# Safe House, L.L.C.

*A Division of Meehan & Daughters Real Estate and Development Co., L.L.C.*

Thank you for your interest our safe house program. Please fill out this form with your information. *** Please have your client complete the application package and **include a copy of their updated insurance card (front and back).** Once everything is completed, please return all documents to us. Fax: 860-423-5113 or E-mail: admin@meehanrealty.com ***

Name of Agency making referral: _____

Case Manager name: _____

Case Manager contact number: _____

Case Manager Email address: _____

Client's name: _____

Client's contact number: _____

What type of the insurance does client have: Medicaid insurance:

Husky A, B, C, D or Private? _____

Please provide copy of proof of insurance - Medicaid insurance ID#/ EMS#:

_____

Did your client use the basic needs programs in the last 12 months: _____

If yes, which date and year was basic needs used: _____

Does your client have a job or other income? _____

Client's current living address: _____

Does your client receive Food Stamps: _____

Has your client ever been accused/convicted of Arson or a Sex Offense?

_____

Is your client from or has he ever lived/worked in the Willimantic area before?

_____

Is your client currently on parole/probation, court case pending, or any?

_____

How can we reach your client after this application for setting up phone intake?

(Counselor, number……etc)

_____

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: _____

# BEHAVIORAL HEALTH RECOVERY PROGRAM
# RECOVERY SUPPORT SERVICES

Consent to Disclosure and Re-disclosure of Confidential Information and Records

I, _____ (Name of Participant), DOB: _____ (Date of Birth), EMS# _____ (EMS Number);

SS# _____ (Social Security Number) **as a participant in the DMHAS Behavioral Health Recovery Program,**

**understand my treatment and 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 Behavioral Health Recovery Program Recovery Support Services program requests:**

1. **The DMHAS Administrative Service Organization; and**
2. _____
   ***[Referring Treatment Provider/Program]***
3. _____
   ***[Requested Service Vendor(s)]***

**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, Behavioral Health Recovery Program 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 Behavioral Health Recovery Program Recovery Support Services.

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 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:

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

Date: _____ _____
*[Signature of Participant]*

_____
*[Signature of parent, guardian or authorized representative where required]*

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

# Behavioral Health Recovery Program (BHRP)
# Recovery Support Services

## JOB READINESS INFORMATION

APPLICANT'S NAME: _____

APPLICANT'S SIGNATURE: _____

Please include information explaining your job readiness efforts. This may include job applications, vocational training, posting resumes online, employment-related employment groups, online education, etc.
***If applicant is employed, please submit legible copies of 2 most recent pay stubs instead of this form.***

_____

_____

_____

_____

**List all job search contacts:**

| | Date | Company & Position | Contact Person & Phone # | Type of Contact *i.e.: Applied or interviewed* |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |

**List all vocational training contacts:**

| | Dates of Training | Name of Training | Agency | Contact Person & Phone # |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |

# Behavioral Health Recovery Program (BHRP)
# Recovery Support Services
# TREATMENT VERIFICATION FORM

Participation in behavioral health treatment is a requirement for individuals to access services through the DMHAS Behavioral Health Recovery Program (BHRP) – Recovery Support Services. This form must be completed by the attesting clinician (or administrative staff with the consent of the attesting clinician) at the provider agency for individuals attending the behavioral health services identified below.

## A. APPLICANT INFORMATION

Applicant's Name: _____

Applicant's Medicaid ID: _____

Applicant's Date of Birth: _____

Applicant's Phone Number: _____

Applicant's Address: _____

## B. BEHAVIORAL HEALTH PROVIDER INFORMATION

Treatment Provider: _____

Provider Address: _____

Level of Care (check one):

Level I: ☐ Outpatient Services ☐ Medication-Assisted Therapies

Level II: ☐ Intensive Outpatient/Partial Hospitalization

Level III: ☐ Residential/Inpatient Services

Treatment Start Date: _____ Expected Discharge Date: _____

## C. PROVIDER ATTESTATION

I attest that the applicant is currently participating in behavioral health treatment/services through the provider agency identified on this form.

_____

Name Agency Contact Number

_____ ____/____/____

Signature Date

**Please fax the completed form to ABH at 1-866-249-8766**

If there are any questions contact BHRP – RSS staff at 1-800-658-4472.

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