



## Connections Program Referral

*Community Health Workers are your connection to essential services*

### Referring Partner Information:

Referral Organization: \_\_\_\_\_

Name of person placing referral: \_\_\_\_\_

Phone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

Signature of Referring healthcare provider: \_\_\_\_\_

### Client Information:

First and Last Name \_\_\_\_\_

Date of Birth (MM/DD/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip code \_\_\_\_\_

Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Race:**

American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or other Pacific Islander

White / Caucasian

Unknown

**Ethnicity:**

Hispanic / Latino

Not Hispanic / Latino

**Insurance Information:**

Name of Policy Holder \_\_\_\_\_

Policy Holder Date of Birth (MM/DD/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_

Group Number \_\_\_\_\_

**Select all reasons for referral:**

Food Assistance

Housing/Utilities Assistance

Healthcare Coverage Assistance

Substance Use/Harm Reduction Services

Medical Care / Mental Health Services

Social Services Assistance

Transportation Assistance

Employment Assistance

Other

If selected other please define: \_\_\_\_\_

Does the client require a translator or any additional accommodations? \_\_\_\_\_

Please include any additional information that will be helpful in preparation of assisting this client:

\_\_\_\_\_

Completed forms can be faxed to BEDHD at 517-543-0451