Reset Form

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

State Form 54824 (R6 / 10-13)

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/E-mail address
Community Outreach Network Services **2105 North Meridian Street, Suite 102, Indianapolis, IN 46202**	317-926-5463	317-926-5498
Public Advocates in Community re-Entry (PACE) Inc. **2855 North Keystone Avenue, Indianapolis, IN 46218**	317-612-6800, ext.21	317-612-6811
Libertad Counseling **2840 North High School Road, Indianapolis, IN 46224**	317-240-2801	317-240-2807
Bethlehem House **130 East 30th Street, Indianapolis, IN 46205**	317-920-1519	317-920-1515

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)*