Reset Form

CLIENT CHOICE - INDIANA ACCESS TO RECOVERY (ATR) – ST JOSEPH COUNTY

State Form 54821 (R7 / 9-13)

IN access to RECOVERY
CLIENT CENTERED AND RECOVERY FOCUSED

I _____ , IDOC number _____ understand that Indiana Access to Recovery
(Enter name of client) *(If applicable)*

is a voluntary program and that my participation in the program is because I want to recover from my addictions. I understand that there are a number of providers qualified to provide many services that I may require during my participation in the ATR program. I also understand that I may choose the providers that provide services to me while I participate in the program. I understand that the following providers are ready to provide Indiana ATR clients with Recovery Consultation.

Name and Address of Recovery Consultant Agency	Telephone number	Fax number
Calvary Chapel **53494 Fir Road, Granger, IN 46530**	574-273-9987	574-273-9784
Healthy Communities Initiative of St. Joseph County **401 East Colfax Avenue, Suite 207, South Bend, IN 46617**	574-239-8585 Ext. 2	574-239-3577
Power in Praise Crusade Ministries **610 North Logan Street, Mishawaka, IN 46545**	574-258-1170	574-258-1173

From the above list I have selected _____ to provide this service.
(Enter name of recovery consultant agency)

No one has exerted pressure on me to select this particular provider and I am confident that this provider is best suited to meet my needs for recovery consultation. I understand that if I find that this provider does not meet my needs, I may select another provider to replace this provider at any time. I understand that _____
(Enter name of recovery consultant agency)

may not be willing or have the ability to provide recovery consultation to me at this time, in which case I will need to select a different provider.

I authorize the referral agency to release my information to help the Recovery Consultant contact me:

Name of referral agency	
Name of referral agent	Telephone number ( )

I understand that the Recovery Consultant will need to contact me.
I authorize my chosen Recovery Consultant to contact me by contacting me at the following:

Address *(number and street, city, state, and ZIP code)*

Home telephone number	Cellular or Mobile telephone number	Work telephone number
( )	( )	( )

Signature of client	Date *(month, day, year)*