E.S.P. (Empowerment Service Providers)
Case Management Professionals, Inc.
345 Beville Road #106
South Daytona Beach, FL 32119
386-760-7533
Fax: 386-761-5868

Dedicated to providing an alternative approach to individualized case management and to empower individuals toward self-sufficiency

Referral Form **Client Name and #**

Date: _____

REFERRING AGENCY

Agency: _____ Phone: _____

Referred By: _____ Extension: _____

Agency Address: _____ Email: _____

City, State, Zip: _____

Services Requested: _____

CLIENT INFORMATION

Full Name: Last _____ First _____ Phone: _____

Gender: (Check One) ☐ Male ☐ Female Cell: _____

SSN#: _____ Email: _____

Address: _____ D.O.B: _____

City, State Zip: _____ Age: _____

Source of Income: _____ Monthly Amount: _____

Food Stamps: (Check One) ☐ No ☐ Yes Monthly Amount: _____

Military Service: (Check One) ☐ No ☐ Yes Type of Discharge: _____

Parent / Guardian: (if applicable) _____

Relationship: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Relationship: _____ Cell: _____

HISTORY OF HOMELESSNESS

Current Living Conditions: _____ How Long: _____

Length of Homelessness: _____

Number of times Homeless in the past 3 years: _____

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MENTAL HEALTH HISTORY

Mental Health Diagnosis _____

Present treatment for Mental Health (agency and location) Medications / Dosage: _____

_____

_____

Recent hospitalizations (within the past year) ☐No ☐ Yes, date and reason: _____

_____

Doctor / Therapist Name : _____ Phone: _____

_____

DISABILITY HEALTH HISTORY

Disability Health Diagnosis: _____

Disability Certification Statement Attached? (Check One) ☐ No ☐ Yes

Present treatment for Mental Health (agency and location) Medications / Dosage:

_____

_____

Recent hospitalizations (within the past year) ☐No ☐ Yes, date and reason:

_____

_____

Doctor / Therapist Name: _____ Phone: _____

_____

MEDICAL INFORMATION

Medicaid: Applied For: (Check One) ☐ No ☐ Yes ☐ Accepted ☐ Denied

Receiving: (Check One) ☐ No ☐ Yes, Number: _____

SSI: Applied For: (Check One) ☐ No ☐ Yes ☐ Accepted ☐ Denied

Receiving: (Check One) ☐ No ☐ Yes, Number: _____

SSDI: Applied For: (Check One) ☐ No ☐ Yes ☐ Accepted ☐ Denied

Insurance: (Name of Provider) _____

Primary Care Physician: _____

Address: _____

Medical Conditions: (including allergies) _____

Recent hospitalizations (within the past year) ☐No ☐ Yes, date and reason: _____

_____

Smoke Cigarettes? (Check One) ☐ No ☐ Yes

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SUBSTANCE ABUSE HISTORY

How often does the client use alcohol? _____

How often does the client use non-prescribed controlled substances? _____

Has there been use of controlled substance within the past year? (Check One) ☐ No ☐ Yes ☐ Unknown

Drugs of Choice: _____

Rehab Agency _____

Address: _____

Counselor: _____

Past treatment (inpatient or outpatient) for substance abuse: _____

FORENSIC HISTORY

Does client have any charges or convictions related to Sex Abuse? (Check One) ☐ No ☐ Yes

Does client have any Felony Convictions (Check One) ☐ No ☐ Yes

Is client currently on Probation or Parole? (Check One) ☐ No ☐ Yes

Has client ever been incarcerated for more than two (2) years? (Check One) ☐ No ☐ Yes

Does client have any pending Legal Charges? (Check One) ☐ No ☐ Yes

LIVING SKILLS

Housing History and Patterns: (Including timelines for homelessness if possible) _____

_____

_____

Activities of Life: (Hygiene, Housekeeping, Budgeting, Etc.) _____

_____

Social Skills and Needs: (Family Support, Social Functioning, Privacy Needs, etc.) _____

_____

Other Comments or Concerns: _____

_____

_____

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Certification Statement

I certify that this statement is true to the best of my knowledge and belief. I have attached all necessary documentation to support that the information provided is accurate.

Signature _____ Date _____

Title _____ Phone Number _____

Agency _____

To be completed by RECEIVING STAFF:

Date Referral was Received: _____

Date of Follow-up Phone Call or Interview _____

Referral Determination: (Initial) ___ Accepted ___ Rejected Date: _____

Reason for Rejection: _____

Staff Signature _____