JOURNEY HEALTH

Client Counseling Referral Form

Client Name: _____ **DOB:** _____ **Age:** _____

Case Manager: _____ **Email:** _____ **Phone** _____

Placement: _____ **Email:** _____ **Phone** _____

Address: _____ **Medicaid No.:** _____

MO Alliance Contract: ☐ No ☐ Yes

Greater Coalition Contract: ☐ No ☐ Yes

Which Service is needed?

Family ☐

Individual ☐

Both ☐

Parenting Education Classes ☐

Therapeutic Supervised Visits ☐

Reason for seeking counseling:

_____

_____

_____

_____

Please include a copy of the client's Medicaid Letter and Placement Letter. Once we receive those documents, we will send intake paperwork and work on scheduling. Thank you!