Chemical Dependency Treatment Verification

Pioneer Transition House

Client name: ________________________________________

Chemical Dependency Eligibility Screening

☐ Currently Accessing Chemical Dependency Services

Chemical Dependency Provider: ________________________ Phone #: __________________

Release of Information (ROI) YES ☐ NO ☐

☐ Client identifies as having Chemical Dependency issues and will need assistance to access services. (You must include a brief description of client behaviors or symptoms below)

☐ Referral due to Chemical Dependency concerns. Resulting behaviors are creating a barrier to stable housing. (You must include a brief description of client behaviors or symptoms below)

BRIEF DESCRIPTION OF BEHAVIORS:

Housing Status

Describe current housing situation (where client is staying, how long they can be there, any information regarding why it is an unstable living situation):

Staff name and title: ________________________________________________________________

Organization: ______________________________________________________________

Staff signature: ___________________________ Date: ___________________