Program Referral Form

To be completed and faxed to 563-888-8629.
For referral questions, please call 563-383-1900, option 4.

Today's Date:___________________________

Patient Information

Last Name:	First:	Middle:	❑ Mr. ❑ Mrs. ❑ Ms.
Birth date:	Social Security #:	Sex: ❑ F ❑ M	Phone #: Alternate Ph #:
Address:			
City:	State:	Zip Code:	

Insurance Information

Is this patient covered by insurance? ❑ Yes ❑ No	Primary Insurance:			
Subscriber's Name:	Subscriber's SS #:	Birth date:	Group #:	Policy #:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Patient Needs:

❑ Mental Health Services	❑ Substance Abuse Services	❑ Co-Occurring Services (Both Mental Health and Substance Abuse)

Select a Program:

❑ Assertive Community Treatment (ACT)	❑ Carol Center Clubhouse	❑ Community Based Peer Support	❑ Habilitation Homes
❑ Homeless Outreach	❑ Individual Counseling/Therapy	❑ Individual Placement & Support (IPS)	❑ Integrated Health Homes (IHH)
❑ Medication Management - Carol Center	❑ Multisystemic Therapy (MST)	❑ Prescriber Services	❑ Residential Care Facilities (RCF)
❑ Rick's Ray of Hope (RROH)	❑ School & Community-Based Services	❑ Supported Community Living (SCL)	❑ Other:

Referral Source (if applicable)

Name of facility:	Referred by:
Complete Address:	
Office Phone #:	Office Fax #:
Contact Person:	

Created: 11/2023 MH
Updated: 12/2023 MH