

## Services Referral Form

Referral Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Referring Individual / Agency \_\_\_\_\_

Phone \_\_\_\_\_

Address \_\_\_\_\_

### Potential Client Information

Referred Individual Name \_\_\_\_\_

Home Phone \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Medicaid Type: \_\_\_General \_\_\_UNICARE \_\_\_The Health Plan \_\_\_WV Family Plan \_\_\_AETNA

### Responsible Individual

Name \_\_\_\_\_

Phone \_\_\_\_\_

Address \_\_\_\_\_

Email \_\_\_\_\_

### Area of Service:

\_\_\_Northern Panhandle

### Potential Service(s):

\_\_\_Professional Individual Counseling

\_\_\_Supportive Individual Counseling

\_\_\_Substance Abuse Assessment

\_\_\_Mental Health Assessment

\_\_\_Therapeutic Behavioral Services

\_\_\_Psychiatric / Medication Services

\_\_\_Professional Group Counseling

\_\_\_Supportive Group Counseling

\_\_\_Psychological Testing & Interpretive Report

\_\_\_Skills Training + Development (Para-professional)

\_\_\_Skills Training + Development (Professional)

Is there any knowledge of previous behavioral health concerns or services? \_\_\_\_\_

## Submit a referral

Send referral forms to

[Referrals@homebaseinc.org](mailto:Referrals@homebaseinc.org)