The data on this form will be transmitted over secure servers that are fully compliant with Federal HIPAA and Georgia Department of Behavior Health and Developmental Disorders (DBHDD) rules for electronic transmission of protective medical information.

ACR ASSERTIVE COMMUNITY RECOVERY
ACCOMPANYING INDIVIDUALS ON THEIR WELLNESS JOURNEY

Office: 404 508-0078 Fax 404 508-0071
email: info@Assertiverecovery.com

4151 Memorial Drive, STE 209-C
Decatur, GA 30032

Intake Referral Form

☐ **Child/Adolescent Services** ☐ **Adult Services**

Individual Referred Information

Last Name **First Name** **Middle Initial** **Suffix**

Medicaid or Other Insurance Number

Type: ☐ Reg Medicaid ☐ Wellcare ☐ Peachstate (Cenpatico) ☐ Amerigroup ☐ Other:

Date of Birth **Age** **SS#** **Grade Level**

Gender: (Please Check) ☐ **Male** ☐ **Female**

Street Address

City **State** GA **Zip**

Home Phone#: **Cell #:** **Work #:**

Parent/Guardian or other Individual to contact:

What Services Needed:

1. Has the adult/child had other services (e.g. Case Management, Individual and /or Family Counseling)?
   ☐ **Yes** ☐ **No** ☐ **Not Sure**
2. Does the adult/child have a known Mental/Behavior Health / Serious Emotional Disturbance and/ or Substance Abuse issue/diagnosis?
   ☐ **Yes** ☐ **No** ☐ **Not Sure**
3. If there is a diagnosis, what is the diagnosis, if known?
4. Is the adult/child and/or family in need of intensive, coordinated clinical and supportive intervention?
   ☐ **Yes** ☐ **No**
5. Is the adult/child at immediate risk of out of home placement or is currently in out of home placement and re-unification is imminent? ☐ **Yes** ☐ **No**
6. Has Psychological/Psychiatric Evaluation been completed?
   ☐ **Yes** ☐ **No** If yes, please fax to 404-508-0078

Name & Title of Person making referral:

Agency: **County:** **Court Mandated?** ☐ **Yes** ☐ **No**

Phone # of person making referral: **Fax number:**

Service (s) Requested (Please Check)

☐ Child/Adolescent CORE ☐ Adult CORE ☐ ACT ☐ Intensive Family Intervention ☐ Peer Support Only ☐ Other

Presenting Problem: (List problem behaviors; include any medications for emotional and/ or behavior problems)

Submit