CENTRAL CITY CONCERN
HOMES HEALTH JOBS

IMANI CENTER REFERRAL FORM

709 NW Everett Street, Portland OR 97209
Phone: (503) 226-4060
Email: ImaniCenter@ccconcern.org Fax: (503) 445-4913

Today's date:	**PLEASE PRINT LEGIBLY OR TYPE**

PARTICIPANT INFORMATION

Client's name:	DOB:
Gender identification: ☐Male ☐Female ☐Transgender ☐ Other:	Race Identification: ☐Black/African American ☐Caucasian ☐ Asian ☐Native American ☐ Other:
Address: (mailing)	City, State, Zip:
Homeless: ☐Yes ☐No	How long have you been homeless? ☐ 0-6 months ☐7-12 months ☐ More than 1 year:
Phone:	Message Phone:

Insurance Carrier:	PCP:	PCP Location: PCP Phone:

Type of Services needed: Mental Health / Alcohol & Drug	MH ☐ A&D ☐	
If you currently involved with DHS or DCJ? If yes complete on right side →→→ →→→	☐ Y ☐ N	DHS / DCJ contact information: Name: Phone: Fax: Mailing Address: ROI obtained? ☐ Yes ☐ No
Are you currently receiving services at CCC or another agency? If yes where, when, complete on right side →→→	☐ Y ☐ N	Other Agency information Agency: Contact Person: Phone: Fax: Mailing Address: ROI obtained? ☐ Yes ☐ No
Do you know anyone who works here or is receiving services here? If yes who?	☐ Y ☐ N	Patient Medications:
Reason For Referral:		

REFERRING AGENCY INFORMATION
(Attach Release of Information (ROI) for notification of client status)

Referred from:	
Contact Person:	Phone#:
ROI Obtained? ☐ Yes ☐ No	

Will the referent continue to be involved with the client after this referral?
☐ Yes ☐ No ☐ Self-Referred
If 'Yes', how? :