



Addiction Treatment Program

www.SASC-dbq.org

Gambling Treatment Program

www.TreatmentFirst.org

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Gambling Recovery Support Services - Assessment Form

Date of Session: _____ Client Name: _____

Client DOB: _____ Client ID: _____

Client Address: _____

Client Phones: _____

Care Coordination Provider: Substance Abuse Services Center

Section I - The client is eligible for Recovery Support Services if questions 1 through 5 are answered Yes and the agency has obtained the required documentation that the individual meets the federal poverty guidelines.

Recovery Support Services Eligibility

1. The client is a resident of the state of Iowa YES NO
2. The client has been admitted to treatment less then 30 days and is eligible for gas and bus only. YES NO
3. The client has been admitted to treatment and has actively participated in treatment for a minimum of 30 days and is eligible for all services. YES NO
4. The client has provided SASC with proof of income. YES NO
5. One of the following applies:
 - a. Client is at or below 200% of Federal Poverty level. YES NO
 - b. Burden of gambling related debt drives the client income at or below 200% of the Federal Poverty Level. YES NO
 - c. Client is without other financial resources to pay for the service(s). YES NO
6. The client does not have any other funding sources for the service. YES NO

**Section II - Document client needs and requests for specific ATR covered services.
Document lack of insurance or other financial resources for requested ATR covered services**

Document need, request, and lack of other payment for the following covered services that the client will be utilizing:

Recovery Support Services—Treatment Addendum

- Life Skills Coaching: _____
- Housing Assistance: _____
- Recovery Peer Coaching: _____
- Electronic Recovery Support Messaging: _____
- Supplemental Needs – Clothing/Hygiene: _____
- Supplemental Needs – Education: _____
- Supplemental Needs – Gas Cards: _____
- Supplemental Needs – Housing Rental Assistance: _____
- Supplemental Needs – Utility Assistance: _____
- Supplemental Needs – Wellness: _____
- Supplemental Needs—Bus/Cab: _____

Client Signature: _____

Date: _____

Parent / Guardian Signature: _____
(if applicable)

Date: _____

Provider / Witness Signature: _____

Date: _____

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