HARPS Referral Form

Office 360.763.5828 Fax 360.489.1435

Name:	**Date:**	**SSN:**

Date of Birth:	**Phone Number (Yours, Caseworkers, or Family?):**
ICD10 (Diagnosis) Code:	**Provider 1#:**
Referral Agency:	**ROI** ☐ **Assessment** ☐ **Treatment plan** ☐
Sexual Orientation: ☐Heterosexual ☐Bisexual ☐Gay/Lesbian ☐Questioning ☐Undisclosed	**Gender:** ☐Male ☐Female ☐ Intersex ☐Undisclosed ☐Transgender ☐Trans-Identify Female ☐Trans-Identify Male

Race (check all that apply): ☐White ☐Black/African American ☐Korean ☐American Indian/Alaskan Native ☐Asian Indian ☐Native Hawaiian ☐Cambodian ☐Chinese ☐Filipino ☐Japanese ☐Laotian ☐Guamanian/Chamorro ☐Middle Eastern ☐Other Pacific Islander ☐Other Asian ☐Other Race ☐ Not Reported/Unknown

Hispanic Origin: ☐Puerto Rican ☐Cuban ☐Mexican ☐Hispanic – Specific Origin Unknown ☐Not Spanish/Hispanic ☐Other Specific Hispanic

Do you have any income? ☐ Yes ☐ No If yes, please indicate the amount $__________(monthly) **Have you been:** **Homeless for one year or longer (12 consecutive months)?** ☐Yes ☐No **Or Homeless more than 4 times in past 3 years?** ☐Yes ☐No	**Where are you currently residing/staying?** ☐ Emergency shelter (including hotel/motel paid for with voucher) ☐ Place not meant for human habitation (e.g., streets, car, abandoned building, anywhere outside) ☐ Other:____________________________________

Have you been discharged from a SUD or Inpatient care facility in the last 30 days? ☐ Yes ☐ No

If currently in a treatment facility, expected discharge date:

Have you left any of the following in the last 14 days prior to today with a stay of 90 days or less? ☐ None

☐County jail/workhouse ☐Drug/alcohol treatment ☐Mental health treatment

☐Combined MH/CD treatment ☐State/federal prison ☐Hospital

Do you feel you have a problem with drugs or alcohol? Why or why not?

Have you been treated for substance abuse (drug of alcohol) in the past year? ☐Yes ☐No

Do you feel like you would benefit from:

☐Vocational Support (Job related support) **and/or** ☐Substance use treatment

Are you currently receiving any of these services? Where?

☐Case Management ________________________ ☐Care Coordination ________________________

☐Clinical Supervision ________________________ ☐Behavioral Health Services ________________________

Screened by: Print name: Signature:	**Participant Signature:**

***Referral is unable to be processed if the following items are not submitted:**

1. Referral form fully filled out (signed by referring professional)

2. Intake/assessment including ICD 10 code (s)

3. Treatment/Service Plan regarding housing stability

4. ROI for coordination of care