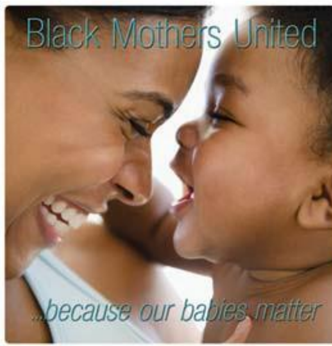

REFERRAL FORM

Fax # to (916) 970-5950

CENTER FOR COMMUNITY HEALTH AND WELL BEING, INC.

CCHWB Black Mother United Eligibility Criteria

⇒ Resident of Sacramento County
⇒ Mother is pregnant
⇒ Mother identifies as African American

Referral Source Information

Date referred: ____________________

Name of person making referral: ____________________

Agency/organization: ____________________

Address: ____________________ Telephone number: ____________________

City and zip code: ____________________ Fax number: ____________________

Client Information

Name: ____________________

Address: ____________________

City and zip code: ____________________ Approx. due date: ____________________

Telephone #1: ____________________ Telephone #2: ____________________

Fluent in English? ☐1 Yes ☐2 No → If not, must mark a language to receive services: (mark only one)

☐1 Spanish ☐2 Hmong ☐3 Russian ☐4 Other: ____________________

Was client notified of this referral? ☐2 No ☐1 Yes →Date: ____________________

By signing this consent, I hereby give my permission for the referring agency and representatives from Black Mothers United to view, copy, release and exchange the following information and/or records via verbal, written, and/or electronic communication:

Client Signature: ____________________ Date: ____________________

If no, why not? ____________________

Reason(s) for referral/notes: ☐

REFERRAL RECEIPT (for CCHWB use):	CCHWB received the referral on:__________(date) Received by: (name) __________ ☐1 Case opened ☐2 Case not opened, specify why: __________ __________

Created for Center for Community Health and Well Being, Inc. by LPC Consulting Associates, Inc.
4625 44th Street, #9, Sacramento, CA 95820 (916) 558-4809 last updated: 10-28-15

Funding provided by: