Heartland Assistance Program Referral Form

***** Please fax this form to our office and the client will receive a call back to set up an intake appointment*****
Urbandale phone: 515 331 0303/Fax: 515 331 9086
Pella phone: 641 628 9599/Fax: 641 621 1493

Name of Referring Organization:_____
Leader referring the potential client:_____
Date of the Referral: _____

Name of Client:_____
Date of Birth:_____
Telephone Number: _____

Why is the client being referred for mental health counseling?
_____
_____
_____
_____
Does the referred client have private health insurance with a Mental Health Benefit? (Circle) Yes or No

If yes, please provide the following:
Name of the Insurance Provider:_____
Member ID#:_____
Group ID: _____
Policy Holder's Name:_____
Policy Holder's Date of Birth:_____

If **no**, the organization is committed to (Circle one) **PARTIALLY** or **FULLY** funding the referral's counseling for a duration of _____ sessions. If the client decides to continue with additional sessions after the determined amount of sessions, the client may either seek more financial assistance from the referring facility or they may have to fund their own counseling. If the organization elects to partially fund the referral's counseling, it is assumed that the client has been advised of their responsibility to pay a portion of the bill prior to their intake at Heartland Christian Counseling.

The signatures below indicate that this form has been reviewed between a representative of the Leadership of the Organization and the potential Client being referred to for counseling at Heartland.

_____ _____
Signature of Church Leadership **Signature Client or Guardian (if under 18)**

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