THE SAFE HOUSE, LLC.
A DIVISION OF MEEHAN & DAUGHTERS REAL ESTATE

Meehan & Daughters Real Estate
Phone: 860-456-7610
Fax: 860-423-5113

824 Main Street Willimantic, CT 06226
Go to our website: www.meehanrealty.com
Email Us: meehanh@hotmail.com

Date: _____ Intended Occupancy Date: _____ Sobriety Date: _____

Name: First _____ Middle _____ Last _____

Current Address: _____

Home Phone: _____ Work Phone: _____ Email: _____

SS #: _____ Date of Birth : _____ Lic State & Driver License # _____

Car Make and Model: _____ Plate State and # _____

Are You A Member Of The Military ____Yes ____ No Military Status: _____

Length of Years: _____ Months _____ at current Address

Landlord/ Manager Name: _____ Phone #: _____

Reason For Leaving: _____

Previous Address: _____

Length of Years: _____ Months _____ at current Address

Landlord/ Manager Name: _____ Phone #: _____

Reason For Leaving: _____

Income Information: All Applicants Must Include Proof of Income

Present Employer Name & Address: _____

Phone # of Employer: _____ Position Held: _____

Supervisor Name: _____ Supervisor Phone #: _____

Employed From Year: _____ Month: _____ Current Monthly Income: _____

If not employed Source of Income: _____

Monthly Income: _____ Contact Person: _____ Phone #: _____

Are you eligible for ATR? _____

Have you ever been evicted? _____

Have you ever been arrested? _____ **If yes, please explain:** _____

Explain any history of drug or alcohol abuse? _____

Name Of Bank: _____ Town: _____ St.: _____

Personal References:

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____
3. Name: _____ Phone: _____

Credit Check Release:

I am applying for an apartment through your agency. I hereby authorize and request all credit reporting agencies, employers, credit and personal references release all pertinent information about myself. A photocopy/fax copy of this shall be as valid as the original.

Signed: _____ Date: _____

Please Read and Sign:

I agree that the landlord may terminate any agreement entered in reliance on any misstatement made in this application.

I vow that all information entered on this application is true.

Security Deposits are not refundable until the **lease** has been fully executed.

Security Deposits that are put down to hold an apartment are not refundable unless the applicant is rejected.

Signed: _____ Date: _____

STATE OF CONNECTICUT
Department of Mental Health and Addiction Services
SUPPORTED RECOVERY HOUSING SERVICES

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

I, _____, DOB: _____,
(Name of Participant) (Date of Birth)

EMS#: _____, SS#: _____ as a
(EMS Number) (Social Security Number)
Husky D #1
participant in the DMHAS Behavioral Health Recovery Program (BHRP) or the Access To Recovery (ATR) III Program, 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 and ATR III requests:

1. The DMHAS Administrative Service Organization; and
2. The Safe House, LLC
3. _____

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 or ATR III 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 or ATR III 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:

6 months from date signed

[Specific date, event or condition upon which this consent expires, only if different from above]

Date: _____ _____
(Signature of Participant)

dmhas

STATE OF CONNECTICUT
Department of Mental Health and Addiction Services
SUPPORTED RECOVERY HOUSING SERVICES

ABH
Creating Solutions Together®

Behavioral Health Recovery Program (BHRP)
Administrative Services Organization:
Advanced Behavioral Health, Inc.
P.O. Box 735, Middletown, CT 06457

PHONE: 1-800-658-4472 FAX: 1-866-249-8766

TREATMENT VERIFICATION FORM

DATE:

RE: Request for BHRP - Basic

Applicant's Name: _____

Treatment Provider: _____

Provider Address: _____

Level of care / Type of treatment: _____

Treatment Start Date: _____ Expected Discharge Date: _____

Participation in behavioral health treatment is a requirement for individuals to access services through the DMHAS Behavioral Health Recovery Program (BHRP) – Basic. I am attesting that the individual named above is participating in behavioral health treatment.

_____
Name of Clinician Clinician Phone #

_____ ____/____/____
Signature of Clinician Date

Please fax the form to **1-866-249-8766.**
If there are any questions contact BHRP – Basic staff at 1-800-658-4472.