**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**

**Fax:** 641-201-4342

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

**Phone:** 641-954-7244