WORK FIRST PROGRAM REFERRAL TO QUALIFIED PROFESSIONAL IN SUBSTANCE ABUSE

This referral must be completed when making a referral for a Work First Program applicant or recipient for further assessment by a Qualified Professional in Substance Abuse.

Referring Agency Information

County Name _____ Date of Referral _____

Person making referral _____ Title _____

Telephone No. _____ Email _____

☐Please contact me for more information.

☐Contact me with appointment time for the person referred.

☐Contact me if the person does not keep appointment.

Applicant/Recipient Information

Name of Person being referred: _____ PDC#: _____

Mailing Address: _____

_____ _____

City State zip code Telephone Number

Signed Consent for Release of Confidential Information (DSS-8219) Attached

Substance Use Information given to applicant/recipient ☐ yes ☐no

Reason for Referral	Mandatory*	Optional+
Mental Health Assessment or Referral to LME-MCO for Assessment		
Assessment due to AUDIT Screening		
Assessment due to H & I Felony (North Carolina)		
Determination of Satisfactory Completion of Substance Use Treatment		
Determination of Satisfactory Participation in Substance Use Treatment		
Information and Referral Regarding Substance Use Disorders and Treatment		

*** Mandatory- Referral is an eligibility/program requirement. Applicant/recipient compliance is a condition of eligibility.**

+Optional – Applicant/recipient compliance is not a condition of eligibility.

Comments:_____

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