Empowerment Resource Center

Integrated Care Partnership of Metro Atlanta
Participant Referral Form

Referrer Information:

Referring Agency: _____

Referring Agency staff: _____

Address: _____ City / State / Zip: _____

Phone #: _____ Fax #: _____

Client Information:

_____ ____ _____ _____/_____/_____

First Name MI Last Name DOB

Patient's Address: _____ City/State/Zip: _____

Phone #: _____ Sex: ☐ Male ☐ Female

Last 4 of Social Security #: ---- / ----- / _____

Referral Diagnoses: ☐ Mental Health Counseling ☐ Substance Abuse Treatment ☐ CRCS Counseling

☐ Other: _____

Service Information:

Type of Service Requested: ☐ Behavioral Health Services

☐ Clinical Services (HIV/STI Testing/Screening/Vaccination)

At Risk Criteria: ☐ Sexual Behavior ☐ Mental Health Illness ☐ Substance Abuse

Required Documents: ☐ Photo ID ☐ Proof of Income ☐ Proof of Residence ☐ Proof of Status

The above mentioned person is being referred to the Integrated Care Partnership of Metro Atlanta (ICP) Program for enrollment.

Form must be faxed to:
Empowerment Resource Center
Fax: 404.902.6989
For additional information:
404.526.1145
ICP@erc-inc.org

For Office Use Only:

ICP Personnel: _____

Print Name

_____ Date Acknowledgement Sent: _____

Signature