

Advancing the wellness
and leadership capacity
of Latino populations.

Avanzando el bienestar
y la capacidad de liderazgo
de la gente Latina.



Request for services of Promotor/Promotora REFERRAL FORM

A promotor/a is a cultural broker who helps Latinos receive culturally and linguistically appropriate services. They build a bridge of trust between providers and the recipient, which improves outcomes for Latinos and helps the provider better understand the cultural nuances of their families.

For Promotor/a Use Only

Date Opened _____

Date Re-Opened _____

Date Entered into Dbase: _____

Date Emailed to Mgr _____

Date Entered into Universal Tracker _____

CREER / FSP / First5 / SGPIT / PP/ NEOP

| | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------|----------------------|----------|-------------------|------------------------|
| Date of Request: | | Full Legal Name: _____ DOB: _____ Age: _____ | | | | |
| | | Preferred Name: _____ | | | | |
| Date of Service: | County of Origin | #Yrs in US Mono SP? Y or N | School | Ed Level | Empl Status \$ | Health Ins.? Y or N |
| Address: | | Apt. # | City, State, Zip | | | |
| Cell #: | | OK to leave message? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | |
| Alternate #: | | OK to leave message? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | |
| Best Time to Reach Family: | | Su M T W Th F Sa | | | Times: | |
| Family Members: | First Name: | | | | | |
| | Middle Name: | | | | | |
| | Last Name: | | | | | |
| | Relationship: | | | | | |
| | Date of Birth: | Age: | Age: | Age: | Age: | Age: |
| | Schools: | | | | | |
| | Insurance: | | | | | |
| | Ed. Level: | | | | | |
| | Empl. Status: | \$ | \$ | \$ | \$ | \$ |
| Issues / Concerns (please be specific as to why you believe this would be an appropriate referral for a promotor/a): | | | | | | |
| Would you say this person's need (Acuity) is: 3 (high need) 2 (medium) 1 (low / early stages) | | | | | | |
| Have you informed the patient/family about the submission of this referral? | | | | | | (Y or N) |
| Referring Person | | | Affiliation / Agency | | | |
| Phone Number | | | Email | | | |
| Best Day / Time to reach you (should we have any questions) | | | | | | |
| Please call 530-320-5353 to arrange follow up. You may go to LatinoLeadershipCouncil.org website home page and complete ONLINE Referral or email this form to Referral@LatinoLeadershipCouncil.org . | | | | | | |



If possible, have client sign this disclosure. If not, the promotor/a will meet with them and have them sign. If you need the client to complete your **AGENCY** disclosure form in order to communicate with us about this case, please email that form with this referral form and we will have them complete that also when we meet with them.

AUTORIZACIÓN PARA DIVULGAR INFORMACIÓN CONFIDENCIAL

Comprendo que he sido referido a un/a promotor/a. Autorizo que la agencia/persona que me refirió comparta mi información con el/la promotor/a del LLC, esto incluye los/las promotoras, la coordinadora del Promotores y otros colaboradores para que dialoguen acerca mis necesidades para poder crear estrategias para ayudarme a mí y a mi familia.

Entiendo que LLC debe informar el número de personas con acceso a los servicios y los resultados del paciente a sus financiadores. Estos datos se introduce en una base de datos, que está protegida por contraseña, e información específica a disposición del equipo de promotores de LLC, terapeutas u otros miembros del equipo que trabajan con la familia (s). Toda la información es estrictamente confidencial. Los informes presentados a los financiadores corresponden solamente al total de números reportados y en ningún modo identifican a los clientes por su nombre.

Nombre _____

Fecha _____

Firma _____

Esta autorización se vence en un año a partir de la fecha de hoy a menos que sea anulada antes por el cliente

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

I understand that I have been referred to the Promotor/a program. I authorize the referring agency / person to share my information with the Latino Leadership Council's Promotor/a team, including the promotor/a, the Promotor/a manager and their collaborators so that they can discuss my family's needs and develop strategies to help my family and me.

I understand that the LLC is required to report numbers of people accessing services and client outcomes to its funders. This data is input into a database, which is password protected, and specific information made available to the LLC team of promotores, therapists or other team members working with the family (ies). All information is treated as strictly confidential. Reports provided to funders are tallied with only aggregate numbers reported and do not in any way identify any clients by name.

Name _____

Date _____

Signature _____

This authorization expires one year from today's date unless earlier revoked by client.