Referral Form
(Please Print or Type)

Please send this form to Josh Clay
Fax: 828-327-8796 or Email: jclay@thecogcon.com

Member Name:	DOB:	SSN: XXX– XX–	Gender: M ☐ F ☐
Hispanic/Latino: ☐ Race:	Employment:		
Phone Number:	Email:		
Physical Address:	City:	Zip:	
Mailing Address:	City:	Zip:	

Additional Member Information:
Does the member speak English? ☐ Yes ☐ No, What is the primary language spoken in the household?
Is the member currently receiving counseling services? ☐ Yes ☐ No If yes, where?
List any current medical problems:
List all current medications:
Does the member have private medical insurance? ☐ Yes ☐ No If Yes, Policy Number:
Does the member have Medicaid/Health Choice? ☐ Yes ☐ No If Yes, Policy Number:
If "no", has member applied for Medicaid or Health Choice? ☐ Yes ☐ No
Additional Comments:

Name of Person Making the Referral:	
Title:	Agency:
Phone Number:	
Email:	
Date of Referral:	
Describe the reason why you're referring this member to this program:	
Date the referral is received by the program:	