

State of Tennessee
Department of Mental Health and Developmental Disabilities
Division of Alcohol and Drug Abuse Services

Tennessee Access to Recovery II Consumer Profile

Last Name: _____ First Name: _____ M.I. _____ Suffix: _____
Address: _____
City: _____ State: TN Zip: |__|__|__|__|__|__| - |__|__|__|__|__|
County: _____ Phone: |__|__|__|__| - |__|__|__|__| - |__|__|__|__|__|
SSN: |__|__|__| - |__|__| - |__|__|__|__|__| Date of Birth: |__|__| / |__|__| / |__|__|__|__|__|
Gender: M F Email: _____

1. What is your annual family income? _____
1a How many family members are supported by the income in #1 above? ____
2. Do you have private health insurance coverage that will pay for your alcohol & drug treatment and / or recovery services? Yes No

2a. If yes, would your private insurance pay for these services? Yes No

Consumer Signature

Date

To be completed by the screener

Screener Name

Screening Location

Date

Type of I.D. Checked: Tennessee Drivers License Other Photo I.D. _____

Meets ATR II basic eligibility criteria Yes No