Georgia Association of Recovery Residences
Membership Application/Database Information Form

Name of Individual or Agency: _____

Contact Name (if different from above): _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (___) _____ Fax: (___) _____

E-Mail: _____ Web Address: www. _____

What type of service(s) do you or your organization provide: (Circle all that apply)

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

Ethnic: _____ Office of Regulatory Services Approved? YES NO ORS License # : _____

Education: _____ Other Approvals/Associations: _____

Populations Served	**Financial**	
H.I.V. Positive	Fee's Charged $ _____	Rehabilitation Services
Pregnant Women	Nominal/Sliding Scale/Negotiable	County Mental Health
Women with Children	Free	Medicaid
Senior Citizens	Scholarship Available	Medicare
Adolescents	Insurance Accepted	
Handicapped	SSI Accepted	**# of Beds Available**
Dual Diagnosis	Veterans Administration	Male _____ Female _____
Other: _____		

Please give a brief description of the program: _____

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

Additional Information about your program: _____

_____ _____

Signature and Title of Applicant Date