State of Illinois
Department of Human Services

Referral Form

6A (1 Year)

Date: _____

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Case Number: _____

Office Name: _____

Office Address: _____

_____

Phone: _____

TTY: _____

Fax: _____

NAME: _____
ADDRESS: _____
ADDRESS: _____
CITY, ST. ZIP _____

Tenemos este aviso en español. Para solicitar avisos en español, por Internet vaya al sitio ABE-MMC o llame al 1-800-843-6154 (TTY 1-866-324-5553 TTY/ Nextalk, 711 TTY Relay).

You can manage your account online at abe.illinois.gov

Agency:		Date:
Address:		Phone:
Contact:	Fax Number:	
Appointment Status: ☐ Walk-in ☐ Please initiate contact ☐ Scheduled for: Date:		Time:
Comments:		
SERVICE NEED/PROGRAM		

CASE INFORMATION

Person Being Referred:			Date of Birth:		☐ M ☐ F	
Address:		City:		Zip Code:		
Home Phone:	Work Phone:		Other Phone:			
Case Name:		Case Number:				
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	☐ SNAP	☐ Medical	☐ Child Care	☐ Child Support
Special Needs:						
Results from Basic Skills Testing:	Reading	Math	Other	Date of Test:		

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Please check as many boxes as appropriate
Agency Action:

- ☐ Client Assessment Completed ☐ Yes ☐ No Date: _____ Expected Service Date: _____
- ☐ Client Placed on Waiting List ☐ Yes ☐ No Date: _____ Expected Service Date: _____
- ☐ Client Service Initiated ☐ Yes ☐ No 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

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Referral Form

6A (1 Year)

Case Number: _____

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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):

☐ _____ Client Initial: _____
(Information to be Disclosed)

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):

☐ _____ Client Initial: _____
(Information to be Disclosed)

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 otherwise 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.