Behavioral Health Recovery Program (BHRP)
Recovery Support 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 service documentation files for each client they serve. These forms may be stored as a hard copy or scanned and saved to an electronic record. 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), vocational/educational opportunities, housing subsidies, medical or other treatment appointments, energy assistance, food stamps and other potential sources of income and community recovery supports.

SRHS case management supports may not 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 form only*)
- Discharge (*sample form only*)
- Treatment Verification Form
- Sober Living Homes Disclosure Form

• 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, this form describes services offered under SRHS, what clients can expect from staff, and as their responsibilities as a part of the program.

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. Form must be stored in paper or electronic client chart file.

• 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 ROI must be completed again to extend through the end of services. Providers may recommend that clients make the form valid for 180 days. Form should be stored in paper or electronic client chart file.

• 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. Form must be stored in paper or electronic client chart file.

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- **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. Form must be stored in paper or electronic client chart file.

- **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.

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. This form should not be given to clients to fill out, but instead should be completed by staff as part of the intake discussion and then signed by both client and staff. Form must be stored in paper or electronic client chart file.

- **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. This form should not be given to clients to fill out, but instead should be completed by staff as part of the intake discussion and then signed by both client and staff. Form must be stored in paper or electronic client chart file.

- **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 or when any BHRP-RSS services have been received in the last 12 months. 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 job readiness form should also be reviewed at case management meetings and should be stored in paper or electronic client chart file. Clients who are employed should substitute copies of their two (2) most recent pay stubs for this form. Clients who are receiving cash benefits should substitute verification of income for this form.

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- **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: Progress Notes are submitted electronically in the Web-based BHRP system. The online 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 BHRP system. It is recommended provider also maintain a record of each client's sign-in for weekly case management meetings.

- **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 electronically in the Web-based BHRP system when each client completes services successfully or leaves services prematurely.

WHAT IS ON THE FORM: The form is available electronically in the Web-based BHRP system. Providers must enter discharge date, reason for discharge, and living situation at the time of discharge.

WHEN THE FORM SHOULD BE COMPLETED: Directly before or directly after discharge, depending upon the circumstances. All discharges must be documented in the Web-based BHRP system.

- **TREATMENT VERIFICATION FORM**

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

WHAT IS ON THE FORM: Information related to client's participation and engagement in treatment.

WHEN THE FORM SHOULD BE COMPLETED: For each BHRP request. Form should be stored in paper or electronic client chart file.

- **SOBER LIVING HOMES DISCLOSURE FORM**

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

WHAT IS ON THE FORM: This form clarifies that sober living homes are not licensed to provide treatment. It also provides a list of links to local recovery and housing resources.

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 document. Form must be stored in paper or electronic client chart file.

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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;
  - submit to alcohol or drug screenings as requested; and
  - obtain a signed *Treatment Verification Form* from my treatment provider.
- With an approval through the Behavioral Health Recovery Program (BHRP-RSS), $33.00 per day 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 during this time.
- The maximum period that I may receive BHRP payment for SRHS is 30 days, with the possibility of a second month extension. This time period may be reduced based on my previous use of the service.

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

_____

Client Signature Date

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

I, _____ , DOB: _____ , EMS#_____;
(Name of Participant) **(Date of Birth)** **(EMS Number)**

SS# _____ as a participant in the DMHAS Behavioral Health Recovery Program,
(Social Security Number)

as a participant in the DMHAS Behavioral Health Recovery Program (BHRP), 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 requests:

1. The DMHAS Administrative Service Organization; and

2. _____
[SRHS Provider Name]

3. _____
[Additional parties, if needed]

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 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 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)

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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 or visitor of the house. Any client possessing or using alcohol or drugs will be immediately discharged. Law enforcement officials will be notified if there is illegal drug use in the house by any client or visitor.
    b. House staff has the right to request clients provide a urine sample or other drug test (including random testing). If a client fails to submit to any testing, the client may be immediately discharged.
    c. Those who relapse will be offered an opportunity to address their needs for additional and more intensive treatment by the staff. Any refusal may have an impact on their ability to remain in the house.
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. All medical and behavioral health conditions must be reported upon admission.
    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 hours (e.g. six hours) each day. Employment is a mandatory criterion for ongoing housing supports to most clients and may impact your ability to remain in the house. Clients who receive other forms of cash benefits are required to submit verification of income to case manager and participate in community service or other productive daytime activities.
6. Sponsorship and Case Management
    a. Clients should begin actively seeking a sponsor immediately with a goal to obtain one within 30 days of admission.
    b. Clients must meet weekly with a case manager (see Client Service Agreement for additional details on case management services).
7. Complaints
    a. All clients are encouraged to contact the owner/manager of the house to resolve any issues and, if there is no resolution, use the written grievance procedure. There is a grievance procedure posted at each SRHS house.
8. Behavior and Personal Relationships
    a. Sexual relationships between any clients in the house (including staff) are not acceptable.
    b. Clients are not allowed to borrow money from other clients or staff.
    c. Theft of any items will result in immediate discharge.
    d. No threatening, violence, or acts of dishonesty.
9. 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.
10. Limit the use of shared Internet, phone, and any other communal house services to 15 minutes.

