Kentucky Counseling Center Referral Form

FAX to 502-631-9660
Or Email to sgrammer@kentuckycounselingcenter.com

Date: _______________ Referred by: _____________________________________

Client Name: ______________________________________

School Name:____

Age: ______ DOB: _____________________ Male/Female:______________

Parent/Guardian: _______________________________ Phone #: _________________________

Full Address: ____

Insurance Information:

1. Insurance:
   Passport: ____ WellCare:____ Humana CareSource____
   Aetna/Coventry Medicaid: ____ Anthem Medicaid: ____ Traditional Medicaid:____

   Other Insurance:______________________________

2. Medicaid Number- (10 digit number typically begins with 00 or 01)_______________________________

Is this individual currently receiving outpatient services? What Agency?

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Needs: Counseling: ____ Psychiatry: ____ Case Management: ____

Why individual is being referred for services?

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1939 Goldsmith Lane #143 Louisville, KY 40218 | Phone: 855-591-0092 | Fax: 502-631-9660 | Web: kentuckycounselingcenter.com