REFERRAL FOR SERVICES

Referral Source

Date of Referral: _____

Name & Title: _____ Agency: _____

Contact Number: (_____)_____-_____ Email: _____

Client Information

Name: _____ Pronouns:_____Date of Birth: _____

Contact Number: (_____)_____-_____ Email: _____

Preferred Language: _____

Are any accommodations needed (translator, assistive technology, etc)

_____

Does the individual have Medicaid coverage? ☐ Yes ☐No

Note: At this time, we are only able to accept clients with Medicaid coverage. Talk to Envision Staff about referrals if needed.

Why is the client being referred for services: _____

What services is the client interested in?

- ☐ Individual Counseling
- ☐ Group Counseling
- ☐ Peer Support Services
- ☐ Psychiatry
- ☐ Case Management
- ☐ Life Skills Coaching

Please email completed form to cmhc-info@envisionunlimited.org