

REFERRAL FORM - (A NEW REFERRAL IS BEING CREATED)

Refer To: Provider IDHS (Reverse Referral)

Mid-South - Cook County - 3.0 mi

Participant Being Referred: [Redacted]

Participant Username: [Redacted]

Participant Birthday: 5/21/2002

[Review Assessment](#)

No Active Customer Consent for the provider selected has been found.

[Submit for Customer Consent](#) [Submit](#)

Submit a customer referral:
Submit for Customer Consent

CUSTOMER CONSENT: (TAMARA RADCLIFF)

If you do not understand something or have questions, be sure to ask.

I hereby authorize (Mid-South - Cook County - 3.0 miles) to view Employment & Training Program information for the purpose of providing me with service coordination. Information entered into the system will be disclosed to Department of Human Services only as necessary in order to administer the service coordination or for audit and evaluation purposes.

I understand that I may revoke this consent at any time in writing, but that revoking it will not cancel what was already done before I revoked it. I understand that I have the right to inspect and copy the information that is disclosed. If not previously revoked, this consent will terminate upon the completion of the service coordination, but in no event shall exceed one year from today.

It has been explained to me that if I refuse to consent to this disclosure or if I revoke my consent during the case coordination I may not receive case coordination services and my public assistance may be affected. I understand that I may, however, receive mental health services and substance abuse treatment services without agreeing to this consent.

OPTION 1 - UPLOAD A SIGNED REFERRAL FORM (SIGNED 4970, IDHS INFORMATION RELEASE FORM, PROVIDER INFORMATION RELEASE FORM: [CLICK HERE FOR FORM](#))

I attest that the uploaded form contains a customer signature

Two options:

OPTION 2 - ENTER CUSTOMER USERNAME AND PASSWORD

Upload signature page
Username and password

Customer Username: [Input Field]

Password: [Input Field]

I have read and agree to the terms

[Submit Consent](#)

Can't remember password - reset on any page of the customer profile.

ISETS OVERVIEW

Overview | Intake/Referral | EP/Case Management | Customer Form

OVERVIEW

Profile: Tamara Radcliff [Update Demographic Information](#)

Email

DOB 05/21/2002

User Name Tamararadcliff

Last 4 SSN 6149

Individual Number 1007280083

Redetermination Date 03/07/2025

Midpoint Date N/A

Enrollment Date N/A

E&T Provider(s) N/A

Provider(s) Pending Referral N/A

DHS Office Unassigned

Program Enrollment N/A

[See All](#)

[Reset Password](#)

Participant Summary Tools

[Assessments](#)

Referrals

Status

- Redetermination Date:** [Link to: ABE - Manage My Case](#)
- E&T Status:**
- Most Recent Case Note:**
- Universal Assessment:**
- Level of Progress:**
- Employment Verification Status:**
- SNAP Case Number:**
- SNAP Eligibility Status:**
- Individual Number:**

[Save](#)

Integrated Resource Team

Attendance

Activities / Case Management

Support Services

<https://www.illinoisworknet.com/DownloadPrint/445179-202209.pdf>

The above checked information is to be disclosed to the DEPARTMENT OF HUMAN SERVICES, only as necessary in order to administer the service coordination or for audit and evaluation purpose.

I understand that I may revoke this consent at any time in writing, but that revoking it will not cancel what was already done before I revoked it. I understand that I have the right to inspect and copy the information to be disclosed. If not previously revoked, this consent will terminate upon the completion of the service coordination, but in no event shall exceed one year from today. It has been explained to me that if I refuse to consent to this disclosure or if I revoke my consent during the case coordination, I may not receive case coordination services and my public assistance benefits may be affected. I understand that I may, however, receive mental health services and substance abuse treatment services, without agreeing to this consent.

Check here if client refuses to sign the consent.

Signature of Client: _____ Date: _____

Signature of Parent, Guardian, or Authorized Representative (if appropriate) _____ Date: _____

Signature of Witness: _____ Date: _____

NOTICE TO RECEIVING PERSON: The information released hereunder may not be re-disclosed except as set forth herein or as otherwise allowed by law. If the information pertains to substance abuse services, it has been disclosed to you from records