Integrated Community Alternatives Network

CORE Services Referral

Date of Referral: ____ / ____ / ____

Name: _____ DOB: ____ / ____ / ____ Phone #: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ County: _____

Social Security #: _____ - _____ - _____

Do you have Medicare?: ❍ Yes ❍ No

Sex assigned at birth: ❍ Male ❍ Female **Identified gender:** ❍ Male ❍ Female **Interpreter needed:** ❍ Yes ❍ No

Ethnicity: ❍ Latino/Hispanic ❍ Non-Latino/Non-Hispanic ❍ Declined to specify **Veteran Status:** ❍ Yes ❍ No

Race (select all that apply): ❍ American Indian or Alaskan Native ❍ Asian ❍ Middle Easter ❍ Black or African-American ❍ Multiracial ❍ Declined to specify ❍ White ❍ Native Hawaiian or Other Pacific Islander

MCO: _____ CIN #: _____

Referred by: _____ Credentials: _____

Contact information (phone/email): _____

Diagnosis: _____ ICD -10 Code: _____

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This is a goal oriented program, not to be used for personal care, home health, transportation services. We do not provide financial assistance.

PSR - I need help learning	*Peer - I want support with*
❍ **Life skills** (budgeting, cleaning, hygiene, paying bills, understanding paperwork)	❍ **Substance Abuse** (going to meetings, maintaining recovery)
❍ **Coping skills**	❍ **Mental Health** (coping skills, social anxiety, advocacy support, social support)
❍ **Skills for finding/keeping a job** (interview skills, resume writing, assistance with applications, internet job searches)	❍ **Community involvement** (social programs, volunteer support)
❍ **Skills to go back to school** (financial aid paperwork, researching programs & schools)	
❍ **Finding a new hobby or creative outlet**	
❍ **How to access community resources**	
❍ **Improving physical health** (healthy eating, cooking, exercise)	

❍ **I need in-home therapy to address my mental health needs and I am not engaged in a traditional clinic setting.**

Additional information: