



**Tennessee Association  
of Recovery Residences**

***Application Packet  
pre-screening application***

Name of Individual or Agency: \_\_\_\_\_  
Contact Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
E-Mail: \_\_\_\_\_ Web Address: \_\_\_\_\_

**What type of Service(s) do you or your organization provide: (circle all that apply)**

<b>Modality/Specialty</b>	<b>Substance Abuse</b>	<b>Counseling</b>	<b>DUI Services</b>
___ Medical	___ Detox	___ Individual	___ Licensed
Evaluation			
___ Mental Health	___ Inpatient	___ Group	___ Licensed
___ 12-Step	___ Outpatient	___ Couples/Marital	___ Driving
School			
___ Christian	___ Residential	___ Family	other:
_____			
___ Other Religion	___ Individual	___ Pastoral	
___ Disciplinary	___ Group(s)	other: _____	

Are you licensed? : \_\_\_\_\_  
Other Approvals/Associations: \_\_\_\_\_

**Financial**  
Fees Charged: \$ \_\_\_\_\_      \_\_\_ Rehabilitation

**Populations Served**

\_\_\_ H.I.V Positive  
Services  
\_\_\_ Pregnant Women      \_\_\_ Nominal/Sliding Scale/Negotiable      \_\_\_ County Mental  
Health  
\_\_\_ Women with Children      \_\_\_ Free      \_\_\_ Medicaid  
\_\_\_ Senior Citizens      \_\_\_ Scholarships Available      \_\_\_ Medicare  
\_\_\_ Adolescents      \_\_\_ Insurance Accepted      \_\_\_ SSI Accepted  
\_\_\_ Handicapped      \_\_\_ Veterans Administration      Other: \_\_\_\_\_  
\_\_\_ Dual Diagnosis  
Other: \_\_\_\_\_      Number of Beds Available: \_\_\_\_\_  
Male: \_\_\_\_\_ Female: \_\_\_\_\_

Please give a brief description of the program:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any special services (included or at additional costs):  
\_\_\_\_\_  
\_\_\_\_\_

Additional Information about the program:  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature and Title of Applicant

\_\_\_\_\_  
Date