Another Choice
ANOTHER CHANCE

Service Site
☐ Office
☐ School Site
_____
☐ Telehealth
☐ Other _____

ANOTHER CHOICE, ANOTHER CHANCE

REFERRAL FORM

Please complete ALL items and fax to (916) 388-9273.

Client Information: Date of referral: _____

Last name:_____ First name: _____ DOB:_____ Age: _____
☐Male ☐ Female ☐Transgender ☐ Non-Binary ☐ Other: _____ Pronouns:_____ SS#:_____

Ethnicity: _____ School: _____ Grade Level: _____

Home Address: _____ City/Zip: _____
Primary Phone #: (___)_____ Can we leave a message at this number? ☐ Yes ☐ No
Alternative Phone #: (___)_____ Can we leave a message at this number? ☐ Yes ☐ No
Email address: _____

Insurance Information:
PRIVATE INSURANCE: ☐ YES ☐ NO INSURANCE COMPANY: _____ INS. CO. PH.#: _____

PRIMARY INSUREDS NAME: _____ DOB:_____ SS# : _____

INSURED'S RELATION: _____ EMPLOYER: _____

INS. ID# : _____ GROUP # : _____ PPO : ☐YES ☐NO

MEDI-CAL: ☐ YES ☐ NO BIC/CIN: _____ Confirmation #: _____

Reason for Referral: _____

Services	Program type
☐ Drug/Alcohol Counseling ☐ Anger Management (fees may apply) ☐ Case Management ☐ Other	☐ Adult ☐ Youth

Does parent or caregiver have knowledge of referral for services? ☐YES ☐NO ☐N/A

Need Translator? ☐ YES - Primary/Preferred Language: _____

How Did You Hear About Us? _____

Guardian Information (if applicable):

Parent/Caregiver Name: _____
Primary Phone #: ( ) _____ Can we leave a message at this number? ☐ Yes ☐ No
Alternative Phone #: ( ) _____ Can we leave a message at this number? ☐ Yes ☐ No
Guardian's Email address: _____

Referring Agency Information:

Organization: _____ Contact Person: _____ Phone: ( ) _____

For Office Use Only:

Referral Received By: _____ Date: _____ Time _____ am / pm

Intake Scheduled For: _____ at _____ am / pm Counselor Assignment _____

7000 Franklin Blvd., Suite 200• Sacramento, CA 95823• (916) 388-9418 Fax (916) 388-9273
Email referrals to referral@acacsac.org or go to our website at www.acacsac.org

SCAN ME