State of Illinois
Department of Human Services

Referral Form

6A(1 Year)

Office Stamp/Address:

REFERRED TO:	DATE:
Agency:	Contact:
Address:	Phone:

Appointment Status: ☐ Walk-In ☐ Please initiate contact ☐ Scheduled for: Date: _____ Time: _____

SERVICE NEED/PROGRAM (check one) the shaded area requies completion of a consent to release information.

☐ Adoption	☐ Legal Services	☐ Basic Needs	☐ Education/Training
☐ Child Risk/Safety	☐ Mental Health	☐ Child Care	☐ Immigrant Services
☐ Disability Services	☐ Senior Services	☐ Child Support (only)	☐ Refugee Services
☐ Domestic Violence	☐ Substance Abuse	☐ Cash, SNAP, Medical	☐ Transportation
☐ Health	☐ Youth Services	☐ Employment	

Program(s) referring to (use the name(s) identified in the assessment):

CASE INFORMATION

Person Being Referred:	Date of Birth:	☐ M ☐ F
Address:	City:	Zip Code:
Home Phone:	Message Phone:	Number in Household:
Case Name:	Case Number:	
DHS Client? ☐ Yes ☐ No ☐ Pending	Social Security Number (last 4 digits only):	
	Relationship to Case Name:	
Referred person receives the following services:	TANF Months Used:	

☐ TANF	☐ TANF child only	☐ AABD	☐ GA-Chicago Only	☐ SNAP	☐ Medical	☐ Child Care	☐ Child Support

Special Needs:

Results from Basic Skills Testing: Reading _____ Math _____ Other _____ Date of Test::

DHS USE ONLY

DHS Employee Name:	Caseload Number/ORS District No:
Phone:	Fax:

Comments:

TO BE COMPLETED BY THE REFERRAL AGENCY Reply Needed	☐ Yes	☐ No	By Date:

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Please check as many boxes as appropriate
Agency Action:

☐ Client Assessment Completed Date: _____ Expected Service Date: _____

☐ Client Placed on Waiting List Date: _____ Expected Service Date: _____

☐ Client Service Initiated Date: _____

Specify Service _____

☐ No Contact from Client

☐ Referral Rejected Please Explain: ☐ Service not offered ☐ Service offered, but not available
☐ Client Ineligible ☐ Client refused services
☐ Other:

☐ Other Pending Action Please Explain: _____

Date Returned: _____ Returned By: _____

Distribution: Original & Copy 1 - Provider Agency: Copy 2 - Client, Copy 3 - File

Name of Client: _____

Printed Last First M

Date of Birth: _____ ☐ Female ☐ Male

(Month) (Day) (Year)

By signing below you agree that you have read and agree to the following. If you do not understand something or have questions, be sure to ask.

I hereby authorize the DEPARTMENT OF HUMAN SERVICES to disclose the following information about me for the purpose of providing me with service coordination.

Information to be disclosed (date, type of services including treatment recommendations, compliance status, schedule of activities, ability to engage in work activities, work schedule, supportive service needs, and justification):

☐ Mental health services I receive ☐ Substance abuse treatment services I receive

☐ Family Case Management Services I receive ☐ Developmental disability services I receive

☐ Department of Aging Services I receive ☐ D.C.F.S. services I receive ☐ My school records

☐ Rehabilitation services I receive ☐ Other: _____ ☐ W.I.C. services I receive

The above checked information is to be disclosed to, _____ , only as necessary in order to administer the service coordination or for audit and evaluation purposes.

I hereby authorize (Service Provider Organization Name) _____

to disclose the following information about me for the purpose of providing me with service coordination.

Information to be disclosed (date, type of services including treatment recommendations, compliance status, schedule of activities, ability to engage in work activities, work schedule, supportive services needs, and justification):

☐ Mental health services I receive ☐ Public Health Family Case Management Services

☐ Developmental disability services I receive ☐ My school records

☐ Substance abuse treatment services I receive ☐ Department of Aging Services I receive

☐ Rehabilitation services I receive ☐ D.C.F.S. services I receive

☐ W.I.C. services I receive ☐ Other

The above checked information is to be disclosed to the DEPARTMENT OF HUMAN SERVICES, only as necessary in order to administer the service coordination or for audit and evaluation purposes.

I understand that I may revoke this consent at any time in writing, but that revoking it will not cancel what was already done before I revoked it. I understand that I have the right to inspect and copy the information to be disclosed. If not previously revoked, this consent will terminate upon the completion of the service coordination, but in no event shall exceed one year from today.

It has been explained to me that if I refuse to consent to this disclosure or if I revoke my consent during the case coordination I may not receive case coordination services and my public assistance benefits may be affected. I understand that I may, however, receive mental health services and substance abuse treatment services, without agreeing to this consent.

☐ Check here if client refuses to sign the consent

Signature of Client: _____ Date: _____

Signature of Parent, Guardian, or Authorized Representative(if appropriate) _____ Date: _____

Signature of Witness: _____ Date: _____

NOTICE TO RECEIVING PERSON: The information released hereunder may not be re-disclosed except as set forth herein or as otherwise allowed by law. If the information pertains to substance abuse services, it has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as other wise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or persecute any alcohol or drug abuse patient. Violation of the federal rules is a criminal offense.