

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**

Referring Partner Information

Date of Referral:*

Referring Person's Name:*

Agency Making the Referral:*

Referring Person's Role (i.e., CASA, GAL, Attorney, OPD Social Worker, Parent Ally):*

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

Individual Being Referred

First Name:*

Last Name:*

Date of Birth:*

Phone Number:*

Email Address:

Is the individual unhoused?* Yes No

Residential Street Address (if applicable):

Suite or Apartment #:

City:*

State:*

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):*

Is the individual institutionalized?* Yes No

If yes, what is their release date?

DCYF Famlink Case ID (if available):

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**