A close up of a logo

Description automatically generated

**RESIDENTIAL PROGRAM REFERRAL**

***PLEASE PRINT***

|  |  |  |
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| **CLIENT INFORMATION:** | | |
| Client Name: | | |
| Race: | Age: | Gender Preference: |
| Address: | | Phone Number: |
| County of Residence: | Date of Birth: | Last 4 Digits of SS#: XXX-XX-\_\_\_\_\_\_\_\_ |
| Emergency Contact: | Contact Number: | Alternative Number: |
| Referring Agency: | Contact Person: | Agency Phone: |
| Is the client currently experiencing withdrawal?  Yes  No | | |
| Does the client require accommodations?  Yes  No If yes please specify: TTY  Interpreter  Sign language  Ambulatory limitations  Other | | |
| **SUBSTANCE ABUSE HISTORY**  **WHICH OF THE FOLLOWING HAVE THE INDIVIDUAL USED IN THE LAST 30 DAYS?** | | |
| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | **Substance** | **Amount**  **Per Day** | **How long has client been using** | **Date of Last Use** | **Substance** | **Amount**  **Per Day** | **How long has client been using** | **Date of Last Use** | | Alcohol |  |  |  | Heroin |  |  |  | | Barbiturates |  |  |  | Other Opiates |  |  |  | | Marijuana/Weed |  |  |  | Benzodiazepines |  |  |  | | Cocaine (Crack |  |  |  | Fentanyl |  |  |  | | Hallucinogens |  |  |  | Buprenorphine |  |  |  | | Methamphetamines |  |  |  | Other |  |  |  | | | |

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| **INSURANCE: PLEASE SUBMIT A COPY OF THE INSURANCE CARD WITH THE REFERRAL** |
| Does the client currently have insurance? Yes  No |
| If yes, please list the company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| MA #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **UNINSURED APPLICANTS:**  *PROOF OF INCOME IS REQUIRED FOR:*   * All uninsured individuals and Medicare recipients who do not also have Medicaid * Determination of eligibility for a reduction in payment for services rendered utilizing the state of Maryland or Federal sliding fee scale and other state funding sources   If proof of income is not provided at the time of admission, clients will be charged 100% per day |

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| **LEGAL STATUS** | |
| Are you currently on parole or probation? Yes  No | Is there a current warrant? Yes  No |
| Name of Probation or Parole Officer: | Phone Number: |
| Court Date Pending? Yes  No | Court Date: |
| Charges: | |

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| **MEDICAL STATUS** | | | | | |
| Is the client medically stable?  Yes  No | | | | | |
| Current Medications | Dose/Frequency | How long on Meds? | Current Medications | Dose/Frequency | How long on Meds? |
|  |  |  | 5. |  |  |
|  |  |  | 6. |  |  |
|  |  |  | 7. |  |  |
|  |  |  | 8. |  |  |
| **MEDICAL PROBLEMS, RECENT ILLNESS OR INJURIES** | | | | | |
|  | | |  | | |
|  | | |  | | |
| **ALLERGIES** | | | | | |
| **PLEASE LIST ALL ALLERGIES** | | | | | |
| **PPD SCREENING** | | | | | |
| History of +PPD  Yes  No If yes, client must has a x-ray prior to admission. | | | | | |

**FAILURE TO COMPLETE THE REQUESTED REFERRAL INFORMATION COULD RESULT IN A DELAY OR DENIAL OF ADMISSION TO THE PROGRAM**

**I agree that the above information is accurate and complete. Misrepresentation of the information provided on this form may result in the denial of admission.**

**Service Recipient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **DISCLOSURE AUTHORIZATION FORM** |

I agree to this referral and authorization. In an event I cannot be reached or additional information is needed, I authorize other service providers or organizations listed on this referral be contacted on my behalf for the purpose of coordinating this referral.

|  |  |  |
| --- | --- | --- |
| Print Name  Service Participant Signature |  | Date \_\_\_\_\_ |
| Print Name  Guardian Signature |  | Date \_\_\_\_\_ |

Referral Source Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Source Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_