

STATE OF MARYLAND Department of Health and Mental Hygiene
Alcohol and Drug Abuse Administration
Maryland RecoveryNet : Access to Recovery

Service Assessment/Needs Matching

Region: _____

Service Need	Assessment Information	Provider Name and Contact	Date/Time Appointment
Care Coordination	N/A (Required Service)	1.	
Recovery Housing Assistance	<input type="radio"/> Bio-Pysch -Soc. <input type="radio"/> Client Interview <input type="radio"/> Explanation:	1. 2.	
Halfway House	<input type="radio"/> Bio-Pysch -Soc. <input type="radio"/> Client Interview <input type="radio"/> Explanation:	1. 2.	
Family /Marital Counseling	<input type="radio"/> Bio-Pysch -Soc. <input type="radio"/> Client Interview <input type="radio"/> Explanation:	1. 2.	
Job Readiness Counseling	<input type="radio"/> Bio-Pysch -Soc. <input type="radio"/> Client Interview <input type="radio"/> Explanation:	1. 2.	
Pastoral Counseling	<input type="radio"/> Bio-Pysch -Soc. <input type="radio"/> Client Interview <input type="radio"/> Explanation:	1. 2.	
Childcare	<input type="radio"/> Bio-Pysch -Soc. <input type="radio"/> Client Interview <input type="radio"/> Explanation:	1. 2.	
Transportation	<input type="radio"/> Bio-Pysch -Soc. <input type="radio"/> Client Interview <input type="radio"/> Explanation:	1. 2.	

Referral Choice Verification:

_____ I have been shown a listing of ATR service providers and I enrolled with a provider of my choice.

_____ The ATR service voucher creation and redemption process has been explained to me, and I understand the time-related limitations associated with redemption of the ATR vouchers that have been created for me.

_____ I understand that if I still have questions about my choice of service providers I may contact my Care Coordinator : _____ Phone _____

Participant (Signature) (Date)

Enroller (Signature) (Date)