



HEALTHY EDUCATED EMPLOYED

Counseling Referral Form

Date: _____

Client Name: _____

Referring Provider & Staff Name: _____

Client Date of Birth: _____

Clients' Language: _____ Insurance: Medicaid (RIN) _____

****Please provide a copy of the most recent Medicaid card****

Social Security Number: _____

F-Code & Diagnosis: _____

Reason for Referral (*brief description of behavioral, social or emotional problems*):

Please use additional pages for description if needed

Is there interest in supported employment services? Yes No

Details: _____

(By Signing below, I am attesting that this form has been reviewed and I am in agreement with corresponding document as I give my consent for Asian Human Services to verify my medical coverage, review the information on this referral form and to contact me regarding behavioral health services)

Print Name _____ Client Phone # _____

Client Email: _____

Signature of Client _____ Date of Signature _____

Please send this referral form to:

CC: Ha Tran – Program Manager htran@ahschicago.org

CC: Cathryn Savino – Clinical Manager csavino@ahschicago.org

CC: Zahidul Haque – AHS Uptown Intake Coordinator zhaque@ahschicago.org