ASCEND
MENTAL WELLNESS

Dual Recovery Application

REFERRAL SOURCE

Date	Referring Person, Name, Title, Department
Phone	Email

CLIENT INFORMATION

Name	Date of Birth	Phone Number
Address		
City	State	Zip

FOR THE CLIENT TO COMPLETE

I want to join Dual Recovery because:

----------Office Use Only----------

Contact Date: _____ **Peer Support:** Y/N

Staff Name: _____ **First 1:1 Appt:** _____

JOT: Y/N **Assign Peer:** _____

Send Form To:
Ginger Miller, CRPA, PS
Dual Recovery Coordinator
230 Maple Street
Glens Falls, NY 12801
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(518) 401-5991
Fax: (518) 793-5858