



Bad River Social and Family Services

OUR MISSION STATEMENT

To provide services, referrals, and program support that promote self-sufficiency, family unity through our cultural teachings, economic stability, and wellbeing to eligible families in our service area.

REFERRAL FOR SERVICES

REFERRAL INSTRUCTIONS

- 1. Drop referral form off in person at 72772 Elm Street, Odanah, WI, 54861.**
With the Social and Family Services Administrative Assistant.
- 2. Fax referral form to (715) 682-7883.**
Attention to Social and Family Services Administrative Assistant.
Include “Confidential Referral” on the cover sheet.
- 3. Email referral form to sfsreception@badriver-nsn.gov.**
Include “Confidential Referral” in the subject line.
- 4. Mail referral form to P.O. Box 55, Odanah, WI, 54861.**
Addressed to Social and Family Services Administrative Assistant.
Include “Confidential Referral” on the envelope.

CONTACT INFORMATION

Social Services Administrative Assistant
(715) 682-7127 Extension 1400
sfsreception@badriver-nsn.gov
72772 Elm Street Odanah, WI 54861



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Full Name: _____
Last *First* *M.I.*

Address: _____
Physical Address *Apartment/Unit #*

City *State* *ZIP Code*

DOB: _____ SS#: _____

Phone: _____ Type: Home Cellular Work

Message: Yes No Email: _____

Preferred method of communication: Phone Text Email Mail

Are you a tribal member? Yes No Tribal ID: _____

Individual completing the referral:

Name	Agency	Phone No.

Individual to receive referral:

Name	Program	Phone No.

Purpose of Referral:

- Coordination of services Determine eligibility for services
 Continuity of services Program administration
 Other: _____



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I understand that:

- By signing this “Referral for Services,” I certify that the information provided is true and correct. Any information obtained will be kept confidential and used only for the purpose of determining eligibility and/or providing services.
- My personal information and information concerning my case will be exchanged between identified agencies and/or individuals.

Client Signature

Date

Witness Signature

Date

FOR OFFICE USE ONLY

Date Received:

Staff Initials:

Confidentiality Notice: This document contains confidential information that is legally privileged, confidential, and exempt from disclosure. The information is intended only for the use of the individual or entity listed. If the reader of this document is not the intended recipient, you are hereby notified that any disclosure dissemination, copying, distribution or taking of any action in reliance on the contents of this confidential information, is strictly prohibited. If you have received this communication in error, please destroy it and immediately notify our agency.