Referral Form to ATR

This form is to be completed by the referral agency; not the interested participants themselves.

- *Treatment providers:* please fax a recent bio-psych-social assessment along with this form
- *Non-treatment providers*: please answer the questions on page 2 and fax along with this form

Name of Individual _____ Date of Birth _____

Social Security Number _____ Phone Number _____

Individuals must meet all of the following criteria to be eligible for ATR:

Demographics and Priority Population Eligibility:

❑ **The State policy is that people cannot re-enroll in ATR within the same grant cycle. The individual you are referring has not been enrolled in ATR during the CURRENT grant cycle (we are currently in the SOR grant cycle, which runs from January 1, 2019 through September 29, 2020).**

❑ **18 years old or older**

❑ **Resides in Boston, Hampden County, New Bedford or Worcester, and plans to stay there for the next 6 months** (please list which city the individual resides in: _____)

❑ **Identifies with at least one of the following priority populations:**

- ❑ **Recently released from incarceration**
- ❑ **Currently a participant in a MA drug court**
- ❑ **Served in the US Military**
- ❑ **Pregnant, post-partum or parenting woman with child/children under 18 years old living in the home**
- ❑ **Part of a substance use treatment program (e.g. long-term residential treatment, medication assisted treatment program)**

Substance Use History and Recovery-based Eligibility:

❑ **Has an opioid use disorder/substance use disorder or a history of opioid overdose**

❑ **In the early stages of their recovery (2 years or less) and motivated to work on their recovery**

❑ **Connected with a case manager (or some other staff person) in the recovery community**

Preference is given to authorized referral portals

Please list the contact information below of the staff person this individual is working with:

Case Manager/Staff Name:	From what organization?
Phone:	Email:

Name of person making referral: _____ **Date** _____

Phone and email _____

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These questions should be completed by referring providers who do not have a bio-psych-social assessment to send with the referral. The purpose is to provide some additional background information on the individual that is being referred to the ATR program.

Participant's name, date of birth, social security number, and phone number:

How long has this person been in recovery from drugs or alcohol?

What is their substance use disorder/substances used?

List community supports this person is using (please include agency name, contact person and phone number):

How is this person doing in their recovery? What is their level of motivation to maintain recovery?

What does the person hope to accomplish from ATR? What ATR services would benefit this individual?