Empowering Spaces, LLC

REFERRAL APPLICATION

Member's Name:	Medicaid # if Applicable:	LME Record # if Applicable:

Date of Referral: _____ **Medicaid County:** _____

Date of Birth: _____ **Social Security:** _____ **Sex:** ☐ Male ☐ Female

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Telephone: (Home) _____ **(Work)** _____ **(Cell)** _____

Referral Source: ☐ **Self/No Referral** ☐ **LME** ☐ **Hospital** ☐ **DSS** ☐ **Schools** ☐ **Doctor**

☐ **Family/Relative/Friend**
☐ **Other, list:** _____

Referral Source's Name: _____ **Phone #:** _____

Presenting Problems / Reason for Referral:

_____

_____

Check all applicable — Presenting Problems / Reason for Referral:
☐ **Housing/Residential** ☐ **Financial** ☐ **Legal** ☐ **Transportation** ☐ **Family Conflicts**

☐ **Emotional/Mental Health Tx** ☐ **Social** ☐ **Medical/Health Issues** ☐ **Safety Issues** ☐ **Day Program**

☐ **Other(s), list:** _____

DIAGNOSIS: Code, Description, and/or Clinical Impression
Primary: _____

Secondary: _____

LEGAL STATUS (check all that apply):
☐ **Competent** ☐ **Incompetent** ☐ **Minor** ☐ **Denies legal history** ☐ **On Probation/Parole**

☐ **Juvenile Court** ☐ **In Jail** ☐ **Legal history / prior charges, list:** _____

GUARDIANSHIP / LEGALLY RESPONSIBLE PERSON / EMERGENCY INFORMATION
Who is the Legally Responsible Party? ☐ **Self** ☐ **Guardian** ☐ **Parent** ☐ **LRP**

☐ **Other, specify:** _____

Name of Guardian / LRP / Emergency Contact: _____

Address of Guardian / LRP / Emergency Contact: _____

Home #: _____ **(Work)** _____ **(Cell)** _____

What services does the person currently have, if any? _____

_____

What services are you requesting? _____

_____