



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:** _____

CHILD CARE FUND ELIGIBLE? (Eaton Ct. Adolescent Drug Court and/or Intensive Probation, ECFY program)

YES **NO**

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 ECFY 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:** _____



SERVICE DESCRIPTIONS

CHECK ALL PREFERENCES THAT APPLY

<p style="text-align: center;"><u>ADULT THERAPY SERVICES</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Assessment/Evaluation <input type="checkbox"/> Early Intervention Services <ul style="list-style-type: none"> ✓ Individual counseling sessions <input type="checkbox"/> Outpatient Services (1-8 hours per week): <ul style="list-style-type: none"> ✓ Individual and/or Family Therapy ✓ Insight Group ✓ Men’s and Women’s Early Recovery Groups ✓ Women’s Trauma & Recovery Group ✓ Men’s Fight, Flight or Freeze Group (Reactions to Trauma) ✓ Cognitive Transitional Group <input type="checkbox"/> Intensive Outpatient Services (9 hours per week): <ul style="list-style-type: none"> ✓ Individual and/or Family Therapy ✓ 8 hours of group therapy per week (Transition to outpatient level when appropriate) <input type="checkbox"/> Eaton Co. Jail Residential Substance Abuse Treatment Program (RSAT) <ul style="list-style-type: none"> ✓ Medication Assisted Treatment if appropriate ✓ Individual and Group Therapy ✓ Case Management & Ancillary Services <hr style="border-top: 1px dashed black;"/> <p style="text-align: center;"><u>OTHER SERVICES</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> State of Michigan Driver’s License Evaluation and Urinalysis 	<p style="text-align: center;"><u>ADOLESCENT THERAPY SERVICES</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Assessment/Evaluation <ul style="list-style-type: none"> ✓ Includes recommendation and referral to Eaton RESA’s CHOICES or Prime For Life program if appropriate <input type="checkbox"/> Early Intervention Services <ul style="list-style-type: none"> ✓ Individual counseling sessions <input type="checkbox"/> Outpatient Services (1-5 hours per week): <ul style="list-style-type: none"> ✓ Individual and/or Family Therapy ✓ Group Therapy <input type="checkbox"/> Intensive Outpatient Services (6 hours per week): <ul style="list-style-type: none"> ✓ Individual and Family Therapy ✓ 4 hours of group therapy per week (Transition to outpatient level when appropriate) <hr style="border-top: 1px dashed black;"/> <p style="text-align: center;"><u>TREATMENT ENHANCEMENT SERVICES</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Family and/or Individual Case Management <input type="checkbox"/> Care coordination with other treatment or healthcare providers, legal, or community services <input type="checkbox"/> Acupuncture Detoxification Services <input type="checkbox"/> Referral for Medication Assisted Treatment (MAT) in combination with EBH services <input type="checkbox"/> Integrated Mental Health and Substance Use Services
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COMMENTS _____

