Codington County Defense Support & Re-Entry Services REFERRAL FORM

Date of Referral: _____ Referred by: _____

Name:	Date of Birth:
Address, City, State/Zip:	Gender:
Current Charges:	Arrest Date:
Case Number/s:	Release Date:
Next Court Date:	Probation/Parole Officer:

Attorney:	Veteran: ___ Yes ___ No
Household members (names & ages):	Employed? ___ Yes, where _____ ___ No
Currently on Medicaid? ___ Yes ___ No	Primary Doctor:
Other Referrals submitted: ___ Yes; Where: _____ ___ No	**ROI must be signed date of referral, see back page.**

NEEDS & REFERRAL

Areas of need:

- Housing: _____
- Food: _____
- Clothing: _____
- Transportation: _____
- Healthcare: _____
- Employment/Career Development: _____
- Mental Health Services: _____
- Peer Support: _____
- Legal Issues: _____
- Income Support/Benefits: _____
- Substance Use Services: _____
- Parenting/Family Support: _____
- Other: _____

Please indicate what is required as part of a probation/parole supervision or a court ordered bond condition: _____

_____

ONCE THE REFERRAL IS COMPLETED, PLEASE EMAIL TO:
Angie.Collignon@codington.sdcounty.gov **OR** Tiffany.Barthel@codington.sdcounty.gov

Program through the Codington County Community Services
7 West Kemp Ave
Watertown, SD 57201
605-882-6286

Office of
Codington County
Community Services

IMPACT
Individuals Making Positive Actions Can Thrive

Codington County Community Services

Authorization for Release of Information

Today's Date: _____

Full Name _____ DOB _____

Address _____ Telephone _____

_____

I, _____, being a client of Codington County Community Services, authorize any person, agency, or institution to provide the Codington County Community Services Office with information regarding my physical, mental, academic, psychological, chemical abuse, social, and economic condition for the purpose of providing appropriate support and determining eligibility for assistance.

I also authorize Codington County Community Services to release such information to _____. All information will be treated as confidential and used only for assistance-related purposes.

I release any person, agency, or institution from any liability for providing such information. This authorization is valid only for use by Codington County Community Services in its administration program and for no other purposes.

A photocopy of this authorization shall be considered as valid as the original and will remain in effect until I end services with Codington County Community Services or submit a written request to revoke it.

Please initial all that apply:

_____ ☐ Open communication to facilitate services

_____ ☐ Release medical records/information

_____ ☐ Release financial information

_____ ☐ Release social history

_____ ☐ Release educational history

Client Signature: _____ Date: _____