IHH Referral Form

Date of Referral: ____

Name: ____

Date of Birth: ______________________ Gender: ______________________

Address: ______________________________________ County: __________

Phone: ______________________________ Email: ______________________

Medicaid Status: ☐ Active ☐ Inactive Medicaid #: ______________________

MCO: ______________________ MCO #: ______________________

Case Manager: ____

Legal Status: ☐ Guardian ☐ Payee ☐ Court Committal ☐ NA

Current Needs: *Why is the individual being referred to IHH services?*

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History of Psychiatric hospitalization:

☐ None ☐ Within Past Year ☐ Current ☐ Over a Year Ago

Diagnosis:

____

____

Psychiatrist: ____

Primary Family Dr: ____

Dentist: ____

Other Providers: ____

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Please email to: Services@arceci.org
Or mail to: The Arc of East Central Iowa Attn: Whitney Alber
680 2nd Street SE • Cedar Rapids, IA 52401
Questions - Please call: 319-365-0487 ext:1022