Eaton Behavioral Health
1033 Health Care Dr.
Charlotte, MI 48813
Phone: 517-543-2580
Fax: 517-543-8191

EBH SERVICES REFERRAL FORM

Please fill out all information

PERSONAL INFORMATION

CLIENT TO CONTACT EBH BY: _______________TODAY'S DATE: ______________CLIENT DOB: _________________

CLIENT SS#: _____________________CLIENT NAME: __________________________________ PHONE: __________________

STREET, CITY, STATE, ZIP: ____

REFERRING AGENCY &/OR PERSON: ___________________________________ PHONE: _____________________________

STREET, CITY, STATE, ZIP: ____

INSURANCE INFORMATION

Client needs to present proof of income (if any) and actual card at first visit.

Medicaid or Healthy Michigan Plan ☐ **MIChild** ☐ **Medicare** ☐ **Private Insurance Health Plan** ☐

Client lives at the ECYF or is incarcerated (skip insurance section-does not apply) ☐ Client has no insurance* ☐

* If client has no insurance please assist the client in enrolling in a plan | Annual Household Income_______________________

Insurance Company Name_________________________________Subscriber Name______________________________________

Subscriber Relationship to Client___________________________Subscriber DOB______________________________________

Subscriber SS#____Enrollee ID____

Group Number_________________________Insurance Company Phone # (back of card)________________________________

RELEASE OF INFORMATION

I, ______________________________________, hereby authorize Eaton Behavioral Health, its director or designee, to release information to (person or referring agency) ______________________________ under the following conditions. The extent and nature of this information will concern my assessment findings, attendance and progress in the program, and when necessary will include information regarding recommendations for additional referral services. The purpose or need for such disclosure is to assist the referring agency in reaching a satisfactory disposition of my case. This authorization will remain in effect from the date signed below until the purpose for which it was given no longer exists, or unless revoked by me in writing. In the case of criminal justice referrals, the authorization will expire when the program receives official written notice of a change in my legal status or sixty days after authorization is given, whichever is later. Without my expressed revocation, this consent will expire on (date) ____________________________________; (event) ________________________________; (or condition) ______________________________________. If at the time this consent is given, I am under arrest, formally charged, brought to a trial that has commenced, or sentenced, my consent will expire when there is a substantial change in my legal status. In all other instances, this consent shall have a duration of no longer than that reasonably necessary to effectuate the purpose for which it is given. I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR, Part2, and Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45CFR Parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Client Signature: ____ Date: _________________________

Witness Signature: ____ Date: _________________________

Barry-Eaton District Health Department
Be Active • Be Safe • Be Healthy

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SERVICE DESCRIPTIONS

CHECK ALL PREFERENCES THAT APPLY

ADULT THERAPY SERVICES

☐ **Assessment/Evaluation**

☐ **Early Intervention Services**

☐ **Outpatient Services (1-8 hours per week):**
- ✓ **Individual & Family Therapy**
- ✓ **Insight Groups I & II**
- ✓ **Weekly Early Recovery Groups- Men's and Women's**
- ✓ **Weekly Cognitive Transitional Group**
- ✓ **Women's Trauma & Recovery Group**

☐ **Intensive Outpatient Services (9+ hours per week):**
- ✓ **Weekly Individual and Family Therapy**
- ✓ **8 hours of group therapy per week (Transition to outpatient level when appropriate)**

☐ **Eaton Co. Jail Services**
- ✓ **Individual Therapy**
- ✓ **Men's and Women's Jail Group**

☐ **Eaton Co. Jail Residential MAT Program**
- ✓ **Medication Assisted Treatment for Opioid or Alcohol Use Disorders**
- ✓ **Weekly Individual and Group Therapy**
- ✓ **Case Management & Ancillary Services**

OTHER SERVICES

☐ **State of Michigan Driver's License Evaluation and Urinalysis.**

ADOLESCENT THERAPY SERVICES

☐ **Assessment/Evaluation**

☐ **Early Intervention Services**

☐ **Outpatient Services (1-5 hours per week):**
- ✓ **Individual & Family Therapy**

☐ **Intensive Outpatient Services (6 + hours per week):**
- ✓ **<u>Ask if interested</u>- depends on therapist availability and minimum enrollment levels**
- ✓ **Individual and Family Therapy**
- ✓ **Group Therapy**

☐ **CHOICES –Early Intervention Program**

TREATMENT ENHANCEMENT SERVICES

☐ **Family and Individual Case Management**

☐ **Acupuncture Detoxification Services**

☐ **Outpatient MAT- Suboxone and Vivitrol Assisted Therapy**
- ✓ **Referral for Medication Assisted Treatment for Opioid or Alcohol Use Disorders**

COMMENTS____

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