



Use this form to refer a veteran to The Kaufman Fund Mental Health Collaborative to receive mental health services. This form is for those organizations who are not yet members of the CIE.

Once completed, the form needs to be emailed to [anortz21@gmail.com](mailto:anortz21@gmail.com) AND [downslauren123@gmail.com](mailto:downslauren123@gmail.com)

**If you are a CIE member, please login to Unite Us to complete the referral form there.**

First and Last Name			
Date of Birth		Last 4 of social security	
Email			
Phone Number			
Address			
current mental health needs/concerns			
Barriers?			
Therapist preferences	Male / Female / no preference	Virtual / In person / no preference	
Insurance, if any			
Income, if any			
Person making referral name and contact info			

**Consent to Participate in the Unite Us Network**

By consenting, you agree to share information with a Network of health and social service partners powered by Unite Us software. This Network is made up of entities and individuals who are directly involved in your care or payment of care. Your personal information may be shared securely on the Network in accordance with privacy laws to connect you with services.

This consent covers all information shared by you or by anyone that has the right to share information on your behalf and is relevant to the recipient's involvement in your care or payment for your care. You can always limit the information you provide on the Network by requesting to have it removed.

To understand how your information may be used and kept safe on the Network, please see [uniteus.com/privacy](http://uniteus.com/privacy).

If you no longer want your information shared on the Network, you can email [consent@uniteus.com](mailto:consent@uniteus.com) or ask any Network partner.

Client: Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Personal Representative or Guardian (only if applicable):

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_