Carol Jones Recovery Center

A Division of A.O., Inc.

# MAT Approval Form

Date: ____/____/____

Client Name: _____

Last 4 digits of SSN: _____ Date of Birth: ____/____/___

The CJRC team has reviewed the treatment progress of the individual named above. It is determined that the client remains engaged in treatment while actively pursuing goals identified within his/her plan. He/she remains eligible to receive Medication Assisted Treatment (MAT) via CJRC/AO Treatment services.

Counselor initials: _____ CSW initials: _____

The above client is approved to receive Medication Assisted Treatment Services in collaboration with Dr. Thompson. This authorization shall expire on the following date: (not to exceed 30 days from the date of approval): ____/____/____.

Signature: _____

Registered Nurse

Carol Jones Recovery Services

Phone: [417] 862-3455

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