# Recovery Works: Jail-Based Services

Please complete below information regarding Recovery Works Certified providers who provide services in your county's jail.

| | |
|---|---|
| **Jail Name (County):** _____ | |
| **Address:** _____ | |
| **Main Jail Contact:** _____ | **Phone:** _____ |
| **Jail Medical Vendor:** _____ | |

| Recovery Works Provider | Services (select all that apply) | Contact Name/# | MOU/BAA? |
|---|---|---|---|
| | ☐ Mental Health ☐ Individual Treatment<br>☐ Addiction ☐ Group Treatment | | ☐ Yes<br>☐ No |
| | ☐ Mental Health ☐ Individual Treatment<br>☐ Addiction ☐ Group Treatment | | ☐ Yes<br>☐ No |
| | ☐ Mental Health ☐ Individual Treatment<br>☐ Addiction ☐ Group Treatment | | ☐ Yes<br>☐ No |
| | ☐ Mental Health ☐ Individual Treatment<br>☐ Addiction ☐ Group Treatment | | ☐ Yes<br>☐ No |

| **Form Completed By:** | |
|---|---|
| Name: _____ | Title: _____ |
| Signature: _____ | Date: _____ |

**Please submit this form via email to Recovery Works at recovery.works@fssa.in.gov.**

**THANK YOU!**