

**MH/SA Targeted Case Management
Referral to Integrated Family Services, PLLC**

Referral Date: _____ Name of Referral Source/Contact Information: _____

First: _____ Middle: _____ Last: _____

Sex (circle) M F Date of Birth: _____ SS#: _____

Street Address: _____ Town/City: _____ Zip: _____

Mailing Address (if different): _____ Town/City: _____ Zip: _____

Home Phone: _____ Cell: _____ Work #: _____ Email: _____

Race (please circle) Black White American Indian Alaskan Native Asian/Pacific Islander Biracial
Ethnicity (please circle) Not Hispanic Origin Hispanic, Mexican American Hispanic, Cuban
Hispanic, Puerto Rican Hispanic, Other

Do You Speak English? Y N Do You Understand English? Y N

Current Medications Prescribed: _____

Mother's Name: _____ Father's Name: _____

Guardian if Not Parent: _____ (relationship) _____

Does Guardian have legal custody? Y N

Emergency Contact: _____

EDUCATION

School Attending: _____ Grade: _____

If not enrolled in school, what is the highest grade completed? _____

INSURANCE (TCM can only be provided to Medicaid Recipients and those with no insurance)

Type of Insurance: Medicaid Y N Co-Pay: _____ Copy of Card Attached: Y N

Private Y N Co-Pay: _____ Copy of Card Attached: Y N

Name of Insurance Provider: _____

No Insurance: Y N

REASON FOR REFERRAL Use space on back for additional information

Referring behaviors that make client at risk of being placed out of the home:

Legal Involvement:

Current Living Situation: (Home, Group Home, Therapeutic Foster Care, etc)
