REGION II HUMAN SERVICES

ADULT SUPPORT SERVICES REFERRAL

Check only one:

☐ **Emergency Community Support** OR ☐ **Community Support:** (circle one) Mental Health or Substance Use

And/or, referral to: ☐ **Day Support Program**

REFERRAL SOURCE INFORMATION:

Date: ______________________Referral Source Name: ____

City: ____________________________ Phone: ____________________ FAX: ____________________________

CLIENT INFORMATION:

Name: ____ Age: _______ Date of Birth: _________________

Address: __________________________ City: _________________ Zip: ___________ County: __________

Phone: _____________________________________ Social Security #: _________________________________

Guardian Name & Phone Number *(if applicable)*: ____

Payee Name & Phone Number *(if applicable)*: ____

Income Source & Amount: ________________________ Medicaid #*(if applicable)*: __________________________

IMMEDIATE NEED:

STATEMENT OF PROBLEM AS IT RELATES TO SERVICES REQUESTED:

Check all functional deficits that apply:

☐ Substance Abuse ☐ Family ☐ Relationships ☐ Social Skills ☐ Legal ☐ Daily living ☐ Community Living Skills

☐ Vocational ☐ Financial ☐ Medical ☐ Disabilities ☐ Educational ☐ Transportation ☐ Recreation ☐ Self-Advocacy

PAST PSYCHIATRIC HOSPITALIZATIONS:

Current Psychiatrist/Physician:

Current Diagnosis:

Other Service Providers:

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All completed referral forms, collateral information, ROI's, IDI's, etc. to be faxed to:

ATTENTION: REFERRALS **FAX #: 308-532-4737**