



**STATE OF CONNECTICUT
ACCESS TO RECOVERY II PROGRAM (ATR II)**
Department of Mental Health and Addiction Services

Phone 1-866-580-3922

Fax application to: 1-866-580-4322

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?

- | | | | | |
|------------------------------------|--------------------------------------|---------------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Sunday | <input type="checkbox"/> 8AM – 10 AM | <input type="checkbox"/> 10 AM – 2 PM | <input type="checkbox"/> Any Day | <input type="checkbox"/> Any time |
| <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? (_____) _____ - _____

*PLEASE RETAIN A COPY OF THIS PAGE IN THE CLIENT'S CHART FOR AUDIT.
THIS PAGE DOES NOT NEED TO BE FAXED TO ABH*