COBB COUNTY COMMUNITY SERVICE BOARD
RESIDENTIAL/MMAC OUTPATIENT SERVICES APPLICATION

Individual Name: ____ SS#: _________________________
Last First M

Date of Birth: __________________________________ M _____ F _____ Race: ______________

Current Address: ____ __________________
Street City Zip Code

Telephone #: _____________________________________ Marital Status: S ____ M ____ D ____ X ____

It is requested that the following items accompany the referral form if the Individual is in a hospital or other inpatient community agency:
- ***Psychiatric Assessment (if applicable)***
- ***Doctor's last clinical note***
- ***Nursing Assessment/Physical (if one has been completed)***
- ***Diagnosis signed by credentialed staff (LPC, LCSW or Psychiatrist)***
- ***TB Skin Test***
- ***RPR***
- ***Discharge Summary***
- ***Release of Information Form (if Individual wants information shared with referral***

Is Individual a US Citizen: ____

Individuals participating in the programs must have a State issued driver's license or ID card, social security card, proof of residency, proof of income, and insurance information if applicable. These items must be presented when you come in for your intake assessment.

Name of nearest relative: _____________________________________ Telephone #: _____________________

Number of Children: _______________ Age(s): ________________________ Sex: _________________

Do you have legal custody of your child(ren)? ____

Do your child(ren) currently residing with you? ____

Do you plan on bringing your children into the program with you at any time? ___ yes ___ no

Is Individual pregnant: __________________________ If yes, expected due date: _________________________

Referral Source: ____

Contact Person: ____ Title: _______________________________

Email Address: ____ Telephone #: _____________________

Can staff leave a message for you on the voicemail box: _____ yes _____ no

Can staff email you? ______ yes _____ no (***please note, we will only use Individual initials in emails***).

Individual Name: ______________________________________ Individual CID#: ____________________

Program being referred to: (indicate with a check mark)

______New Start (30 day residential substance abuse program for males who have gone through detox)

______Recovery in Motion (6 months residential program for Individuals with substance abuse disorders)

______Mothers Making A Change (also known as WTRS) Residential Treatment Program for pregnant women and women with minor children

______Mothers Making A Change (also known as WTRS) Outpatient Services

______ WTRS Transitional Housing (temporary housing for females who are in the aftercare phase of their treatment program and meets criteria)

Is Individual incarcerated? _____ yes _____ no ***If Individual is incarcerated (in jail), the Individual must be able to be released from jail in order to be considered for residential treatment.***

Reason for referral ***(be specific)*** ____

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____

Current Diagnosis(es) names/codes: ____

____

____

Describe current symptoms and behaviors: ____

____

____

____

List all hospitalizations (including CSU Stabilization) within the past six months.

Inpatient Facility	Dates	Reason	Outcome

Has the Individual had any suicidal or homicidal ideations or attempts within the past six months:

If yes, describe in detail:

____

____

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____

Individual Name: ____ Individual CID#: ______________________

Describe any history of violence and/or aggressive behavior. ____
____
____
____
____
____

Does the Individual have any medical issues? If so, please describe:_____________________________________
____
____
____
____

Medical Provider: _________________________________ Last date seen by doctor: ____________________

If no, explain: ____

Legal history:

Date	Type of Arrest	Outcome

Is Individual currently on probation? _____ yes _____ no

If yes, name of parole/probation officer:

____________________________ ______________________________________ __________________

name address telephone #

Is Individual involved with Dependency Treatment Court? _____ yes _____ no

If yes, what county? ____

Substance Abuse History:

Age of initial drug use: ____________________ Age of initial alcohol use: ____________________________

Current and/or previous use (list type of drug, amount, frequency and last use:

Drug	Frequency	Last Reported Use

Individual Name: ____ Individual CID#: ______________________

Is the Individual an IV user: _____ yes _____ no

Describe what you see as being the goals and objectives of residential for Individual being referred:

List medications Individual is taking (mental health and medical/physical):

Name	Dosage	Prescribing Physician

If accepted into the program; how will the Individual pay for medications? ______________________________
____

Is Individual in agreement with referral? _____ yes _____ no

Does Individual have DFCS CPS involvement: _____ yes _____ no

If yes, name of case worker: ___________________________________ Telephone #: ____________________

Financial Information:

Does Individual have any income? _____ yes _____ no If yes, amount: _____________________________

Source of income: ____

Does Individual receive food stamps? ____ yes ____ no Does Individual have Medicaid: ____ yes ____ no

Does Individual have insurance: ___ yes ___ no If yes, insurance carrier? _______________________________

____ ______________________________

Signature of person completing form Date

NOTE: The residential programs reserve the right to request additional information as deemed appropriate to assist the review team in making a decision relating to admission.

All sections of this referral must be completed

PLEASE FAX REFERRAL
AND ANY ADDITIONAL
INFORMATION TO
678-784-1515