



Marinette County  
**HEALTH AND HUMAN SERVICES**  
 2500 Hall Avenue, Marinette, WI 54143-1604



Voice (715) 732-7700 FAX (715) 732-7667 Toll Free: 1-888-732-7549  
 www.marinettecounty.com

## Comprehensive Community Services (CCS) Program Referral Form Age 18 and older

\*\*Form must be completely filled out when turned in. Contact CCS Manager with any questions.

Please return to: CCS Manager

ccs@marinettecounty.com

Name of referral (include middle initial): \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_

If referral is under guardianship please complete:

Name of guardian: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Phone Number (if different from above): \_\_\_\_\_

Type of health insurance(s) (**REQUIREMENT:** Medicaid): \_\_\_\_\_

Name of treating physician (**REQUIREMENT:** Physician must prescribe CCS program): \_\_\_\_\_

**REQUIREMENT:** Diagnosis of mental illness and/or substance abuse - list diagnosis: \_\_\_\_\_

Please check all that apply:

- Use of multiple services (check all that apply:  Mental health,  AODA,  under court order, other: \_\_\_\_\_)
- Other interventions have not been successful over time

List significant people in the home: \_\_\_\_\_

List significant people outside of the home: \_\_\_\_\_

How are the mental health and/or substance abuse issues causing the need for psycho-social rehabilitation (what issues are caused by the mental health/substance abuse): \_\_\_\_\_

What recovery goals does the referral source want to see (CCS is a recovery based program):  
 \_\_\_\_\_

Name of referral source: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email address: \_\_\_\_\_

Referral Source Signature: \_\_\_\_\_ Date submitted to CCS Manager: \_\_\_\_\_