

## Adult Assessment Referral

REFERRING CSO
DATE

Section A. Identifying Information			
1. CLIENT LAST NAME	FIRST NAME	MIDDLE NAME	2. DATE OF BIRTH
3. EJAS ID NUMBER	4. GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	5. SOCIAL SECURITY NUMBER	6. CLIENT TELEPHONE
7. MESSAGE NUMBER	8. LIMITED ENGLISH PROFICIENCY? <input type="checkbox"/> No <input type="checkbox"/> Yes; Primary language:		
8. STREET ADDRESS		CITY	STATE ZIP CODE

Section B. Assessment Appointment Information			
1. NAME OF ASSESSMENT CENTER/ENTITY			2. TELEPHONE NUMBER
3. STREET ADDRESS		CITY	STATE ZIP CODE
4. APPOINTMENT DATE		5. APPOINTMENT TIME	

**Please Note:** Take this form (and any attachments) with you to your appointment. Failure to keep this appointment may result in denial, delay, termination or sanction of your benefits. Failure to accept a program of treatment as prescribed by the assessment center means you refuse treatment, which may result in denial, termination, or sanction. If you have questions about treatment requirements, please ask your CSO worker.

Section C. To Assessment Center		
1. DATE OF APPLICATION	2. NAME OF REFERRING AGENCY, OTHER THAN CSO (I.E., HOSPITAL, JAIL, DETOX, ETC., IF APPLICABLE)	3. AGENCY TELEPHONE NUMBER
4. CLIENT TYPE (CHECK ALL THAT APPLY) <input type="checkbox"/> TANF <input type="checkbox"/> Other:		
5. PRIORITY GROUP: <input type="checkbox"/> Pregnant <input type="checkbox"/> CPS Referral <input type="checkbox"/> I.V. Drug <input type="checkbox"/> HH/Children		
<b>6. The above named client is</b> (Check appropriate box): <input type="checkbox"/> Applicant <input type="checkbox"/> Current Recipient <input type="checkbox"/> Transfer from another program <input type="checkbox"/> A. Title XIX Medicaid eligible. <b>Provider One Number:</b> _____ <input type="checkbox"/> TANF <input type="checkbox"/> Other: _____ OR <input type="checkbox"/> Attach printout of medical coverage.		
7. <input type="checkbox"/> Other incapacity/health problems: _____ <input type="checkbox"/> A. Other evaluation pending (indicate type and date scheduled): _____ <input type="checkbox"/> B. Medical/psychological information attached. <input type="checkbox"/> Screening information attached. <input type="checkbox"/> C. Special needs for this client. Describe: _____		
8. Comments / Other:		
9. WFPS / WFSSS	TELEPHONE NUMBER	10. CASE WORKER
		TELEPHONE NUMBER

**COPIES TO:** Client File; Client; Assessment Center

## INSTRUCTIONS

The initiating worker:

1. Enters the referring community Services Office (CSO) name and current date.
  2. Completes Section A, including the client's full name. The full middle name (not just initial) is requested.
  3. Completes Section B when the assessment appointment is established.
  4. Completes Section C:
    - A. Item 1 designates date the application was initiated.
    - B. Completes Items 2 and 3 by entering the name and telephone number of the agency or other entity that prompted the individual to seek chemical dependency services.
    - C. Item 4 designates client's program type(s).
    - D. Completes Item 5 designating the client's priority category by:
      - 1) Checking "Pregnant" for anyone currently pregnant or up to two months postpartum;
      - 2) Checking "CPS Referral" for anyone that is a direct referral for chemical dependency services from Children Protective Services;
      - 3) Checking "I.V. Drug" for anyone that is an intravenous drug user;
      - 4) Checking "HH/Children" for individuals with children in the home.
- NOTE: If the client is pregnant, contact the local assessment center immediately for an assessment, as these individuals are fast tracked through the assessment process.
- E. Completes Item 6, as appropriate. If Item A is checked, indicate Title XIX the Provider One number for medical coverage.
5. Completes Items 7 and 8 as needed. Checks Item 7C if the client has a special need.
6. Completes Items 9 and/or 10 with the names and telephone numbers of the referring WFPS / WFSSS.

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