Believe In Big Change

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Believe In Big Change Referral Form

Referring Agency_____

Contact Name_____ **Contact Info_____**

*Please read the client criteria below before filling out this form and **submitting**

- **We review each applicant on a 'case by case' basis so please complete the entire form.**

BIBC General Eligibility Requirements:

- **Education of GED/HSE preferred but not required.**
- **Single Mothers with 2 children or less. (Children ages 5-12)**
- **Will consider single women without children as well.**
- **Mothers that are not bringing their children are also welcomed.**
- **Minimum of 3 months sobriety**
- **Mental health conditions that are currently being treated**
- **Covid-19 Vaccination Card**
- **Copy of Physical Exam (Less than 6 months)**
- **Copy of TB Clearance**

Note: Core program is for 6 months and is a full-time program! Mothers are not working during this program until Phase IV, so full participation is required. There is no charge for this program and housing, meals, and transportation is provided during the stay.

Reason for Referral:			
CLIENT INFORMATION			Referral Date:
Last Name:		First Name:	
Home Address:			Phone#:
City, State:		Zip:	Ethnicity:
D.O.B:	Age:	Gender: ϒ Female ϒ Male	Social Security Number:
MEDI-CAL #:		Issue Date:	Other Health Insurance:

Other programs involved? WrapAround ϒ DCFSϒ CalWorks ϒ Other:

Birthplace City: State: Country:

CLIENT GOALS:

Family:

Personal:

Professional:

How many children do you have?

Please list the ages of each child.

Are you currently receiving government assistance (Cal works, Cal Fresh, GR, Food Stamps)? If so, then please list the program and the monthly amount that you are receiving.

Can you show proof of citizenship?

Do you have any felonies? If so, please explain and provide the years and the offense.

How many months of sobriety do you currently have?

Are you currently being treated for a mental health condition? If so, then please explain and list the prescribed medication.

Are you currently working with a psychiatrist? If so, then please provide their contact information.

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Referral received by:_____ Date: _____

Appointment Scheduled for:_____ Date/Time:_____

_____

Completed by:_____ Date:_____

BIBC INTAKE NOTES:
