



Behavioral Health Division

Referral Form

NOTE: Individual being referred **MUST** be informed of referral prior to submitting.

Today's Date:		Referral Source: Agency Self	
		Individual is aware they are being referred:	
Referral Source Information (only required if another agency is referring):			
Agency or Individual's Name:		Telephone Number:	Email:
Client Demographics:			
Last Name:		First Name:	M.I. Gender DOB:
Address: Street City Zip		Telephone Number:	Alternate Telephone Number:
County of Residence:		Best time to reach client:	
Legal Status:		Responsible for Self Legal Guardian Activated POA-HC Minor	
Guardian/POA/Parent Name (if applicable):		Guardian/POA/Parent Telephone Number:	
Reason for Referral:			
<p>I would like to refer for the following services/programs:</p> <p style="padding-left: 20px;"> <input type="checkbox"/> Outpatient Behavioral Health Clinic <input type="checkbox"/> Substance Use Counseling <input type="checkbox"/> Mental Health Counseling <input type="checkbox"/> Substance Use & MH Counseling <input type="checkbox"/> Comprehensive Community Services (CCS) <input type="checkbox"/> Community Support Program (CSP) <input type="checkbox"/> Children's Long-Term Support (CLTS) <input type="checkbox"/> Coordinated Services Team (CST) <input type="checkbox"/> Certified Crisis Program <input type="checkbox"/> Residential AODA Treatment <input type="checkbox"/> I am unsure what services/programs are appropriate </p> <p>Please specify: <input type="checkbox"/> I am interested in a referral to additional programs if eligible </p>			
Expected outcome of services:			
Insurance Information:			
No insurance		Medicaid	Private Insurance Medicare
Name of Insurance Company or HMO (if applicable):			
Crisis Information:			
If you or the individual you are referring is experiencing a mental health or substance use crisis and needs immediate assistance, you may call the following crisis line telephone number: (888)552-6642			
Additional Information:			
A staff member from the Behavioral Health Division of Jackson County Department of Health & Human Services will contact the referred individual (or parent/guardian) within 3-5 business days to collect further information. Your referral information will be reviewed by our team of professionals and appropriate follow-up will be completed.			