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11. Any outstanding warrants must be documented at intake and addressed within 30 days of admission.
12. In case of an emergency, call 911 immediately and then notify staff.
13. 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
        v. Other mandatory meetings may be set by the housing provider.
14. 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 and according to BHRP policies.
15. House Chores
    a. Each client must complete chores as assigned by housing staff 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.
16. Cars
    a. Any motor vehicle on the property must be registered and insured. 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.
17. Departure and Discharge
    a. All clients will be discharged from SRHS assistance after 60 days and depending on individual circumstances become a self-pay resident, or
    b. be guided to alternative living options in the community, based on their individual recovery plan.
18. Personal belongings
    a. I agree to accept full responsibility for any personal property. I have been advised to not bring any item of significant sentimental or monetary value into the house because of the risk of loss or theft in a shared living arrangement
    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, unless prior arrangements have been agreed upon.

I, _____, agree to follow all rules.

Client Signature _____ Date _____

Staff Signature _____ Date _____

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

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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 the Behavioral Health Recovery Program (BHRP) at (800) 658-4472. **You are required to try to resolve your grievance at the SRHS level before calling BHRP.**

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: _____

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INTAKE ASSESSMENT

Demographics

Name: _____ Phone: ( ) _____- _____

Previous Address: _____ City_____ Zip _____

Email Address: _____

Date of Assessment: _____/_____/_____ Social Security #: _____-_____-_____ Date of birth: _____/_____/_____

Gender:	☐ Male	☐ Female	If female, pregnant:	☐ Yes	☐ No	Smoker:	☐ Yes	☐No	
Military Service:	☐ Yes	☐ No	Dates of Service	____/____/_____ through ____/____/_____					
Marital Status:	☐ Married	☐ Civil Union	☐ Divorced	☐ Separated					
	☐ Widowed	☐ Never Married	☐ Other _____						
Race:	☐ Native American	☐ Asian	☐ African American	☐ Native Hawaiian	☐ White/Caucasian				
Ethnicity:	☐ Non-Hispanic	☐ Hispanic							
	☐ Unknown	If Hispanic:	☐ Puerto Rican	☐ Mexican	☐ Cuban	☐ Other			

Primary Language:_____ Religious/Spiritual Practice: _____

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

Emergency contact address: _____

Legal Information/History

Pending Cases:	☐ Yes	☐ No	Previous Involvement with the Criminal Justice System?	☐ Yes	☐ No
Current Probation:	☐ Yes	☐ No	Criminal Justice Contact Name: _____		
Current Parole:	☐ Yes	☐ No	Criminal Justice Contact Phone: (_____) _____-_____		
Conservator:	☐ Yes	☐ No	Number of arrests in the last 30 days: _____		

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Health Status

	Currently Experiences/Uses	History Of	In Treatment For	No History
Mental Health conditions				
Substance Use disorders				
Medical Conditions				
Trauma/ Abuse				
Prescribed Medications				
Please list all medications below:				

Current Health Problems:	Allergies:
_____	_____
_____	_____
_____	_____
☐ No current health problems	☐ No known allergies

Current Doctor/Clinician Name: _____ Phone Number: (_____) _____ - _____

Do you attend AA/NA? ☐ Yes ☐ No	Number of times attended in the last 30 days? _____

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Substance Use History

What is/was your substance of choice?	Date of last use:
_____	_____/ _____/ _____
What is your longest period of sobriety or stability?	
_____	
_____	
_____	

Substance Type	Method	Days used in last 30 days	Age at first use

Entitlements and Benefits

Principal Source of Income:	☐ None	☐ Public Assistance	☐ Retirement	☐ Salary	☐ Disability
Number of People Dependent on Income: _____		Number of Minors Dependent on Income: _____			
Benefits:	☐ Medical	☐ SNAP	☐ TANF	☐ SSD/SSI	☐ Other _____
Medicaid Status:	☐ Active	☐ Not Active	☐ Pending	☐ Unknown	EMS ID # _____

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Other State/Provider Agency Involvement

Are you currently working with another agency or case manager? (e.g. DCF, ABH ICM) ☐ Yes
If so, please list their contact information below: Name: _____ Agency: _____ Phone Number: (_____) _____-_____ Email Address: _____ Name: _____ Agency: _____ Phone Number: (_____) _____-_____ Email Address: _____

Referral Source

Who referred you to this program?				
☐ Self	☐ SUD Residential Provider ☐ Other SUD Provider Agency Name: _____	☐ MH Provider Agency Name: _____	☐ Probation/Parole	☐ Other Please Specify: _____ _____ _____

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Family and Supports

Do you feel you have social supports (family, friends, etc.)?	☐ Yes	☐ No	
How would you describe your current relationship with your family members?	_____		
Do any of your immediate family members have service needs?	☐ Yes If yes, please explain: _____	☐ No	
Do you currently have a sponsor?	☐ Yes	☐ No	☐ Not Sure

Employment Status

Employment Status:	☐ Employed full-time	☐ Employed part-time	☐ Non-competitive or volunteer work
	☐ Unemployed, looking for work	☐ Not in labor force	☐ Other _____
Highest Grade Completed: _____			

Housing Status

Living situation immediately prior to SRHS:	☐ Private Residence	☐ Single Room Occupancy	☐ Residential care/treatment	
	☐ Hospital	☐ Prison/Jail	☐ Homeless Shelter	☐ Homeless (on street)
Reason For Leaving:	_____			

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Have you experienced homelessness within the last six months?	☐ Yes	☐ No	Are you at risk of homelessness?	☐ Yes	☐ No

In the Client's Own Words

I need help with the following:				
☐ Housing	☐ Arranging Medical Care	☐ Education/Training	☐ Finding Employment	☐ Paying Rent/Utilities
☐ Securing Benefits	☐ Shopping & Meal Preparation	☐ Mental Health Services	☐ Substance Use Services	☐ Health & Wellness Services
☐ Hygiene/Personal Care Needs	☐ Money Management	☐ Opening a Bank Account	☐ Medication Management	☐ Legal Assistance

What do you think is your biggest or most challenging issue with maintaining a sober lifestyle?	_____ _____ _____
What are specific relapse triggers you can recognize?	_____ _____ _____
What are your strengths?	_____ _____ _____
What specific assistance or support would best help you to reach your 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

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RECOVERY PLAN

CLIENT NAME: _____ DATE: _____

Suggested Goals in order to maintain recovery: find a sponsor, locate stable housing, secure full-time employment, apply for relevant benefits or entitlements, (re) establish community network, secure basic needs/transportation, access treatment services

Short-Term Goal #1				
Barriers to Goal				
Steps client will take to reach goal				
Review Date & Progress 30-day Review: 60-day Review:	Date of Review: _____ _____	Circle One Status: Goal Met	Goal Revised Goal Met	Goal Not Met Goal Not Met
Progress at discharge (select one)	Met Goal	Partially Met Goal	Goal Revised	Goal Not Met

Short-Term Goal #2				
Barriers to Goal				
Steps client will take to reach goal				
Review Date & Progress 30-day Review: 60-day Review:	Date of Review: _____ _____	Circle One Status: Goal Met	Goal Revised Goal Met	Goal Not Met 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 _____

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JOB READINESS INFORMATION

APPLICANT'S NAME: _____

APPLICANT'S SIGNATURE: _____

Please include information explaining your job readiness efforts, such as job applications, vocational training, posting resumes online, employment-related employment groups, online education, etc. This list must cover the entire month and you may attach additional sheets as needed.

If applicant is employed, please submit legible copies of 2 most recent pay stubs instead of this form.
If applicant is receiving cash assistance, please submit verification of benefit type and amount.

_____

_____

_____

List all job search contacts:

	Date	Company & Position	Contact Person & Phone #	Type of Contact
1				
2				
3				
4				

List all vocational/educational training courses:

	Dates of Training	Name of Training	Agency	Contact Person & Phone #
1				
2				
3				
4				

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PROGRESS NOTE

Client Name: _____

At a minimum, answer each of the following questions in each note: What is the immediate goal client is focusing on at this time? What steps has client taken and overall progress has been made towards each goal? What intervention did the case manager provide to help client in this area? Has client expressed additional needs? What are the next steps to be taken by both client and case manager prior to next meeting?

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

SAMPLE FORM ONLY

PROGRESS NOTES MUST BE DOCUMENTED DIRECTLY IN THE WEB-BASED BHRP SYSTEM

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DISCHARGE SUMMARY

Client Name:	
Date of Admission:	**Date of Discharge**:

Discharge Reason (check one):

- ☐ Recovery Plan Completed
- ☐ Non-Compliant With Rules
- ☐ Hospitalized
- ☐ Death
- ☐ Left Against Advice
- ☐ Incarcerated
- ☐ specify): _____

SAMPLE FORM ONLY

ALL DISCHARGES MUST BE DOCUMENTED DIRECTLY IN THE WEB-BASED BHRP SYSTEM

Living Situation at time of discharge

- ☐ Continued SRHS as a self-pay
- ☐ Private Residence (client lease)
- ☐ Private Residence (friend or family)
- ☐ Private Residence (community agency)
- ☐ Rooming House (SRO, YMCA)
- ☐ Nursing Facility/Nursing Home
- ☐ Psychiatric Inpatient Treatment
- ☐ SUD Inpatient Treatment
- ☐ Medical Inpatient Treatment
- ☐ acility
- ☐ ence Shelter
- ☐ lter
- ☐ Homeless (on street)
- ☐ Unknown
- ☐ Other (Please specify): _____

Signature of SRHS Staff:_____ Date:_____

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TREATMENT VERIFICATION FORM

Participation in behavioral health treatment is a requirement for individuals to access services through the DMHAS Behavioral Health Recovery Program (BHRP) – Recovery Support Services. This form must be completed by the attesting clinician (or administrative staff with the consent of the attesting clinician) at the provider agency for individuals attending the behavioral health services identified below.

SRHS provider staff may complete this form for individuals who have an intake scheduled, ONLY for the first month. Once individuals have begun attending treatment, this form must be completed by the treatment provider.

A. APPLICANT INFORMATION

Applicant's Name: _____

Applicant's Medicaid ID: _____

Applicant's Date of Birth: _____

Applicant's Phone Number: _____

Applicant's Address: _____

B. BEHAVIORAL HEALTH PROVIDER INFORMATION

Treatment Provider: _____

Provider Address: _____

Level of Care (check one):

Level I: ☐ Outpatient Services ☐ Medication-Assisted Therapies

Level II: ☐ Intensive Outpatient/Partial Hospitalization

Level III: ☐ Residential/Inpatient Services

Treatment Start Date: _____ Expected Discharge Date: _____

C. PROVIDER ATTESTATION

I attest that the applicant is currently participating in behavioral health treatment/services through the provider agency identified on this form.

_____

Name Agency Contact Number

_____ _____/____/_____

Signature Date

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SOBER LIVING HOME DISCLOSURE FORM

I, _____, understand that the purpose of this disclosure form
(name of prospective resident)

is to help persons like myself who are considering becoming a resident of the Sober Living Home

_____,
(name of sober living home)

I understand the following:

Sober Living Homes are not licensed or certified to provide substance use disorder treatment services.

Sober Living Homes are a type of residence where unrelated adults recovering from a substance use disorder voluntarily choose to live together in a supportive environment during their recovery.

The Department of Mental Health and Addiction Services (DMHAS) suggests the following resources and links that provide information on treatment, community resources and sober living homes for individuals recovering from a substance use disorder.

How to find mental health and substance use services in your area: www.ct.gov/dmhas/services

Behavioral Health Recovery Program / Supportive Recovery Housing Service Providers (SRHS, Contracted by Advanced Behavioral Health for DMHAS: www.ct.gov/dmhas/bhrp

CT Alliance of Recovery Residences: http://ctrecoveryresidences.org/

Housing and Homeless Services: www.ct.gov/dmhas/housing

Medication Assisted Treatment: www.ct.gov/dmhas/mat

Connecticut Community for Addiction Recovery: https://ccar.us/

Advocacy Unlimited: http://www.mindlink.org/

211Infoline: https://www.211ct.org/

_____
(Signature of prospective resident) (Date)

A copy of a blank disclosure form is available online at www.ct.gov/dmhas/soberhomes