Peer Assistance Services

# Meeting Verification Form

*Client Name:*_____ *Month Submitted for:*_____

*Monthly Requirement____ per* _____

**Please use a separate sheet for each meeting type. Check One:**

☐ **Sponsor** ☐ **Therapist** ☐ **Pain Management Provider** ☐ **Psychiatrist** ☐ **Psychologist** ☐ **Addictionologist**

**Treatment Provider** ***(Check one)*****:** ☐ **IOP/Partial Hospitalizaion** ☐ **Continuing Care** ☐ **Relapse Prevention**

**Week 1(Sunday – Saturday)**

| Date | Location - City/State | Verification Signature | Printed Name |
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**Week 2 (Sunday – Saturday_**

| Date | Location - City/State | Verification Signature | Printed Name |
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**Week 3 (Sunday – Saturday)**

| Date | Location - City/State | Verification Signature | Printed Name |
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**Week 4 (Sunday – Saturday)**

| Date | Location - City/State | Verification Signature | Printed Name |
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**Week 5 (Sunday – Saturday)**

| Date | Location - City/State | Verification Signature | Printed Name |
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**Reports may be submitted via:**

**Email:** reports@peerassist.org

**Fax:** Last name A-L 720.213.1007
Last Name M-Z 720.213.0002

**Mail:** Peer Assistance Services
2170 S. Parker Road, Suite 229
Denver, CO 80231

**In Person:** Peer Assistance Services, Inc.
2170 S. Parker Road, Suite 229
Denver, CO 80231

or

Peer Assistance Services, Inc.
200 Grand Avenue, Suite 270
Grand Junction, CO 81501