Zero Hour Life Center Inc
www.zerohourlifecenter.org

RECOVERY SUPPORT SERVICES REFERRAL

FL: (352)765-4943
NC: (910)340-0100
Send referral to:
Fax: (352-)388-1921

DATE OF REFERRAL:		**Intake Date:**	
COUNTY:	☐ CITRUS ☐ MARION ☐ HERNANDO ☐ SUMTER ☐ LAKE ☐ ONSLOW ☐ OTHER _____		
PROGRAM:	☐ RECOVERY COACHING ☐ PEER RECOVERY SUPPORT MEETINGS ☐ SOAR (SSI/SSDI) ☐ MEDICAID/SNAP ☐ CRIMINAL OFFENDER RE-ENTRY ☐ SEN ☐ TEEN RECOVERY PROGRAM		

CLIENT INFORMATION

CLIENT NAME:					
IS THE APPLICANT AWARE OF THE REFERRAL?		YES		NO	
APPLICANT DATE OF BIRTH:		CONTACT NUMBER:			
PHYSICAL ADDRESS:					
MALE	☐	FEMALE	☐	RACE/ETHNICITY:	MARITAL STATUS: S M D W
VETERAN: YES ☐ NO ☐		HOMELESS OR AT RISK (CIRCLE ONE)			
REASON FOR AT RISK:					
IF HOMELESS, LOCATION APPLICANT SPENDS NIGHTS:					
HAS APPLICANT BEEN DIAGNOSED WITH A MEDICAL CONDITION?		YES	NO	UNKNOWN	
HAS APPLICANT BEEN DIAGNOSED WITH A MENTAL HEALTH DISORDER/DISEASE?		YES	NO	UNKNOWN	
LIST ANY DIAGNOSIS					
DOES APPLICANT HAVE A CASE MANAGER? YES ☐ NO ☐					
CASE MANAGER NAME:		PHONE:			
DOES APPLICANT HAVE A RELIABLE CONTACT PERSON? YES ☐ NO ☐					
CONTACT NAME:					
CONTACT PHONE:		CONTACT EMAIL:			

REFERRAL SOURCE INFORMATION

NAME:		TITLE/ROLE:	
AGENCY:		PHONE:	
EMAIL:		FAX:	
REFERRAL SIGNATURE:			

Comments: