Reset Form

REFERRAL

State Form 55940 (R8 / 8-19)
FAMILY AND SOCIAL SERVICES ADMINISTRATION
DIVISION OF MENTAL HEALTH AND ADDICTION

Recovery Works
INDIANA'S FORENSIC TREATMENT PROGRAM

Please verify the following eligibility requirements. Check all boxes that apply. If the participant does not meet all four (4) requirements he/she is NOT eligible for Recovery Works. All Recovery Works referrals are valid for one (1) calendar year.

ELIGIBILITY REQUIREMENTS
☐ Is the participant a resident of Indiana?
☐ Is the participant at least eighteen (18) years old?
☐ Taxable income of the participant does not exceed 200% of the federal income poverty level. *(Taxable income includes participant, spouse, and dependents.)* (i.e. How much would the participant claim on taxes?) 2019 FPL = 1: $24,980; 2: $33,820; 3: $42,660; 4: $51,500; 5: $60,340; 6: $69,180; 7: $78,020; 8: $86,860
☐ Has the participant entered the criminal justice system with a felony charge or with a prior felony conviction?

I affirm that I have verified the above eligibility requirements to the best of my knowledge, information and belief.	
Referring Criminal Justice Provider Signature	Date *(month, day, year)*
Referring Criminal Justice Provider Name *(Printed)*	

I _____, understand I am being referred to Recovery Works. I will inform my
(Enter Name of Participant.)
Criminal Justice Provider (CJP) if I have been involved with Recovery Works previously in order to help plan my referral appropriately. I understand there are a number of providers qualified to provide the many services I may require during my participation in Recovery Works. I also understand I may interact with multiple providers throughout my participation in Recovery Works. I understand the agency below will help me get started.

Name of Recovery Works Agency *(Agencies can be found at www.RecoveryWorks.fssa.IN.gov.)*	
Telephone Number ( )	Information Sent to Recovery Works Agency? ☐ Yes ☐ No

I understand if I find the above agency does not meet my needs, I will speak with my Criminal Justice Provider (CJP) and together we will find a new agency and/or provider that does meet my needs. I also understand the above agency may not be willing or have the ability to provide services to me at this time, in which case my CJP and I will need to select a different provider. If a participant is not engaged with a treatment provider for more than thirty (30) days, a new referral is required by the CJP. All Recovery Works referrals are valid for one (1) year provided there are no gaps in treatment.

<table>
<tr><td colspan="4">I authorize the referral agency (CJP) to release my information to help the Recovery Works agency contact and serve me:</td></tr>
<tr><td colspan="2">Name of referring CJP agency</td><td colspan="2">Referring Agent E-mail</td></tr>
<tr><td colspan="3">Name of referral agent</td><td>Telephone Number
( )</td></tr>
<tr><td colspan="4">I understand that the Recovery Works Agency/Provider will need to contact me. I authorize them to contact me by contacting me at the following:</td></tr>
<tr><td colspan="4">Address (number and street, city, state, and ZIP code)</td></tr>
<tr><td>Date of birth (month, day, year)</td><td>Home telephone number
( )</td><td>Cell telephone number
( )</td><td>Work telephone number
( )</td></tr>
<tr><td colspan="2">Signature of Client</td><td>Date (month, day, year)</td><td>DOC identification number (optional)</td></tr>
<tr><td colspan="4">If client is currently incarcerated, please share the date of release if accessing services within thirty (30) to ninety (90) days pre-release (month, day, year). Services can be provided at ninety (90) days pre-release in our pilot counties <u>only</u>. (Leave blank if not applicable.)</td></tr>
<tr><td colspan="4">Comments:</td></tr>
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