Heartland Health Services
Community Engagement Referral

Date: ______________________________
Referral Organization: ____
Staff Member: __________________________________ Contact Info: ______________________________

Applicant Information

Person Being Referred: _______________________________________ DOB: __________________________
Sex: ___ Male ___ Female Ethnicity: _________________
Phone Number(s): _________________________________ Email: ____________________________________

May we leave a detailed phone message? ___ Yes ___ No

Areas of Referral (please check all that apply):

____ Medicaid ____ Medicare/Medicare Savings Program ____ Marketplace
____ Social Security ____ Food Pantry ____ Heartland Financial Assistance Application
____ OSF Financial Assistance Application ____ Unity Point Financial Assistance Application
____ Housing Resources ____ Safelink Application ____ Transportation ____ Primary Care
____ Diabetic Education ____ Benefit Access Assistance ____ Legal Assistance
____ Mental/Behavioral Health ____ Health & Wellness Education ____ Nutrition
____ Other: ____

Consent for Release of Information

APPLICANT AUTHORIZATION: I, ____________________________________ (print applicant name), authorize staff of _____________________________ (organization name) to refer me to Heartland Health Services. I understand that a referral to Heartland Health Services does not guarantee services or requests will be approved.

Agreed: ____ (signature/authorization of applicant required)

Date: _____________________

Please email completed referral form(s) to: outreach/enrollment@hhsil.com or call 309-680-7632
www.hhsil.com

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