



**CASE MANAGEMENT INTER-AGENCY
REFERRAL FORM**
ND DEPARTMENT OF HUMAN SERVICES
LIHEAP
SFN 98 (3-2006)

The Privacy Act of 1974 (P.L. 93-579, Section 7) requires the following information be provided when individuals are requested to disclose their social security number. Disclosure of your social security number is voluntary and it is requested for identification purposes. Failure to disclose this information will not affect participation in this program.

Date:

TO:

Name:

Address:

City:

State:

Zip Code:

Telephone Number:

Case Number:

Social Security Number:

The North Dakota Department of Human Services has entered into an agreement with the Community Action Agencies (CAP) for case management services. The purpose of this referral to CAP is to assist you to obtain training, seek employment services, adequate housing, financial counseling, energy services, or other services to help you.

Goal Statement: I will work with a case manager to resolve the following problem(s):

The county social service board staff is making a referral to the Community Action Agency for services to resolve the above problems. It is your responsibility to keep your appointment with them and work toward resolving the stated problems.

I give my permission to the following County Social Service Board to make referrals and to request and receive a progress report for the eligibility worker. This Release of Information will be valid for 12 months or until the above problems are resolved, whichever occurs first. (County Social Service Board)

Client Signature:

Date:

Worker/Agency: