ENDEAVORS

GATEWAY RECOVERY MICRO COMMUNITY

Safe Housing. Strong Support. A New Start.

If you're struggling with opioid use and don't have a safe place to stay, Endeavors may be able to help. We support adults in early recovery—especially those with no housing after treatment, incarceration, or care—who are ready to stay sober and work on recovery.

Who This Program Is For

You may be able to join our program if:

- You are 18 years or older
- You don't have stable housing
- You have a diagnosed opioid or substance use problem, with or without a mental health condition
- You are in early recovery
- You were recently discharged from a treatment center, hospital, or detention center

Scan here

for additional information on the program, or to complete the intake form.

How We Can Help

Our program is designed to support your recovery journey through:

- Safe, sober housing in a supportive environment
- Guidance in setting and achieving your recovery goals
- Encouragement and accountability from staff and peers
- Access to counseling, life skills training, and recovery groups
- A small, structured community dedicated to healing

Contact us: gatewayrecoverycenter@endeavors.org 505-445-0150

Endeavors-Gateway to Recovery Community (GRC)

Referral Information Packet for Providers

Welcome

We appreciate your collaboration in referring and supporting individuals in early recovery facing housing insecurity, as we work together to promote recovery and housing stability. This packet outlines the steps and documentation needed to refer a client to the Gateway to Recovery Community (GRC). GRC provides recovery-focused housing and wraparound services for single adults in early recovery.

Eligibility Criteria

Clients must meet the following minimum criteria for referral:

- 18 years of age or older
- In early recovery from opioid use disorder (OUD) and/or other co-occurring substance use disorders (SUDs).
- Currently unhoused or exiting a temporary setting (e.g., detox, jail, hospital, shelter).
- Willing to participate in recovery-focused programming.
- Medically and psychiatrically stable enough for a shared living environment.
- Must not pose an active safety risk to self or others.

Referral Process Overview

Step	Action	Responsible Party
1	Complete Referral Packet	Referring Program
2	Submit Fully Completed Packet	Referring Program
3	Initial Review (within 24–48 hours)	GRC Intake Team
4	Eligibility Verification including interview with client and documentation request	GRC Staff
5	Admission Scheduled	GRC
6	Warm Handoff Scheduled	GRC + Referring Program

Required Documentation Checklist

The following must be submitted for all referrals:

Completed GRC Referral Form
Client Identification (ID, if available)
Signed ROI (Release of Information) – for GRC to speak with referring program
Medical and Behavioral Health Summary (last 30 days, if available)
Discharge Summary (if coming from jail, detox, hospital, shelter)
Current Medication List
Service/Treatment Plan (if applicable)
Risk/Safety Assessment (if behavioral health concern present)

Note: Missing documents may delay acceptance. Please communicate if certain items are pending but expected. Please provide contact information for an addition contact within your team in case the referring party is unavailable.

Warm Handoff Meeting

A joint case conference is strongly encouraged before or upon admission.
Participants: Referring Provider/Case Manager, GRC Intake, Clinical Coordinator (if needed), and Client.
Purpose: Ensure continuity of care, address risks, and align recovery goals.

Admission Hours and Transport

- **Admission Hours:** Monday–Friday, 9:00 AM to 4:30 PM
- **Transportation:** Transportation is available as needed.

Contact for Referrals and Questions

Phone: 505-445-0150
Email: GatewayRecoveryCenter@endeavors.org
Website: https://endeavors.org/gateway-recovery-micro-community

Additional Notes

- GRC is a harm-reduction, trauma-informed environment.
- GRC does not accept walk-ins. Referrals must be approved in advance.
- Expedited placements may be considered in coordination with referring party.

GATEWAY RECOVERY MICRO COMMUNITY

Referral Form

All information is confidential and used for intake eligibility purposes only.

Referring Party Information:

Referring Agency/Facility: _____

Referring Staff Name & Title: _____

Phone Number: _____

Email Address: _____

Date of Referral: _____

Secondary Staff Contact _____

Client Information:

Full Name: _____

Date of Birth: _____

Gender Identity: _____

Contact Phone (if available): _____

Email Address (if available): _____

Emergency Contact (optional): _____

Medicaid/Insurance #: _____

Social Security #(optional): _____

Referral Criteria Confirmation

Please confirm the following intake eligibility criteria for ASAM Level 3.1:

Criteria	Yes	No
Single adult (18+)	☐	☐
Currently unhoused or housing unstable	☐	☐
Diagnosed or suspected OUD	☐	☐
Diagnosed or suspected Co-occurring SUD	☐	☐
Mental Health conditions	☐	☐
In early recovery or recently relapsed	☐	☐
Recently discharged from treatment or detention	☐	☐
Stable enough for low-intensity residential care	☐	☐
Does not require 24/7 medical or psychiatric care	☐	☐

If any "No" answers are selected, please explain:

_____

_____

_____

Clinical & Supportive Information

Question	Response
Current Diagnoses:	
Prescribed MAT? (e.g., Suboxone, Methadone, Vivitrol):	☐ Yes ☐ No
If yes, MAT provider & contact info:	
Co-occurring Mental Health Diagnosis?	☐ Yes ☐ No
History of violence or risk behaviors? *Note: Any history of violence or assault will be reviewed on a case-by-case basis to determine eligibility for the program.*	☐ Yes ☐ No

Question	Response
Current medications (list or attach):	

Recovery Needs and History

Primary Substance(s) Used: _____

Other Substance Used If Known: _____

Date of Last Use: _____

Previous Treatment History: ☐ Yes ☐ No If yes, please list program(s) and dates:

_____

_____

_____

_____

Supporting Documents (Check if attached)

- ☐ Discharge Summary
- ☐ Recent Behavioral Health or SUD Assessments/screenings
- ☐ Medication List
- ☐ ID/Insurance Copy (if available)
- ☐ Other: _____

Referring Staff Signature:
I confirm that this individual appears to meet intake criteria for ASAM Level 3.1 residential services and is appropriate for referral to the GATEWAY RECOVERY MICRO COMMUNITY.

Signature: _____ **Date:** _____

Submission of this referral form does not guarantee acceptance into the Gateway Recovery Micro Community Program. All referrals are subject to review by program staff. Eligibility will be determined based on receiving fully completed referral form and supporting documentation, available capacity, program eligibility, and a formal intake assessment. Cases involving recent violent charges or a history of assault—especially toward healthcare workers or service providers—will be reviewed individually to assess program appropriateness and community safety. The referring party and client will be notified of the decision following the review process.

Initial _____

Release of Information (ROI)

I, _____, Date of Birth _____,

authorize Family Endeavors, Inc. to disclose to and/or obtain from:

Person/Organization: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: _____ Fax: _____

the following information: (Initial each item to be disclosed)

_____ Assessment

_____ Diagnosis

_____ Psychosocial Evaluation

_____ SUD Treatment Information

_____ Psychiatric Evaluation

_____ Treatment Plan or Summary

_____ Medication Management Information

_____ Current Treatment Update

_____ Educational Information

_____ Discharge/Transfer Summary

_____ Continuing Care Plan

_____ Progress in Treatment

_____ Demographic Information

_____ Wellness Program Participation

_____ Psychotherapy Notes *

_____ Other

May be withheld by the therapist in certain circumstances and cannot be combined with any other disclosure

Purpose

This information may be used or disclosed in connection with mental health treatment, wellness treatment, and/or insurance payment.

If the purpose is other than as specified above, please specify:

_____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Endeavors Privacy Department at privacy@endeavors.org or by fax to 726-233-2604.

Expiration

Unless sooner revoked, this authorization expires one year from the date of signature: _____,

or as otherwise indicated: _____

Initial _____

Conditions

I further understand that Endeavors will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA Privacy and/or 42 CFR Part 2 regulations, unless a state law applies that is stricter than HIPAA and provides additional privacy protections.

Revocation of this authorization will not affect prior disclosures made acting in reliance on the authorization.

I will be given a copy of this authorization for my records.

_____ _____

Signature of Patient/Client Date

_____ _____

Signature of Parent, Guardian, or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.) and provide the appropriate documentation.