Korean Community Center of the East Bay

Service Referral Form

Client Information	
First Name:	Last Name:
DOB:	Sex: F ☐ M ☐ Other
Email:	
Phone:	Preferred language:
Address:	

Emergency Contact	
Name:	Phone:

Reasons for Referral		Service Request
☐ Depression	☐ Financial stress	☐ Asian Community Wellness Program
☐ Anxiety	☐ School stress	☐ Senior Case Management Program
☐ Trauma	☐ Housing	☐ Immigration Legal Service
☐ Grief/loss	Others:	☐ Social Services Program
☐ Violence/abuse		

Referee information	
Organization:	Name:
Phone:	Email:
Risk: ☐ Self-harm ☐ Suicide ☐ Homicide ☐ Violence	
Presenting problems and additional note:	

Please contact/email KCCEB after completing the referral form:

christina@kcceb.org | (844) 828-2254 | 101 Callan Ave, Suite 400, San Leandro, CA 94577