

## WORK FIRST PROGRAM REFERRAL TO QUALIFIED PROFESSIONAL IN SUBSTANCE ABUSE

This referral must be completed when making a referral for a Work First Program applicant or recipient for further assessment by a Qualified Professional in Substance Abuse.

Referring Agency Information	
County Name _____	Date of Referral _____
Person making referral _____	Title _____
Telephone No. _____	Email _____
<input type="checkbox"/> Please contact me for more information.	
<input type="checkbox"/> Contact me with appointment time for the person referred.	
<input type="checkbox"/> Contact me if the person does not keep appointment.	

Applicant/Recipient Information			
Name of Person being referred: _____		PDC#: _____	
Mailing Address: _____			
_____	_____	_____	_____
City	State	zip code	Telephone Number

**Signed Consent for Release of Confidential Information (DSS-8219) Attached**

**Substance Use Information given to applicant/recipient**     yes                       no

Reason for Referral	Mandatory*	Optional+
Mental Health Assessment or Referral to LME-MCO for Assessment		
Assessment due to AUDIT Screening		
Assessment due to H & I Felony (North Carolina)		
Determination of Satisfactory Completion of Substance Use Treatment		
Determination of Satisfactory Participation in Substance Use Treatment		
Information and Referral Regarding Substance Use Disorders and Treatment		

\* **Mandatory-** Referral is an eligibility/program requirement. Applicant/recipient compliance is a condition of eligibility.

+**Optional –** Applicant/recipient compliance is not a condition of eligibility.

Comments: \_\_\_\_\_  
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