Referral to Recovery Coordination Agency Form

Date of Referral: _____ ***Updated by the RPC 8/8/19***

Referring Person	**First Name**		**Last Name**	
	Agency Name		**Phone #**	
	Address		**Email**	
Recovery Coordination Agency Information	**Agency Name**			
	Address		**Fax**	
	Phone #		**Email**	

Any Known Safety Concerns? *(Criminal Record, History of Violence, Drug Use, Weapons in the Home, Sex Offender, General Concerns, etc.):* *N/A* ☐

Participant Information	**First Name**		**Last Name**	
	Soc. Sec. #		**Address**	
	Phone #		**Alternate Phone #**	
	Email Address		**Date of Birth**	
	Primary Language			

Participant Health Care Information	**Managed Care Organization (MCO) Name**		**MCO ID #**	
	MCO Contact Name		**MCO Phone Number**	
	MCO Contact Email		**Medicaid CIN Number**	
	Primary Diagnosis & ICD 10 Code		**Secondary Diagnosis & ICD 10 Code**	

Reason for Referral:

Any Identified Service Restrictions Surrounding Client Availability?

Are there any known current services or supports being received?

RCA AGENCY INFORMATION:

AGENCY NAME: _____ POINT OF CONTACT: _____

PHONE: _____ FAX: _____

E-MAIL: _____