BRANCHES
COMMUNITY SUPPORT SERVICES
Independent Living

REFERRAL FORM

Referral Date: _____ Referring Agency / Hospital:_____

Referring Contact Name & Title: _____

Phone: _____ Email: _____

CLIENT INFORMATION

Client Name: _____

Date of Birth: _____ Gender: _____Last 4 of SSN _____

REASON FOR REFERRAL (Check all that apply)

☐ Hospital Discharge ☐ Housing Placement ☐ Re-entry Support ☐ Veteran Support (SSVF / VA) ☐ Other:

_____

Brief Summary of Needs:

_____

_____

_____

CURRENT SITUATION

Current Location (hospital/unit): _____

Expected Discharge Date: _____

Primary Diagnosis / Notes (non-clinical):

_____

_____

REQUESTED SERVICES (Check all that apply)

Supportive Housing ☐ Transportation Coordination ☐ Case Management Support ☐ Life Skills / Independent Living Support ☐ Re-entry Stabilization ☐ Monitoring / Accountability ☐ Other:

_____ ----------

DOCUMENTS ATTACHED (Check all that apply) ---------- ☐ Discharge Summary ☐ ID / Demographics ☐ Insurance Information ☐ Case Manager Notes ☐ Other:

_____

SUBMIT REFERRAL TO

Email: info@branchescss.org or s.johnson@branchescommunitysupportservice.com

Fax: 704-931-5297 Contact us at: Phone: 803-373-1916