STAND, Inc.

CONNECT "THE PLUG TO PREVENTION"

PCT Project Connect Treatment a STAND, Inc. Initiative

The DOOR

Individual Referral Form

Date of Referral:		Medicaid: ☐ Yes or ☐ No		If no, have you ever had Medicaid? ☐ Yes or ☐ No	
Individual Name:			Gender:	☐ Female ☐ Male ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Other/Unknown	
	First Name ***Middle Initial*** ***Last Name***				
Date of Birth:		Age:		Medicaid ID #: Social Security #:	
Address:				Apt:	
City:		State:		Zip:	
Individual Telephone #:		Alternate Contact #:			
Referring Agency:		Contact Person:			
Contact #:		Email Address:			

Additional Information Needed:	
Does the individual have a DSM diagnosis of substance use, abuse or dependence?	☐ Yes or ☐ No
Diagnosis/Diagnoses (if known):	
Does the individual have a DSM – Mental Health Diagnosis?	☐ Yes or ☐ No
Diagnosis/Diagnoses (if known):	
Does the individual have any current suicidal/homicidal ideations?	☐ Yes or ☐ No
Is the individual in need of housing?	☐ Yes or ☐ No
Does the individual have income?	☐ Yes or ☐ No
If incarcerated, what is the expected release date?	
Additional information:	

Requested Service:

☐ Substance Abuse Intensive Outpatient - Medicaid or Fee-for-Service ☐ Addictive Disease Peer Support Program - Medicaid Only

☐ New Directions Family Violence Intervention Program ☐ Project Connect Prevention

☐ The DOOR – Addiction Recovery Support Center ☐ Project Connect Treatment