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

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)

PLEASE RETAIN A COPY OF THIS PAGE IN THE CLIENT'S CHART FOR AUDIT.

THIS PAGE MUST BE FAXED TO ABH