State of Connecticut
Department of Mental Health and Addiction Services
Behavioral Health Recovery Program (BHRP) - Basic

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. By signing below, I am attesting that this individual is participating in behavioral health treatment.

____
Name Agency Contact Number

____ ______/_____/____
Signature Date

This form can be completed by Recovery Support Services staff for individuals who have an intake scheduled, ONLY for the first month. Once individuals have begun attending treatment, this form should be completed by a clinician at the Treatment Provider.

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