



BRIGHTER BEGINNINGS REFERRAL FORM

Richmond Center

2727 Macdonald Ave.
Richmond, CA 94804
510-236-6990
510-236-7346 (fax)

Oakland Center

2648 International Blvd.
Oakland, CA 94601
(510) 903-7516
(510) 437-8955 (fax)

Antioch Center

512 West Fifth St.
Antioch, CA
(925) 757-5303
(925) 978-1775 (fax)

REFERRAL DATE: _____/_____/_____

CLIENT INFORMATION

NAME:		DOB:	AGE:	GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female
SS#:	ETHNICITY:	PRIMARY LANGUAGE:		
ADDRESS:				
SCHOOL ATTENDING:			GRADE:	
PHONE:		CELL:		
<input type="checkbox"/> RECEIVING AID? <input type="checkbox"/> RECEIVING MEDI-CAL? MC#: _____ <input type="checkbox"/> HAS MEDICAL INSURANCE OTHER THAN MEDI-CAL? _____				
<input type="checkbox"/> PREGNANT: Expected Delivery Date: _____/_____/_____ <input type="checkbox"/> PARENTING				
<input type="checkbox"/> NAME OF PARENT/GUARDIAN IF CLIENT IS UNDER 18 YEARS OLD: _____				

CHILD INFORMATION

CHILD #1:	NAME:	DOB:
SS#:	<input type="checkbox"/> RECEIVING MEDI-CAL? MC#: _____	
CHILD #2:	NAME:	DOB:
SS#:	<input type="checkbox"/> RECEIVING MEDI-CAL? MC#: _____	

REFERRAL INFORMATION

NAME OF CLIENT(S) SEEKING SERVICES: _____

PROGRAMS INTERESTED IN: (Check all that apply):

AFLP/CAL-LEARN TEEN SUPPORT SERVICES – Provides case management to adolescent parents and their children. Clients are required to be 18 years old and younger at initial enrollment.

BLACK INFANT HEALTH – Provides case management services for African American pregnant women.

COUNSELING/MH SERVICES – Provides counseling to adults, teen parents, and children 0-5. Must have full scope Medi-Cal.

OTHER _____

REASON FOR REFERRAL: _____

RECEIVING OTHER SERVICES FROM ANOTHER AGENCY: Yes No If so, where and what type? _____

PLEASE CHECK IF CLIENT RECEIVING ONE OR MORE OF THE FOLLOWING BB SERVICES:

AFLP Black Infant Health Cal Learn Counseling/MH Services Other _____

Family Advocate Name _____

REFERRAL SOURCE:

Name & Title: _____ Phone: _____

Agency: _____ Fax: _____

Address: _____

Would you like follow up information? Yes No

Client Signature _____ *Date* _____

Provider Signature (Please attach Authorization to Release Information Form, if possible) _____ *Date* _____

BB Staff Only - Referral taken by: _____ Date: _____