

WVFSRS ENROLLMENT REFERRAL FORM

CLIENT DEMOGRAPHICS		
CLIENT NAME:		
DOB:	SS#/Gov. ID#:	Med ID#:
Address:		
County of Residence:	Address Type: <input type="checkbox"/> BILLING <input type="checkbox"/> HOME <input type="checkbox"/> HOMELESS <input type="checkbox"/> MAILING <input type="checkbox"/> LAST PREVIOUSLY KNOWN <input type="checkbox"/> WORK <input type="checkbox"/> UNKNOWN	Type of Residence: <input type="checkbox"/> PRIVATE <input type="checkbox"/> RESIDENCE <input type="checkbox"/> HOMELESS <input type="checkbox"/> INSTITUTION (<i>i.e., hospital, jail</i>) <input type="checkbox"/> OTHER (<i>specify</i>): <hr style="border: 1px solid black;"/> <hr style="border: 1px solid black;"/> <hr style="border: 1px solid black;"/>
Home Phone #:	Alternate #:	<i>Does the client provide permission to leave a voicemail on identified #?</i> <input type="checkbox"/> YES <input type="checkbox"/> NO
Marital Status: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> LIVING TOGETHER	# Of Minor Children: # Of other dependents:	Religious Preference: <input type="checkbox"/> PROTESTANT <input type="checkbox"/> CATHOLIC <input type="checkbox"/> JEWISH <input type="checkbox"/> ISLAMIC <input type="checkbox"/> OTHER <input type="checkbox"/> AGNOSTIC OR ATHEIST <input type="checkbox"/> PREFER NOT TO ANSWER
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> TRANSGENDER IDENTIFIES AS A MALE <input type="checkbox"/> TRANSGENDER IDENTIFIES AS A FEMALE <input type="checkbox"/> TRANSGENDER UNKNOWN <input type="checkbox"/> PREFER NOT TO ANSWER	ETHNICITY: <input type="checkbox"/> PUERTO RICAN <input type="checkbox"/> MEXICAN <input type="checkbox"/> CUBAN <input type="checkbox"/> OTHER SPECIFIC HISPANIC <input type="checkbox"/> NOT OF HISPANIC ORIGIN <input type="checkbox"/> HISPANIC-SPECIFIC ORIGIN UNKNOWN <input type="checkbox"/> UNKNOWN	RACE: <input type="checkbox"/> ALASKA NATIVE <input type="checkbox"/> AMERICAN INDIAN <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> WHITE/CAUCASIAN <input type="checkbox"/> ASIAN <input type="checkbox"/> OTHER SINGLE RACE <input type="checkbox"/> TWO OR MORE RACES <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER <input type="checkbox"/> HISPANIC/LATINO <input type="checkbox"/> OTHER

PRIORITY POPULATION INFORMATION		
<input type="checkbox"/> Pregnant woman who injects drugs	<input type="checkbox"/> Pregnant woman who uses substances	<input type="checkbox"/> Person who injects drugs
<input type="checkbox"/> Overdose Survivor	<input type="checkbox"/> Veteran	

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INSURANCE INFORMATION	
MEMBER NAME <i>(As it appears on card):</i>	MEMBER ID #:
INSURANCE COMPANY (Name):	Customer Service # <i>(located on back of card):</i>

REFERRAL INFORMATION	
REFERRAL REASON <i>(i.e. MH, SUD, Co-Occurring issues, requesting PRSS services, requesting counseling):</i>	
REFERRAL SOURCE: <input type="checkbox"/> SELF <input type="checkbox"/> COUNTY-MH/ID PROGRAM <input type="checkbox"/> COUNTY DRUG/ALCOHOL COURT <input type="checkbox"/> CRIMINAL JUSTICE SYSTEM <i>(Probation/Parole)</i> <input type="checkbox"/> COMMUNITY PROVIDER <input type="checkbox"/> DRUG/ALCOHOL PROVIDER <input type="checkbox"/> EMPLOYER <input type="checkbox"/> FAMILY/FRIENDS/PARAMOUR <input type="checkbox"/> HEALTHCARE PROVIDER <input type="checkbox"/> HOSPITAL <input type="checkbox"/> OTHER: _____	
REFERRING AGENCY <i>(Name/Address):</i>	
REFERRED BY <i>(Name):</i>	TITLE:
PHONE #:	EXT.:

Client Signature <i>(If applicable):</i>	Date:
Person Completing Form Signature/Credentials:	Date:

**By signing this document, you confirm that all information is correct to the best of your knowledge. By signing this document, you confirm that client has been notified that their information was provided for the purpose to enroll into a Licensed Behavioral Health Center (LBHC), WV Family Support & Rehabilitation Services (WVFSRS).*