

**Community Agency Referral Form**

Date of Referral: \_\_\_\_\_  
Referred by (Name of Authorized Referrer): \_\_\_\_\_  
Referring Agency: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone:(\_\_\_\_) \_\_\_\_\_ Fax:(\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
Clients Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ Gender:  Female  Male  Transgender  
Parent's Name (if patient is a minor): \_\_\_\_\_  
Home:(\_\_\_\_) \_\_\_\_\_ Work:(\_\_\_\_) \_\_\_\_\_ Cell:(\_\_\_\_) \_\_\_\_\_  
Patient's Address: \_\_\_\_\_

**Referral Information:**

**Program Referral Type (check all that apply):**

- Outpatient Therapy
  - Behavior Health
  - Substance Use Disorder
  - Psychological Evaluations
- Case Management
  - HIV Case Management
  - Substance Use Disorder
- Vocational Rehabilitation Services
  - Psychological Services
  - Career Counseling
  - Ticket to Work
- Is client aware that he/she is being referred for Services with Alternative Living Solutions.  Yes  No

**Medications List (if known):**

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=====	=====	=====
=====	=====	=====

**History of Behaviors:**

- Violent  Abusive  Sexually Inappropriate  Other: \_\_\_\_\_

**Presenting Needs/ Reason for Referral:**

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature of Authorized Referrer**

\_\_\_\_\_  
**Date**

### Referral Checklist

To ensure accuracy and a complete referral, please verify that each listed item has been addressed prior to submission.

Completed referral form, each question has been addressed, with the appropriate answer or with an N/A.

#### For Outpatient Therapy

- Proof of Behavioral Health Disorder
- Proof of Substance Use Disorder

#### For Case Management

- Proof of HIV Positive Status
- Proof of Substance Use Disorder

#### For Vocational Rehabilitation Program

- Proof of verifiable Physical Disability
- Proof of Mental Health Disability

#### Funding Source

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> AETNA                                 | <input type="checkbox"/> Blue Cross Blue Shield of NC | <input type="checkbox"/> OPTUM         |
| <input type="checkbox"/> Magellan Behavioral Health            | <input type="checkbox"/> Medicaid                     | <input type="checkbox"/> Medicare      |
| <input type="checkbox"/> Tricare                               | <input type="checkbox"/> United Behavioral Health     | <input type="checkbox"/> Value Options |
| <input type="checkbox"/> Ticket to Work                        | <input type="checkbox"/> NC Vocational Rehabilitation | <input type="checkbox"/> Self-Pay      |
| <input type="checkbox"/> Employment Assistance Programs (EAP): |   |  |

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#### Service Location

- Alternative Living Solutions – Main
- Alternative Living Solutions – Alamance
- Alternative Living Solutions – Concord
- Alternative Living Solutions – Union

\*\*Check all that applies\*\*

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Signature of Referrer

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Date