





Whole Person Wellness Referral Form



Date of Referral: _____

Client Name: _____	Date of Birth: _____
Last 4 of SSN: _____	Phone #: _____
Email: _____	
What area in San Diego does the person experience homelessness/risk of homelessness: _____	

Referring Agency: _____	Phone #: _____
Contact Person Name: _____	Best Contact Information: _____
Does your program fall into any of these type of programs:	<input type="checkbox"/> Justice Involved <input type="checkbox"/> Mental Health <input type="checkbox"/> SUD <input type="checkbox"/> N/A

What type MediCal coverage does the person have? (Managed Care Plan, FFS, Special Program, etc.) Member ID:	
How many ED and in-patient stays has the person had in the past 12 months?	
What is the current living situation of the person? (<i>Streets, emergency shelter, apartment, etc.</i>)	
What Mental Illness, Substance Use Disorder, or Chronic Health Conditions does the person have?	
Does the person have a terminal illness with less than one-year life expectancy?	

Any other pertinent information:

Release of Information Included: Yes No *If no, why:* _____

South/East, Central County Riley McGuire Ph: (619) 810-8638	North County Noelani Dizon Ph: (760) 201-5998
<i>Please e-mail South/East/Central County referrals to WPWreferral@epath.org or fax to 619-346-4536</i>	<i>Please fax to: (760) 305-4780 or email to: exoduswpwreferrals@exodusrecovery.com</i>