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| **BSAS AUTHORIZATION FORM - ATR Providers** |

**This is to notify Advocates for Human Potential (AHP) that DPH/BSAS has authorized the following provider. *Please send to: skratz@ahpnet.com***

Full Legal Name of Provider:

Address of Provider:

City/Town: State: Zip Code:

Type of Service Approved

Purchasing/Basic Needs (Take individuals shopping. Write checks)

Health and Wellness - Describe:

Recovery Coaching

Transportation (Bus passes. T passes. Charlie Cards)

Groups – Describe:

Faith Based Services – Describe:

Housing Search

Job training (either job readiness or occupational training)

Signature of DPH/BSAS Representative:

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contract Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_