PROJECT HOPE
Referral Form

Please mail or fax this form to:

12912 Brookhurst Street, Suite 480, Garden Grove, CA 92840 |Phone: 714-636-6286|Fax: 714-636-8354

CONFIDENTIAL INFORMATION

Referring Person/Title:	Agency/Dept:	Email:
Phone:	Fax:	Date:

PARTICIPANT INFORMATION			
Name:	DOB:	Age:	Gender Identity:
Address:	Phone:		Type of Medical Insurance:
School (if applicable):	Ethnicity:		Language:

PARENT/CAREGIVER INFORMATION		
Name:	Relationship:	
Address:	Phone:	Language:

REASONS FOR REFERRAL (Please explain situation, problems, symptoms, concerns, etc. below)
Please check all that apply: ☐ Case management/Resources ☐ Counseling ☐ Parent Support

☐ Yes ☐ No Does this case need a bilingual worker? If yes, specify language:

☐ Yes ☐ No Does the staff need to talk with referring person prior to intake?

☐ Yes ☐ No Has participant been notified that Project HOPE staff will contact them?

SERVICE AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION

The referring party has explained to me the purpose for this referral and I agree to have a copy of this referral faxed or to take a copy of the referral to OCAPICA. I agree to attend any scheduled appointments with the Program.

I authorize the release of information between _____(referring agency) and OCAPICA for the period this service agreement remains in effect. This information will pertain to the reasons for referral and will be used for assessment and intake of the participant(s) to be served. *This referral was explained to me in my primary language.*

Participant Signature Date Referring Person Signature Date

For PROJECT HOPE Use Only

Referral Received By Date

Assigned Intake Staff Date