**IHH Referral Form**

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| Referral Source/Info: | Date of Referral: |
| Name: | Date of Birth: |
| Gender: | Phone #: |
| Address: | |
| County of Residency: | Social Security #: |
| Medicaid Status: :  Active :  Inactive/None | Applied for Medicaid:  No  Yes  N/A |
| Medicaid #: | MCO: |
| Other Insurance: | MCO #: |
| Legal Status:  Guardian  Payee  Court Committal  Details: | |
| Current needs, why is the person being referred to IHH services? | |
| Source of Income:  SSI/SSDI – Amount:        Employed – Details:        None | |
| History of Psychiatric Hospitalization:  None  History  Within the past year  Currently | |
| Psychiatric Provider & Agency: | |
| Psychiatric Diagnosis (ICD Codes): | |
| Therapist: | |
| Pharmacy: | |
| Family/Primary Doctor: | |
| Emergency Contact: | |
| Other Providers: | |

**Send referrals to:**

**Email:** [**ihh@firstresources.org**](mailto:ihh@firstresources.org)

**Fax:** 641-201-4342

**Address:** 204 S Jefferson Suite 103, Mt. Pleasant, IA 52641

**Phone:** 641-954-7244