*IHAP serves immigrants and refugees who live in* ***Greensboro only****. Languages available are**Spanish, French, Swahili, Kinyarwanda, Kirundi, Vietnamese, Jarai, Rhade.*

**To submit a referral,** please email this form to**ihap@uncg.edu** or fax to **336-334-5413**.

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| **REFERRAL SOURCE INFORMATION** |
| **Date of Referral:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Name** *(person making referral):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Agency Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **CLIENT INFORMATION** |
| **Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Gender:** \_\_\_\_\_**Home Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Alternate Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Country of Origin:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Arrival Date** *(if client is a refugee):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Preferred Language(s):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Client Speaks English:** [ ]  Yes [ ]  No [ ]  Some/Limited **Client Is Aware of Referral:** [ ]  Yes [ ]  No **Family Members Need Assistance:** [ ]  Yes [ ]  No *(if yes, please attach a separate form for each, noting relationship)* |
| **HEALTH ACCESS INFORMATION** |
| **Insurance Status:** [ ]  Medicaid [ ]  Medicare [ ]  Private Insurance [ ]  Uninsured [ ]  Orange Card **Primary Care Provider** *(if applicable)*: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| **REASON FOR REFERRAL** |
| **Has your agency provided any initial interventions?** [ ]  Yes [ ]  No *(if yes, please specify below)***Will your agency be providing any ongoing assistance?** [ ]  Yes [ ]  No *(if yes, please specify below)* |