WALWORTH COUNTY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
1910 County Road NN P.O. Box 1005 Elkhorn, WI 53121-1005
262-741-3200 800-365-1587 FAX 262-741-3217

COMPREHENSIVE COMMUNITY SERVICES (CCS) REFERRAL

Date: _____ Consumer #: _____ (If Known)

CLIENT INFORMATION

NAME: _____ DOB: _____ AGE: _____ GENDER: ☐ M ☐ F ☐ NON-BINARY

PARENT/GUARDIAN NAME (if applicable): _____

PHONE: _____ LEAVE MESSAGE? ☐ YES ☐ NO

CELL PHONE: _____ LEAVE MESSAGE? ☐ YES ☐ NO

BEST TIME TO CONTACT: _____

ADDRESS:_____

COUNTY OR TRIBE OF RESIDENCE: _____

CLIENT IS BEING REFERRED BY:

ORGANIZATION AND/OR PERSON NAME: _____

PHONE: _____ IS CLIENT AWARE REFERRAL IS BEING MADE? ☐ YES ☐ NO

EMAIL: _____

RELEASE OF INFORMATION INCLUDED? *(Not Required)* ☐ YES ☐ NO

REASON FOR REFERRAL:

☐ Medication Assistance	☐ Benefits Coordination	☐ Symptom Management
☐ School Related Issues	☐ Mental Health/Substance Abuse	☐ Housing
☐ Employment/Education Assistance	☐ Social/Recreational	☐ Other: _____

IN THE PAST YEAR CLIENT HAD INVOLVEMENT IN:

☐ Outpatient Counseling	☐ Youth Justice	☐ ADRC
☐ Psychiatry	☐ Child Protective Services	☐ CLTS
☐ Inpatient Hospitalization/Detox	☐ Crisis	☐ Other: _____

PLEASE PROVIDE A BRIEF EXPLANATION OF CURRENT CONCERNS:

DIAGNOSIS (if known): _____

PHYSICIAN/PSYCHIATRIST: _____

THERAPIST: _____

DOES THE CLIENT HAVE A CURRENT AODA OR MENTAL HEALTH COMMITMENT? ☐ YES ☐ NO

DOES THE CLIENT HAVE A GUARDIAN? ☐ YES ☐ NO

GUARDIAN NAME: _____ GUARDIAN PHONE: _____

GUARDIAN ADDRESS: _____

PAYOR SOURCE: ☐ MEDICAID (BadgerCare, Forward Health, other: _____)
☐ MEDICARE ☐ PRIVATE INSURANCE ☐ SELF PAY

NAME OF INDIVIDUAL COMPLETING REFERRAL: _____

CONTACT INFORMATION: _____

(Provide ROI if you would like to be contacted)

Please email form to: ccsreferrals@co.walworth.wi.us, or FAX to 262-741-4705 or Drop off at WCDHHS