BPA Recovery Support Service Form

State of Idaho Substance Use Disorder Treatment System

SECTION A: CLIENT INFORMATION:

1. Client Name: _____
2. Client Date of Birth: _____
3. Client Social Security Number: _____
4. BPA Client ID: _____

SECTION B: RECOVERY SUPPORT SERVICES:

Recovery Support Service Type:	***Provider Name:***	***Justification for Service:***
1. Case Management: **Initial:* ☐ **Additional:* ☐		
2. Adult Safe and Sober Housing: **Initial :* ☐ **Additional:* ☐		
3. Alchohol/Drug Testing: **Initial :* ☐ **Additional:* ☐		
4. Life Skills: **Initial :* ☐ **Additional:* ☐		*Hours Requested each week:*
5. Transportation: **Initial :* ☐ **Additional:* ☐		*Miles Requested each Week:*
6. Child Care: **Initial :* ☐ **Additional:* ☐		*Hours Requested each week:*
7. Medical Needs: *(only available for PWWC and Child Protection Drug Court):* **Initial :* ☐ **Additional:* ☐		*Hours Requested each week:*

SECTION C: PROVIDER INFORMATION:

1. Provider Name: _____
2. Staff Name: _____
3. Staff Signiture: _____ Date: _____