RAS-Col — Referral for Assistance

Phone: 970-826-8010 • Email: PopHealth@memorialrh.org

Client Name: ______________________________ **County:** ______________

Date of Birth: ______________________________ **Phone #:** ______________

Monthly Income: ______________________________

Referred By: ______________________________ **Phone #:** ______________

By signing this form, I attest that I am accessing Substance Use Disorder or Mental Health treatment or recovery services and a Care Plan is in place to support my health and well-being.

Client (sign & date): ______________________________

Referral Source (sign & date): ______________________________

Community members may be assisted with a variety of social service needs in support of their substance use disorder (SUD) and/or mental health treatment and recovery through the *Rural Alliance Addressing Substance Use Disorder – Colorado (RAS-Col)* Consortium. **Please indicate below what support is needed:**

☐ Childcare ☐ Transportation

☐ Housing/Utilities ☐ Other: ______________________________

Specific details about assistance request: ______________________________

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Other organizations* with whom the patient is working and *resources/services being provided? ______________

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Based on the information provided, RAS-Col will assess what resources are available to respond to the needs described and will follow-up with the client.

For Internal Use Only below this line:

Submission Checklist:

1) Referral Form
2) MRH Care Coordination Release of Information Form
3) Copy of rental agreement, childcare invoice, bank statement, cancelled check, etc. showing payment amount
4) Check request
5) IRS Form W9 of business or vendor (landlord, childcare provider or utility company)

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