NEXUS COUNSELING CENTER

DOÑA ANA COUNTY REFERRAL FORM: **PAGE 1/2**

PLEASE FAX TO 575.267.6228

SERVICES REQUESTED

☐ Comprehensive Community Support Services (CCSS)

DATE _____

TIME _____

REFERRER _____

ORGANIZATION _____

PHONE _____

EMAIL _____

REASON FOR REFERRAL

☐ **Legal Involvement. Charged with:** _____

☐ **Problem Sexual Behavior. Describe:** _____

☐ **Physical Aggression** ☐ **Verbal Aggression** ☐ **Academic Issues** ☐ **Substance Use/Abuse**

☐ **Running Away** ☐ **Negative Family Conflict** ☐ **Negative Peer/Gang Involvement**

☐ **Other:** _____

CLIENT INFORMATION

NAME _____ **DOB** _____ **AGE** _____

SSN _____ **SPANISH-SPEAKING THERAPIST REQUIRED?** ☐ **YES** ☐ **NO**

LEGAL GUARDIAN _____

RELATION TO CLIENT _____ **PHONE** _____

IF LEGAL OR CYFD INVOLVEMENT, FACTS # _____

STATUS OF LIVING SITUATION AT TIME OF REFERRAL:

☐ **At Home with Caregiver** ☐ **Living With Other Family Members** ☐ **In Detention**

☐ **In Residential Treatment** ☐ **In TFC** ☐ **In Shelter**

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PAYMENT INFORMATION

Medicaid the only insurance accepted for CCSS Services.

CLIENT IS LEGAL U.S. RESIDENT? ☐**YES** ☐**NO**

CLIENT HAS MEDICAID: ☐**YES** ☐**NO**

IF YES: MEDICAID # _____

CENTENNIAL HEALTHCARE # _____

RECERTIFICATION DATE _____

ADDITIONAL FAMILY MEMBERS TO INCLUDE (IF ANY)

NAME_____**DOB**_____

NAME_____**DOB**_____

NAME_____**DOB**_____

NAME_____**DOB**_____

NAME_____**DOB** _____

ADDITIONAL NOTES (OPTIONAL):

NOTIFICATION:

DO WE NEED TO GET BACK WITH REFERRAL SOURCE FOR ANY REASON? ☐**YES** ☐**NO**

If yes, a signed authorization to release health information must be included.

INTERNAL USE ONLY

FORWARDED TO_____ **DATE** _____

BY _____