CaringWorks
HOUSING • HELP • HOPE

Agency/Program Referral Form

Date of Referral:	

Please email this referral to:	
☐ Outpatient Behavioral Health: bhreferrals@caringworksinc.org	☐ Residential Treatment: hhtreatment@caringworksinc.org

Referral Source:			
Agency:			
Staff's Name and Title:			
Contact #:		**Email:**	

Client Information:			
Client Name:			
DOB:		**Social Security #:**	
Address:			
Phone:			
City, State, and Zip:			
Gender:			
Hearing Status:	☐ Deaf ☐ Hearing ☐ Hard of Hearing ☐ Deaf/blind		
Vision Status:	☐ Low Vision ☐ Total Blindness ☐ Legally Blind		
Preferred Method of Communication:	☐ Visual ☐ Verbal ☐ Non-Verbal ☐ Written ☐ Tactile System ☐ Other:		
Primary Language:	☐ American Sign Language ☐ English ☐ Spanish ☐ Other:		
Technologies for Communication:	☐ Screen Braille Communicator ☐ Hearing Aid ☐ Cochlear Implant ☐ Closed Captioning ☐ Assistive Listening Devices ☐ CART/ Live Captioning ☐ Captioned Phone ☐ Sign Language Interpreter ☐ Videophone or Video relay Service ☐ Other:		
Housing Status:	☐ Outside/Street ☐ Family/Friends ☐ Transitional ☐ Jail/Prison ☐ Hospital ☐ Private/Independent ☐ Shelter/Assessment Center ☐ Supportive Housing ☐ Other:		
Type of Insurance:	☐ Medicaid ☐ Medicare ☐ PeachState ☐ CareSource ☐ VA ☐ Uninsured ☐ Other:		
Insurance Number:	☐ Not Applicable		
HMIS # (*If applicable*):			

Guardian/ Emergency Contact Information:					
Name:					
Relationship to client:		**Phone:**			
Address:					
City:		**State:**		**Zip Code:**	

Please check all that apply:
☐ Individual has discharged from psychiatric facility/crisis stabilization unit within last 72 hours.
☐ Individual has successfully completed residential treatment in the last 90 days.
☐ Individual has completed a psychiatric evaluation within the past 12 months.
☐ Individual has been identified as having a mental health diagnosis.
Reason for Referral:
Services Requested: ☐ Therapy ☐ Peer Support ☐ Groups ☐ Substance Abuse ☐ Psychiatric Evaluation ☐ Psychological Evaluation ☐ Nursing ☐ Family Services ☐ Psychosocial Rehabilitation (PSR) ☐ Case Management

Disposition (for CaringWorks use only)	
Screening Decision:	☐ Accepted ☐ Rejected ☐ Pending ☐ Referred to another program: _____
Reason for Above Action:	
Comments: *(Optional)*	
Staff Signature:	
Date:	