CASE MANAGEMENT INTER-AGENCY REFERRAL

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

LIHEAP

SFN 98 (8-2022)

Clear Fields

Date

To

Client Name				
Address		City	State	ZIP Code
Telephone Number	Billing Number	Case Number	Social Security Number*	

* 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.

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 Human Service Zone office 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 staff of the Human Service Zone Office 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. Zone Office:

☐ I understand that by checking this box and typing my name below, I am signing the Case Management Inter-Agency Referral (LIHEAP). I agree that my electronic signature is the legal equivalent of my handwritten signature.

Client Signature	Date

Worker/Agency