



**STATE OF CONNECTICUT**  
**ACCESS TO RECOVERY II PROGRAM (ATR II)**  
 Department of Mental Health and Addiction Services  
 Phone: 1-866-580-3922 Fax: 1-866-580-4322

**ATR II REGISTRATION AND PORTAL**  
**APPLICANT INFORMATION**

APPLICANT'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
 (MM/DD/YYYY)

APPLICANT DATE OF BIRTH: \_\_\_\_\_ APPLICANT SS#: \_\_\_\_\_ GENDER: M F  
 (MM/DD/YYYY)

APPLICANT ADDRESS: \_\_\_\_\_

ADDRESS CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ APPLICANT EMS #: \_\_\_\_\_

PHONE #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ CELL PHONE #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**PROVIDER INFORMATION**

PROVIDER NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

PROVIDER ADDRESS: \_\_\_\_\_ SECURE FAX: \_\_\_\_\_

ADDRESS CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

NAME OF PERSON COMPLETING FORM: \_\_\_\_\_

**ATR II PROGRAM PORTAL REQUIREMENTS**

**TARGET POPULATION** (check only one):

**CLINICAL SERVICES**

- BUPRENORPHINE: CLINICAL SERVICES WITH SUBOXONE (ATR II CERTIFIED PROVIDERS ONLY)
- BUPRENORPHINE: START PROJECT (CONNECTICUT COUNSELING & HARTFORD DISPENSARY ONLY)
- CO-OCCURRING INTENSIVE OUTPATIENT TREATMENT PROGRAM
- CLINICAL RECOVERY MANAGEMENT CHECK-UP

**COMMUNITY COURT**

- HARTFORD
- WATERBURY

**DEPARTMENT OF CHILDREN AND FAMILIES**

- PROJECT SAFE ABH O & E PROGRAM (HARTFORD & NEW HAVEN)
- PROJECT SAFE ABH RECOVERY CASE MANAGEMENT (NEW BRITAIN)
- PROJECT SAFE CLIENTS ACTIVELY IN TREATMENT
- WOMEN'S BEHAVIORAL HEALTH RECOVERY SPECIALISTS
- WOMEN'S SPECIALIZED RESIDENTIAL TREATMENT CENTER

**DEPARTMENT OF CORRECTION**

- COMMUNITY PAROLE
- END OF SENTENCE (must access ATR II services within 30 days of release)
- PROJECT PREP (HARTFORD ONLY)
- TRANSITIONAL SUPERVISION

**DEPARTMENT OF PROBATION**

- INTENSIVE PRE-TRIAL SUPERVISION
- PROBATION TRANSITION PROGRAM (PTP)
- TECHNICAL VIOLATION UNIT (TVU)
- WOMEN OFFENDER CASE MANAGEMENT (WOCM) PROGRAM

**SPECIALIZED SUBSTANCE ABUSE TREATMENT PROGRAMS**

- BLUE HILLS HOSPITAL
- GREATER BRIDGEPORT COMMUNITY MENTAL HEALTH CENTER
- MERRITT HALL
- NEXT STEPS RESIDENTIAL TREATMENT PROGRAM
- NEW PROSPECTS CO-OCCURRING RESIDENTIAL TREATMENT PROGRAM (BRIDGEPORT)
- PATRICK F. MCAULIFFE CO-OCCURRING RESIDENTIAL TREATMENT PROGRAM (WATERBURY)
- SUBSTANCE ABUSE TREATMENT UNIT (SATU)

CONTACT PERSON: \_\_\_\_\_ PHONE #: \_\_\_\_\_

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 (MM/DD/YYYY)

**SIMPLE SCREENING INSTRUMENT FOR ALCOHOL AND OTHER DRUGS (SSI-AOD)**

I'm going to ask you a few questions about your use of alcohol and other drugs during the past 6 months.

If you have been incarcerated for six months or more, answer the questions based on the 6 months prior to incarceration...

1. Have you used alcohol or other drugs? (such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants).  YES  NO
2. Have you felt that you use too much alcohol or other drugs?  YES  NO
3. Have you tried to cut down or quit drinking or using drugs?  YES  NO
4. Have you gone to anyone for help because of your drinking or drug use?  YES  NO
5. Have you had any health problems? For example, have you:
  - had blackouts or other periods of memory loss?
  - injured your head after drinking or using drugs?
  - had convulsions, delirium tremens (DTs)?
  - had hepatitis or other liver problems?
  - felt sick, shaky, or depressed when you stopped?
  - felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?
  - been injured after drinking or using?
  - used needles to shoot drugs?

Give a "YES" answer if at least one of the 8 presented items is marked ✓

6. Has drinking or other drug use caused problems between you and family or friends?  YES  NO
7. Has your drinking or other drug use caused problems at school or work?  YES  NO
8. Have you been arrested or had other legal problems? (such as bouncing bad checks, driving while intoxicated, theft, or drug possession)?  YES  NO
9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?  YES  NO
10. Are you needing to drink or use drugs more and more to get the effect you want?  YES  NO
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?  YES  NO
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone?  YES  NO
13. Do you feel bad or guilty about your drinking or drug use?  YES  NO

**The next questions are about your lifetime experiences.**

14. Have you **ever** had a drinking or other drug problem?  YES  NO
15. Have any of your family members **ever** had a drinking or drug problem?  YES  NO
16. Do you feel that you have a drinking or drug problem **now**?  YES  NO

**SCORE:** (Questions 1 and 15 are not scored). Screened positive = a score of 4 or greater  
 Number of "Yes" Answers \_\_\_\_\_ is EQUAL TO OR GREATER THAN 4  Yes  No

Center for Substance Abuse Treatment. Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases. Treatment Improvement Protocol (TIP) Series 11. DHHS Publication No. (SMA) 94-2094. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994.

DATE OF LAST USE: \_\_\_\_\_ (MM/DD/YYYY)

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**CAGE-ADAPTED TO INCLUDE DRUGS (CAGE-AID) SCREENING INSTRUMENT**

1. Have you ever felt you should **C**ut down on your drinking or drug use?  
 Drinking:  YES  NO  
 Drug Use:  YES  NO
  
2. Have people **A**nnoyed you by criticizing your drinking or drug use?  
 Drinking:  YES  NO  
 Drug Use:  YES  NO
  
3. Have you ever felt bad or **G**uilty about your drinking or drug use?  
 Drinking:  YES  NO  
 Drug Use:  YES  NO
  
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye opener)?  
 Drinking:  YES  NO  
 Drug Use:  YES  NO

**SCORING**

**SCORE:** Number of "Yes" Answers \_\_\_\_\_

- Screened positive = a score of 1 or greater

**DATE OF LAST USE:** \_\_\_\_\_ (MM/DD/YYYY)

CAGE Adapted to Include Drugs

Brown, R., and Rounds, L. Conjoint screening questionnaires for alcohol and drug abuse: two pilot studies. Unpublished study, 1991.

CAGE

Ewing, J.A. Detecting alcoholism: The CAGE questionnaire. *Journal of the American Medical Association* 252:1905-1907, 1984.

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APPLICANT'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**MENTAL HEALTH SCREENING FORM-III (MHSF-III) SCREENING INSTRUMENT**

I am going to ask you some questions and please note that each item refers to your **entire life history**, not just your current situation, this is why each question begins – “Have you ever...”

1. Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem?  Yes  No
2. Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems?  Yes  No
3. Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem?  Yes  No
4. Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons?  Yes  No
5. Have you ever heard voices no one else could hear or seen objects or things which others could not see?  Yes  No
6. a) Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself?  Yes  No  
 b) Did you ever attempt to kill yourself?  Yes  No
7. Have you ever had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed?  Yes  No
8. Have you ever experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help?  Yes  No
9. Have you ever given in to an aggressive urge or impulse, on more than one occasion that resulted in serious harm to others or led to the destruction of property?  Yes  No
10. Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior?  Yes  No
11. Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner?  Yes  No
12. Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw-up?  Yes  No
13. Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything?  Yes  No
14. Have you ever had spells or attacks when you suddenly felt anxious, frightened, and uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint?  Yes  No
15. Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate?  Yes  No
16. Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling?  Yes  No
17. Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem?  Yes  No

**SCORING** (Questions 1 and 2 are not scored) Screened positive = a score of 1 or greater.  
 Number of “Yes” Answers \_\_\_\_\_ is EQUAL TO OR GREATER THAN 1  Yes  No

*F.X. Carroll, Ph.D. and John J. McGinley, M.S., M.S.W., M.A. Project Return Foundation, 2000*



**MODIFIED MINI SCREEN**

Number of days since last use of alcohol and/or other drugs: \_\_\_\_\_

Section A

1. Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks?  YES  NO
2. In the past two weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time?  YES  NO
3. Have you felt sad, low or depressed most of the time for the last two years?  YES  NO
4. In the past month did you think that you would be better off dead or wish you were dead?  YES  NO
5. Have you ever had a period of time when you were feeling 'up', hyper or so full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol).  YES  NO
6. Have you ever been so irritable, grouchy or annoyed for several days, that you had arguments, verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or overreacted, compared to other people, even when you thought you were right to act this way?  YES  NO

Section B

7. Have you had one or more occasions when you felt intensely anxious, frightened, uncomfortable or uneasy even when most people would not feel that way? Did these intense feelings get to be their worst within 10 minutes? (If "yes" to both questions, answer "yes", otherwise check "no")  YES  NO
8. Do you feel anxious, frightened, uncomfortable or uneasy in situations where help might not be available or escape might be difficult? Examples include: \_\_\_being in a crowd, \_\_\_standing in a line, \_\_\_being alone away from home or alone at home, \_\_\_crossing a bridge, \_\_\_traveling in a bus, train or car?  YES  NO
9. Have you worried excessively or been anxious about several things over the past 6 months? (If you answered "no" to this question, please skip to Question 11.)  YES  NO
10. Are these worries present most days?  YES  NO
11. In the past month, were you afraid or embarrassed when others were watching you or when you were the focus of attention? Were you afraid of being humiliated?  
 Examples include: \_\_\_speaking in public, \_\_\_eating in public or with others, \_\_\_writing while someone watches, \_\_\_being in social situations.  YES  NO
12. In the past month, have you been bothered by thoughts, impulses, or images that you couldn't get rid of that were unwanted, distasteful, inappropriate, intrusive or distressing? Examples include: \_\_\_Were you afraid that you would act on some impulse that would be really shocking? \_\_\_Did you worry a lot about being dirty, contaminated or having germs? \_\_\_Did you worry a lot about contaminating others, or that you would harm someone even though you didn't want to? \_\_\_Did you have any fears or superstitions that you would be responsible for things going wrong? \_\_\_Were you obsessed with sexual thoughts, images or impulses? \_\_\_Did you hoard or collect lots of things? \_\_\_Did you have religious obsessions?  YES  NO



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13. In the past month, did you do something repeatedly without being able to resist doing it? Examples include: \_\_\_Washing or cleaning excessively; \_\_\_Counting or checking things over and over; \_\_\_Repeating, collecting, or arranging things; \_\_\_Other superstitious rituals.  YES  NO
14. Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? Examples include: \_\_\_serious accidents; \_\_\_sexual or physical assault; \_\_\_terrorist attack; \_\_\_being held hostage; \_\_\_kidnapping; \_\_\_fire; \_\_\_discovering a body; \_\_\_sudden death of someone close to you; \_\_\_war; \_\_\_natural disaster.  YES  NO
15. Have you re-experienced the awful event in a distressing way in the past month? Examples include: \_\_\_Dreams; \_\_\_Intense recollections; \_\_\_Flashbacks; \_\_\_Physical reactions.  YES  NO

**Section C**

16. Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you?  YES  NO
17. Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear what another person was thinking?  YES  NO
18. Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Or, have you ever felt that you were possessed?  YES  NO
19. Have you ever believed that you were being sent special messages through the TV, radio, or newspaper? Did you believe that someone you did not personally know was particularly interested in you?  YES  NO
20. Have your relatives or friends ever considered any of your beliefs strange or unusual?  YES  NO
21. Have you ever heard things other people couldn't hear, such as voices?  YES  NO
22. Have you ever had visions when you were awake or have you ever seen things other people couldn't see?  YES  NO

**Section D<sup>1</sup>**

23. Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling?  YES  NO

**SCORING**

**SCORE:** Number of "Yes" Answers \_\_\_\_\_

- Screened positive = a score of 6 or greater – **OR** –Question 4 = yes (suicidality) – **OR** – Question 14 AND 15 = yes (trauma)

Modified Mini International Neuropsychiatric Interview

Alexander, M.J., Haugland, G., Lin, S.P., Bertollo, D.N., and McCorry, F.A. *Mental Health Screening in Addiction, Corrections and Social Service Settings: Validating the MMS. International Journal on the Addictions, (forthcoming).*

Mini International Neuropsychiatric Interview (MINI)

Sheehan, D.V., Lecrubier, Y., Sheehan, K.H., Amorim, P., Janavs, J., Weiller, E., Hergueta, T., Baker, R., & Dunbar, G.C. *The mini-international neuropsychiatric interview (M.I.N.I.): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. Journal of Clinical Psychiatry, 59 (suppl. 20), 1998.*

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<sup>1</sup> This question was added by Connecticut.  
ATR II Application 6.doc  
Rev Date 12/09



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

I, \_\_\_\_\_, DOB: \_\_\_\_\_,  
 (Name of Patient) (Date of Birth)

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

participant in the DMHAS Access To Recovery II Program (ATR II), 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 Access To Recovery II Program (ATR II) 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, Access To Recovery II Program (ATR II) 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 Access To Recovery II Program (ATR II) 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 Statutes, 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 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)

\_\_\_\_\_  
 (Signature of parent, guardian or authorized representative where required)

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**CONSENT TO PARTICIPATE**

I, \_\_\_\_\_, \_\_\_\_\_, agree to participate in the Connecticut  
 (Print Name) (Date of Birth)  
 Access to Recovery II (ATR II) Program.

I understand and agree to the following components of this federally funded program:

- Services provided under this grant are strictly voluntary
- I have choice regarding all of my service providers
- Service providers are required to interview me and ask me questions based on the federal law: Government Performance and Results Act (GPRA) at the following three (3) intervals:
  - Intake
  - Six Months post intake
  - Discharge
- A \$20.00 gift certificate will be available for the six month follow up interview
- In the event that an ATR provider cannot locate me in order to complete a GPRA interview, I agree to allow ATR providers and/or Advanced Behavioral Health (ABH) to contact the individuals listed on my contact page in order to confirm my whereabouts. The provider and/or ABH will then contact me to conduct an interview with me. I understand that no confidential information will be provided to persons on the contact page unless I have authorized it through a consent of authorization document.

\_\_\_\_\_  
 (Signature of Participant)

\_\_\_\_\_  
 (Date)

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**ATR II CONTACT SHEET**

Please read the following to the client: I agree to allow ATR providers and/or Advanced Behavioral Health (ABH) to contact the individuals listed below to confirm my whereabouts. I understand that no confidential information will be provided to persons on the contact page unless I have authorized it through a separate consent of authorization.

**What is your name?** \_\_\_\_\_  
 (Last name) (First name) (Middle name)

Is this your married name?  Yes  No (If yes, what is your maiden name?) \_\_\_\_\_  
 (Maiden name)

**What other name(s) are you known by?** \_\_\_\_\_  
 (Alias/Street name)

What is your mother's maiden name? \_\_\_\_\_

**What is your most recent address?**

Street: \_\_\_\_\_ Apt./Room/Floor: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

What name is on the mailbox? (Does mail need to be in care of someone else?) \_\_\_\_\_

Whose place is it? Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

What is the phone number at this location? (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**What is your phone number?** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Is this a Cell phone?  Yes  No

**Is this the phone number where you want to be called to complete your follow-up GPRA?**  
 Yes  No *If no, what number should we call?* (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

What are the best days and times of the week to reach you?  Any Day  Any time

<input type="checkbox"/> Sunday	<input type="checkbox"/> 8AM – 10 AM	<input type="checkbox"/> 10 AM – 2 PM	<input type="checkbox"/> 2PM – 6PM	<input type="checkbox"/> 6 PM- 8 PM
<input type="checkbox"/> Monday	<input type="checkbox"/> 8AM – 10 AM	<input type="checkbox"/> 10 AM – 2 PM	<input type="checkbox"/> 2PM – 6PM	<input type="checkbox"/> 6 PM- 8 PM
<input type="checkbox"/> Tuesday	<input type="checkbox"/> 8AM – 10 AM	<input type="checkbox"/> 10 AM – 2 PM	<input type="checkbox"/> 2PM – 6PM	<input type="checkbox"/> 6 PM- 8 PM
<input type="checkbox"/> Wednesday	<input type="checkbox"/> 8AM – 10 AM	<input type="checkbox"/> 10 AM – 2 PM	<input type="checkbox"/> 2PM – 6PM	<input type="checkbox"/> 6 PM- 8 PM
<input type="checkbox"/> Thursday	<input type="checkbox"/> 8AM – 10 AM	<input type="checkbox"/> 10 AM – 2 PM	<input type="checkbox"/> 2PM – 6PM	<input type="checkbox"/> 6 PM- 8 PM
<input type="checkbox"/> Friday	<input type="checkbox"/> 8AM – 10 AM	<input type="checkbox"/> 10 AM – 2 PM	<input type="checkbox"/> 2PM – 6PM	<input type="checkbox"/> 6 PM- 8 PM
<input type="checkbox"/> Saturday	<input type="checkbox"/> 8AM – 10 AM	<input type="checkbox"/> 10 AM – 2 PM	<input type="checkbox"/> 2PM – 6PM	<input type="checkbox"/> 6 PM- 8 PM

What is your email address? \_\_\_\_\_  I don't have one

**If something were to happen with your current living arrangements where is the best place to find you in 6 months to do the checkup?** (Check to see if there is some other place client would go, if they were to go out of town.)

Street: \_\_\_\_\_ Apt./Room/Floor: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

What name is on the mailbox? (Does mail need to be in care of someone else?) \_\_\_\_\_

Whose place is it? Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

What is the phone number at this location? (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Have you ever been arrested under a different name (other than the name recorded in Q.1)?**  
 Yes  No If Yes, what was the name? Name: \_\_\_\_\_



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**Name and address of any other services/programs used recently:** (shelter, community center, religious organization, health care clinic, soup kitchen/food pantry, case management, clinical treatment, veteran services, emergency room)

Program/Service Name: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Other Information:** \_\_\_\_\_

**Primary Contact** (relatives, significant other, or someone else that you feel close to or could call for support)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Apt./Room/Floor: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

What name is on the mailbox? (Does mail need to be in care of someone else?) \_\_\_\_\_

Whose place is it? Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

What is the phone number at this location? (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Additional Contact Person** (do not repeat previously given contact)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Apt./Room/Floor: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

What name is on the mailbox? (Does mail need to be in care of someone else?) \_\_\_\_\_

Whose place is it? Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

What is the phone number at this location? (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Additional Contact Person** (do not repeat previously given contact)

(If none ask, what acquaintances do you see or talk with?) (i.e. neighbor)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Apt./Room/Floor: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name on phone listing if different than above: \_\_\_\_\_

What name is on the mailbox? (Does mail need to be in care of someone else?) \_\_\_\_\_

Whose place is it? Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

What is the phone number at this location? (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Additional Contact Person** (do not repeat previously given contact)

(If none ask, what acquaintances do you see or talk with?) (i.e. neighbor)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Apt./Room/Floor: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name on phone listing if different than above: \_\_\_\_\_

What name is on the mailbox? (Does mail need to be in care of someone else?) \_\_\_\_\_

Whose place is it? Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

What is the phone number at this location? (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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ACCESS TO RECOVERY II PROGRAM (ATR II)**  
Department of Mental Health and Addiction Services  
Phone: 1-866-580-3922 Fax: 1-866-580-4322  
**NON-HOUSING SERVICE REQUEST**

APPLICANT'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**BUPRENORPHINE OTP** Start Date of Service: \_\_\_\_\_

1<sup>st</sup> Choice Vendor & Location: \_\_\_\_\_

2<sup>nd</sup> Choice Vendor & Location: \_\_\_\_\_

**BUPRENORPHINE START** Start Date of Service: \_\_\_\_\_

1<sup>st</sup> Choice Vendor & Location: \_\_\_\_\_

2<sup>nd</sup> Choice Vendor & Location: \_\_\_\_\_

**CASE MANAGEMENT** Start Date of Service: \_\_\_\_\_

1<sup>st</sup> Choice Provider & Location: \_\_\_\_\_

2<sup>nd</sup> Choice Provider & Location: \_\_\_\_\_

**CLINICAL RECOVERY MANAGEMENT CHECK-UPS** Start Date of Service: \_\_\_\_\_

1<sup>st</sup> Choice Provider & Location: \_\_\_\_\_

2<sup>nd</sup> Choice Provider & Location: \_\_\_\_\_

**CO-OCCURRING IOP** Start Date of Service: \_\_\_\_\_

1<sup>st</sup> Choice Provider & Location: \_\_\_\_\_

2<sup>nd</sup> Choice Provider & Location: \_\_\_\_\_

**ENHANCED RESIDENTIAL PROGRAM** Start Date of Service: \_\_\_\_\_

1<sup>st</sup> Choice Provider & Location: \_\_\_\_\_

2<sup>nd</sup> Choice Provider & Location: \_\_\_\_\_

**FAITH-BASED SERVICES** Start Date of Service: \_\_\_\_\_  Individual Only  Group Only  Both

1<sup>st</sup> Choice Provider & Location: \_\_\_\_\_

2<sup>nd</sup> Choice Provider & Location: \_\_\_\_\_

**PEER-BASED SERVICES** Start Date of Service: \_\_\_\_\_  Individual Only  Group Only  Both

1<sup>st</sup> Choice Provider & Location: \_\_\_\_\_

2<sup>nd</sup> Choice Provider & Location: \_\_\_\_\_

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**FOOD** 1<sup>st</sup> Choice Provider & Location: \_\_\_\_\_

**CLOTHING** 1<sup>st</sup> Choice Provider & Location: \_\_\_\_\_

**PERSONAL CARE** 1<sup>st</sup> Choice Provider & Location: \_\_\_\_\_

**TRANSPORTATION** (Bus passes/tokens only) **SELECT ONLY ONE TRANSIT COMPANY BELOW**

<input type="checkbox"/> <b>CT Transit-</b> Hartford, New Haven, Stamford, Waterbury, New Britain, Bristol, Meriden, Wallingford, Waterbury
<input type="checkbox"/> <b>GBTA</b> – Greater Bridgeport Transit
<input type="checkbox"/> <b>HART-</b> Housatonic Area Regional Transit
<input type="checkbox"/> <b>MAT</b> – Middletown Area Transit
<input type="checkbox"/> <b>NW</b> Transit – Winsted, Litchfield, Torrington, Canaan
<input type="checkbox"/> <b>SEAT</b> – Southeast Area Transit
<input type="checkbox"/> <b>Wheels</b> – Norwalk Transit
<input type="checkbox"/> <b>WRTD</b> – Windham Regional Transit

**EDUCATIONAL/VOCATIONAL - (Eligible after 30 Days of ATR Services)**

**Start Date of Service:** \_\_\_\_\_ **Requested Amount:** \_\_\_\_\_

1<sup>st</sup> Choice Provider & Location: \_\_\_\_\_

2<sup>nd</sup> Choice Provider & Location: \_\_\_\_\_

*(Documents that must be faxed if requesting Educational/Vocational are an Invoice from the provider and a W9)*

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APPLICANT'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**SUPPORTED RECOVERY HOUSING SERVICE REQUEST**

Net Weekly Total Income: \$ \_\_\_\_\_ (XXXX.XX) (Required after the initial Month)

1<sup>st</sup> Choice Provider & Location: \_\_\_\_\_

2<sup>nd</sup> Choice Provider & Location: \_\_\_\_\_

Exact Address where applicant will be residing: \_\_\_\_\_

Exact floor where applicant will be residing: \_\_\_\_\_

Monthly Rent: \$ \_\_\_\_\_

Applicant's move-in date: \_\_\_\_\_

(Required after the initial Month):  Proof of Income  Job Readiness Information (Sample form available at [www.abhct.com](http://www.abhct.com))

\_\_\_\_\_  
 (Signature of Applicant)

\_\_\_\_\_  
 (Date)

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APPLICANT'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**INDEPENDENT LIVING HOUSING & LANDLORD VERIFICATION FORM**

Net Weekly Total Income: \$ \_\_\_\_\_

Exact address where participant will be residing: \_\_\_\_\_

Monthly Rent: \$ \_\_\_\_\_

Security: \$ \_\_\_\_\_

Name of Owner: \_\_\_\_\_

Owner Address: \_\_\_\_\_

Owner Telephone #: \_\_\_\_\_ FEIN / SSN: \_\_\_\_\_

Participant's move-in date: \_\_\_\_\_

Unit Type (private apartment, shared apartment/house, sober house, room, other): \_\_\_\_\_

Number of bedrooms in the unit: \_\_\_\_\_

What is the maximum allowable occupancy of the dwelling or unit, per local zoning regulations? \_\_\_\_\_

How many people live in this household, per the lease agreement? \_\_\_\_\_

Are all household members related? Y/N If no, how many unrelated people live in this household? \_\_\_\_\_

Please list all residents permitted to use this unit:  
 \_\_\_\_\_

Check any of these included in the rent:  Heat  Electricity  Gas  Oil  Hot Water  Meals  Other: \_\_\_\_\_

Required Documentation (to be faxed to ABH):  Lease  W-9  Proof of Income

Signature of Owner: \_\_\_\_\_ Date: \_\_\_\_\_

***By signing this form, I understand that I am attesting to the truth of the information above, including compliance with local zoning regulations. I further understand that this information is subject to verification and audit, and that intentional misrepresentation may lead to criminal prosecution.***

\_\_\_\_\_  
 (Signature of Applicant)

\_\_\_\_\_  
 (Date)

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