



**CLIENT CHOICE - INDIANA ACCESS TO RECOVERY (ATR) –
VIGO COUNTY**
State Form 54822 (R2 / 5-13)



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
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Friends of Families 103 South Fruitridge Avenue, Terre Haute, IN 47803	812-234-4701	812-242-1741
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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
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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
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Cellular or Mobile telephone number
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Work telephone number
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Signature of client

Date (month, day, year)