Referral Form

Options Counseling (OC)
Case Management (CM)

Referral Source Information
Minimum required fields indicated by (*)

* Referral Date: _____

* Is the client aware of the referral and provided a program description? Yes☐ No☐

* Referred by/relationship to the client: ☐ self ☐ caregiver ☐ family ☐ professional

*Name: _____ *Agency/organization _____

*Phone number: _____ Email: _____

Client Information

*Client name: _____ *Date of birth (DOB): _____

*Street address: _____

*City and ZIP code: _____ *County: _____

*Phone number: _____ *Preferred language: _____

*Refugee/asylee status: yes☐ no☐ *If yes, date of arrival or date of status: _____

Additional Contact Information (Family/Friends/Power of Attorney/Caregiver[s])

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Insurance Information

Medicare number: _____ Part B/D or Advantage Plan number: _____

Social Security number: _____ Is a veteran? yes☐ no☐

Medicaid number: _____ 1B case number: _____

Other insurance/discounts: _____

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Safety Concerns (check all that apply) *Must be completed before home visit will be considered.*

❒ domestic violence ❒ hoarding ❒ infestations ❒ animals in home ❒ weapons in home

❒ substance abuse/use ❒ mental health concerns ❒ cognitive impairments ❒ other concerns

Please elaborate: _____

Reason for referral for services (services needed)

Current living situation ❒ alone ❒ with others

(please elaborate)

What current services and benefits are established?

Is there a support system in place?

Monthly income (please include source)?

*What needs are the priority?

*Why does the client need services?

Submit completed referral form via one of these options:
- fax to **303-480-6827**
- encrypted email to **ADRCreferrals@drcog.org**

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