance or support would best help you to reach these goals? _____

_____

Is there anything else you can tell us about yourself that would assist us in helping you meet your goals? _____

_____

_____ _____

SRHS Staff Signature Date

_____ _____

Client Signature Date

STATE OF CONNECTICUT
Department of Mental Health and Addiction Services
SUPPORTED RECOVERY HOUSING SERVICES

RECOVERY PLAN

CLIENT NAME: _____ DATE: _____

Suggested Goals: Maintain recovery, locate stable housing, locate full-time employment, apply for relevant benefits or entitlements, (re) establish community network, and secure basic needs/transportation, access treatment services

Short Term Goal					
Barriers to Goal					
Steps client will take to reach goal					
When will goal be reviewed (select one)	15 days	30 days	45 days	60 days	Ongoing
Progress at review (select one)	Met Goal	Partially Met Goal		Goal Revised	Goal Not Met
Progress at discharge (select one)	Met Goal	Partially Met Goal		Goal Revised	Goal Not Met

Short Term Goal					
Barriers to Goal					
Steps client will take to reach goal					
When will Goal be reviewed (select one)	15 days	30 days	45 days	60 days	Ongoing
Progress at review (select one)	Met Goal	Partially Met Goal		Goal Revised	Goal Not Met
Progress at discharge (select one)	Met Goal	Partially Met Goal		Goal Revised	Goal Not Met

Client Signature _____ Date _____

SRHS Staff Signature _____ Date _____

STATE OF CONNECTICUT
Department of Mental Health and Addiction Services
SUPPORTED RECOVERY HOUSING SERVICES

JOB READINESS INFORMATION

CLIENT NAME: _____ DATE: _____

SRHS authorizations are contingent upon securing and maintaining employment. Please use this form to detail your job readiness efforts throughout the month. Efforts not directly related to job searching (i.e. resume workshop, vocational training, and treatment groups) should be listed directly below;

_____
_____
_____
_____

List all job search contacts:

	Date	**Company & Position**	**Contact Person & Phone #**	**Type of Contact** *i.e.: Sent resume or interviewed*
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

This list should cover searches for the entire month.

STATE OF CONNECTICUT
Department of Mental Health and Addiction Services
SUPPORTED RECOVERY HOUSING SERVICES

PROGRESS NOTE

Client Name: _____

At a minimum, answer each of the following questions in each note: Is client maintaining recovery? What progress has client made towards each goal? Has client expressed additional needs? How is the case manager helping client in these areas?

Present at Session: ☐ Client ☐ Other	Service Date:	Time (in minutes):
Goal being worked on:		
Intervention Provided:		
Goal Progress:		
Plan / Next Steps:		

STATE OF CONNECTICUT
Department of Mental Health and Addiction Services
SUPPORTED RECOVERY HOUSING SERVICES

DISCHARGE SUMMARY

Client Name:
Date of Admission: **Date of Discharge**(41):

Discharge Reason (42) (check all that apply):

___ Completed SRHS
___ Client Discontinued SRHS
___ Incarcerated
___ Left Against Advice
___ Moved out of Area
___ Moved to Another facility
___ Non-Compliance With rules
___ Death
___ Other: _____

Employment Status (check one):

___ Employed, Full Time
___ Employed, Part Time
___ Paid but non-competitive work
___ Unemployed, looking for work
___ Not in Labor Force (e.g. Social Security)
___ Unknown
___ Other: _____

Living Situation at time of discharge (check one):

___ Private Residence, Client holds lease
___ Private Residence, Client does not hold lease
___ Single Room Occupancy (e.g. YMCA, Hotel)
___ Homeless
___ Correctional Facility/Jail
___ Inpatient (e.g. residential SA treatment)
___ Residential Care (e.g. board and care)
___ Sober House (e.g. continuing at SRHS
___ Unknown
___ Other (Please specify) _____

Referrals made (if any) and any additional comments:

_____

_____

_____

Signature of SRHS Staff:_____ Date:_____

STATE OF CONNECTICUT
Department of Mental Health and Addiction Services
SUPPORTED RECOVERY HOUSING SERVICES

SIGN IN SHEET

Provider		**Date**
Site Address		

CLIENT NAME (PRINT)	CLIENT SIGNATURE
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	

Date Reviewed by SRHS Staff: _____

SRHS Staff's Signature: _____

STATE OF CONNECTICUT
Department of Mental Health and Addiction Services
SUPPORTED RECOVERY HOUSING SERVICES

Behavioral Health Recovery Program (BHRP)
Administrative Services Organization:
Advanced Behavioral Health, Inc.
P.O. Box 735, Middletown, CT 06457

PHONE: 1-800-658-4472 FAX: 1-866-249-8766

TREATMENT VERIFICATION FORM

DATE:

RE: Request for BHRP - Basic

Applicant's Name:_____

Treatment Provider: _____

Provider Address: _____

Level of care / Type of treatment: _____

Treatment Start Date: _____ Expected Discharge Date: _____

Participation in behavioral health treatment is a requirement for individuals to access services through the DMHAS Behavioral Health Recovery Program (BHRP) – Basic. I am attesting that the individual named above is participating in behavioral health treatment.

_____
Name of Clinician Clinician Phone #

_____ _____/_____/____
Signature of Clinician Date

Please fax the form to **1-866-249-8766.**
If there are any questions contact BHRP – Basic staff at 1-800-658-4472.