



ASHLAND COUNTY COMMUNITY SERVICE PROGRAMS

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Terry Barningham, Director

Community Service Programs Referral Form

Referral Date: _____

Name: _____ **Date of Birth:** _____

Gender: Male Female Other/Non-binary **SSN:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Cell:** _____ **Work:** _____

Referring Person: _____ **Contact Information:** _____

Current Programs: IRIS _____ Includa _____ Wellness Court: _____

Commitment or Settlement Agreement? _____ Yes _____ No

If this is a child under 18, please obtain the following information:

#1 Parent/Guardian: _____ **Relationship:** _____

Address (if different than above) _____

Phone: _____ **Cell:** _____ **Work:** _____

#2 Parent/Guardian: _____ **Relationship:** _____

Address (if different than above) _____

Phone: _____ **Cell:** _____ **Work:** _____

WI Medicaid Yes No **MA Number:** _____

*Please have a copy of your Forward Health card at time of admission.

Other Insurance: _____

Are you receiving treatment for a mental illness or substance use? Yes No

If not, would you like help with addressing issues of mental illness or substance use? Yes No

How does your experience of mental illness or substance use interfere with your daily functioning?

What are the most important issues that this program can help you address?

1.

2.

3.

Who is your physician and/or psychiatrist? _____

Any Recent Hospitalizations:

Date _____ Place _____

Reason _____

Date _____ Place _____

Reason _____

Date _____ Place _____

Reason _____

In order to move forward with these services, you must sign a Release of Information (ROI) so that medical records can be acquired from your physician/psychiatrist. What would be the best or easiest way to accomplish this? In-person or by mailing a Release of Information form?

In-person & Date Completed _____ Date Mailed _____

How did you hear about the Community Support Programs?

- Self CSP/CCS
- School _____
- Ashland County Bayfield County
- Other _____

Staff Signature: _____ Date: _____

Service Director/Clinical Coordinator (or designee) Review:

I have reviewed this initial referral and believe that this person would benefit from further screening for psychosocial rehabilitation services.

Service Director/Clinical Coordinator: _____ Date: _____