



The Encouragement Project Referral Form

from
Cabinet for Health and Family Services
to
Catholic Charities of the Diocese of Lexington
60 Martha's Vineyard
Prestonsburg, KY 41653
Phone/Fax: (606) 874-9170 Email: ghall@cdlex.org
for

Counseling and Support Services

Referring Worker: _____ Phone: _____ Fax: _____
Supervisor: _____ Phone: _____ Fax: _____

Case Name: _____ Case Number: _____
Address: _____ Phone Number: _____
Directions to Home from Prestonsburg: _____

Client Name (first, middle, last)	Soc. Sec. #	DOB	Gender	In home	Not home

For CCDL Office Use Only	
___ Case Accepted	
___ Case Denied (Reason: _____)	
Signature of CCDL Worker _____	Date _____

REASON FOR REFERRAL (Check all that apply, see explanations below):

- Family Counseling Services**
 Individual Adult Counseling Services
 Individual Child Counseling Services
 Parenting Education (about: _____)
 Domestic Violence Education
 Child Abuse/Neglect Education
 Budget Counseling
 Support Services/Case Management
 (please specify services needed here: _____)

Family Counseling Services – Counselor meets with two or more family members to treat mental illness, solve problems, improve relationships and /or enhance coping skills. Person-centered, narrative, cognitive-behavioral, play and other therapies may be used. Services begin with a home visit. Thereafter, most meetings will take place in CCDL’s Providence Room at St. Martha Catholic Church.

Individual Adult Counseling Services – Counselor will meet with adult to treat mental illness, solve problems, improve relationships and/or enhance coping skills. Session will be held in CCDL’s Providence Room at St. Martha Catholic Church.

Individual Child Counseling Services – Counselor will meet with child and parents/guardians for initial visit, preferably at the child’s home. Counselor will see child, and possibly parents, for additional sessions in CCDL’s Providence Room at St. Martha Catholic Church. Counselor will use play and talk therapies to work with child. Consideration will be given to including parents and siblings in family sessions.

Parenting Education – Counselor will meet with parents/guardians to teach them about an aspect of family life (discipline, school responsibilities, child development, sex education, sexual safety) for which clients are referred. Type of education should be *specified* in blank provided above. Resources include videos, books, and brochures. Gwen Hall, MSW, LCSW has been trained as a “Positive Parenting FAMILY Rules” provider and has 30+ years of parenting experience.

Domestic Violence Education – Counselor will meet with victim/s to educate them in the identification, understanding, effects and prevention of domestic violence. Clients will develop a safety plan and will be informed of/linked with community resources that will help them stay safe. Perpetrators will be referred to offenders’ counselors.

Child Abuse/Neglect Education – Counselor will meet with victim/s or perpetrator/s (but usually not together) to educate them about the identification, understanding, effects and prevention of child maltreatment. Clients will develop safety plans and will be informed and/or linked with appropriate community resources.

Budget Counseling – Counselor meets once/month for four months with adult client/s to identify and track income and expenses to maximize use of resources to meet needs and wants. The UK Extension Office’s Family Spending Plan is used to create a baseline, set goals and monitor progress.

Support Services/Case Management – Generalist social work services that enhance family or individual functioning are provided. Referring worker should specify what is needed in blank provided above.

AUTHORIZATION FOR RELEASE OF INFORMATION



Catholic Charities of the Diocese of Lexington
60 Martha's Vineyard Prestonsburg, KY 41653 (606)874-9170 (phone & fax)

1. **THE UNDERSIGNED HEREBY AUTHORIZES** _____
 (Facility)

 (Address)

TO RELEASE INFORMATION FROM THE RECORD OF:

 (Name)

 (I.D. Number)

 (Birth Date)

 (Dates of Treatment/Service)

2. **INFORMATION TO BE RELEASED TO:** _____

3. **TYPE OF INFORMATION TO BE RELEASED:** _____

4. **PURPOSE FOR RELEASE:** _____

5. It is understood that this authorization for release is subject to revocation at any time, and that unless another date is specified, this release will expire sixty (60) days after date it is signed.

TIME LIMITATION OF RELEASE: _____

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PROHIBITION ON REDISCLOSURE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42 CFR PART 2) PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION EXCEPT WITH THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IF HELD BY ANOTHER PARTY IS NOT SUFFICIENT FOR THIS PURPOSE. FEDERAL REGULATIONS STATE THAT ANY PERSON WHO VIOLATES ANY PROVISION OF THIS LAW SHALL BE FINED NOT MORE THAN \$500, IN THE CASE OF A FIRST OFFENSE, AND NOT MORE THAN \$5,000 IN THE CASE OF EACH SUBSEQUENT OFFENSE.

 Signature of Client

 Address

 Signature of Client's Representative

 Witness

 Relationship

 Date