CHRISTIAN FAMILY SOLUTIONS
WISCONSIN LUTHERAN CHILD & FAMILY SERVICE, INC.

Referral to Christian Family Solutions Behavioral Health Home Services

Send by secure EMAIL TO: BHHintake@wlcfs.org

GENERAL INFORMATION

Participant's Name_____Date of Birth_____

Address_____

Phone #_____May we leave a message? ☐ Yes ☐No

Email:_____

Have you received any mental health services within the last 12 month? ☐Yes ☐ No ☐Unsure

If yes, By Who?_____ Where? _____

Active MN Medical Assistance or PMAP health insurance benefits? ☐ Yes ☐ No ☐Unsure
If yes: (please provide copy of insurance card)

Health Plan Name:_____Member ID: _____ Group #:_____

REFERRAL SOURCE INFORMATION
Please provide the following information:

Name of Person Making Referral:_____Organization:_____

Contact Phone:_____Email_____

Support Services Requested (check as many as needed):

☐ Medical Care Coordination and Case Management

☐ Mental Health Care Coordination and Case Management

☐ Medication Management

☐ Economic and Financial Information and Assistance

☐ Family Peer Support

☐Housing Assistance Coordination

☐Transportation Assistance Coordination

☐Legal Assistance Coordination

☐Employment Assistance Coordination

☐Social Groups or Faith Based Services Coordination

☐Other _____

Authorization to obtain Protected Health Information (PHI):

Health Care Facility / Provider to whom you are giving permission to Christian Family Solutions to receive a copy of my Mental Health Diagnostic Assessment for the purpose of enrollment in Behavioral Health Home services

Name:_____Location:_____

Address:_____City:_____State:_____Zip:_____

Phone #_____Fax #: _____

I understand that by signing this form, I am requesting that the health information specified above will be released to and used by Christian Family Solutions and its staff to talk to a person or provider named above about your health information. This authorization will expire one year from the date listed below.

_____ _____
Participant or Authorized Representative Date