Codington County Community Services
REFERRAL FORM

Individuals Making Positive Actions Can Thrive

Date: _____ Referral Organization: _____

CLIENT INFO

Name: _____ DOB: _____

Address: _____ Phone Number: _____

Household Members (names & ages):

_____

Is there abuse in the Situation? Yes _____ No _____
Are you a student? Yes _____ No _____
Are you a Veteran? Yes _____ No _____
Currently Employed? Yes____ No _____ If yes, where _____
Currently on Medicaid? Yes, ____ No _____ If yes, Primary _____, Clinic _____

NEEDS & REFERRAL

Areas of need: (Please write **SPECIFIC NEEDS**)

- Housing: _____
- Food: _____
- Clothing: _____
- Transportation: _____
- Healthcare: _____
- Employment/Career Development: _____
- Mental Health Services: _____
- Child Care: _____
- Legal Issues: _____
- Income Support/Benefits: _____
- Substance Use Services: _____
- Parenting/Family Support: _____
- Other: _____

Summary of needs/situation:

_____

_____

Is this client aware of the referral? Yes_____ No_____

When is the best time to contact: _____

Where would be the most effective 1st meeting visit? _____ you introduce us at your location
_____ CHW office: Client is aware CHW will be calling
Are you making any other referrals? Yes_____ No_____ If yes, where _____

ONCE THE REFERRAL IS COMPLETED, PLEASE EMAIL TO: pwelling@codington.org or karik@codington.org SUBJECT: IMPACT Program OR FAX TO (605) 882-5243 ATTN: IMPACT
Follow-up (Date & progress):

_____

Program through the Codington County Community Services
7 West Kemp Ave
Watertown, SD 57201
605-882-6286