Better Health Together (BHT) Community Care Hub – Partner Referral Form

BHT's Community Care Hub (CCH) partners comprise a network of service providers who can assist individuals and families with obtaining services and resources. These include access to: clinics and doctors, food assistance, housing & shelter, transportation, family support, support of substance use disorder, education & employment, connection and community and insurance & benefits.

BHT's CCH partners serve the following counties in Washington: Ferry, Stevens, Pend Oreille, Spokane, Lincoln and Adams. They also serve the Reservations of: The Kalispel Tribe of Indians, The Spokane Tribe of Indians, and The Confederated Tribes of the Colville Reservation.

*Required

Clear Form

Referring Partner Information

Date of Referral:*

Referring Person's Name:*

DCYF Office Making the Referral:*

DCYF Unit Type (i.e., CPS, FAR, etc.):*

Referring Person's Phone Number:*

Referring Person's Email Address:*

Are you referring an older adult, or an adult with a disability seeking support to live independently?* Yes ◯ No ◯

Please indicate reasonable accommodations, if needed:

Permission from individual to place the referral?* Yes ◯ No ◯

Once your individual is assigned a CCH service provider, they may complete a Release of Information (ROI) pertaining to the services they receive. You may request inclusion on the ROI in order to receive relevant service information.

Request to include the referring partner above on the ROI obtained by the assigned CCH partner? (ROI not guaranteed) Yes ◯ No ◯

Individual Being Referred

First Name:*

Last Name:*

Famlink Case ID:*

Case Status : Open for DCYF intervention and ongoing services ◯ Closing/Closed ◯

Date of Birth:*

Phone Number:*

Email Address:

Is the individual unhoused?* Yes ◯ No ◯

Residential Street Address (if applicable):

Suite or Apartment #:

City:*

State:* Washington

Zip Code:*

If the individual is unhoused, please share the zip code of the area they slept last night. For example, if they slept at House of Charity last night, you would input the downtown metro area zip code of 99201.

Total number of household members (including the individual):*

Demographics

Collecting demographic data helps us understand different groups and better meet their needs. It allows us to adjust services and communication to fit each person and helps make sure people are referred to the right services for support.

Preferred Language:* English ◯ Russian ◯ Spanish ◯ Japanese ◯
French ◯ German ◯ Arabic ◯ Chinese ◯ Other: ◯

Race (check all that apply):* American Indian-Alaska Native ☐ Asian ☐
Black-African-American ☐ Pilipino ☐ Native Hawaiian-Pacific Islander ☐
Chinese ☐ White-Caucasian-Blanca ☐ Prefer not to answer ☐ Other

Is the individual a tribal member?* Yes ◯ No ◯ Unsure ◯

If yes, which Tribe(s)?:

Is the individual's ethnicity?* Not of Hispanic/Latino/Latina or Spanish Origin ◯
Hispanic/Latino/Latina ◯ Prefer not to answer ◯

What gender they most identify with?* Male ◯ Female ◯
Non-Binary/third gender ◯ Transgender Male to Female ◯
Transgender Female to Male ◯ Two-Spirit ◯ Genderqueer ◯
Prefer not to answer ◯ Other ◯

Additional Information

Preliminary resources/connections/community services identified (check all that apply):

Connection& Community ☐ Educational/Employment support ☐ Food ☐
Family Support ☐ Housing ☐ Household Safety, Organization/Cleaning ☐
Insurance & Benefits ☐ Medical Care/Support ☐ Mental Health ☐
Transportation ☐ Utilities ☐ Substance Use Disorder ☐ Other

Additional Information or Notes (i.e., Best time of day to reach individual, best methods of contact, engagement strategies):

Please securely email the completed referral to:
communityreferrals@familyimpactnetwork.org