CompeerCORPS
Camaraderie • Support • Friendship

Program Referral Form
"Veterans" Connection

Mental Health Association in Butler County
140 N. Elm Street, Suite A, Butler, PA 16001
(724) 287-1965, ext. 228 or (724) 287-4083
Fax: (724) 287-7090

CLIENT REFERRAL INFORMATION: to be completed by the referring Agency

Name: _____

Address of Residence: Street: _____

Apt. #: _____ City: _____ State: _____ ZIP: _____

Mailing Address: Street: _____ P.O. Box: _____

City: _____ State: _____ ZIP: _____

Telephone: ( ) _____ E-mail: _____

Date of Birth: ____/____/____

Is Transportation Available? Yes: ____ No: ____ Own a car? Yes: ____ No: ____

Age: _____ Height: _____ Weight: _____ Race: _____

Religion/Faith: _____

Branch of Service: Army: _____ Navy: _____ Air Force: _____ Marines: _____

Reserves: _____ National Guard: _____ Other: _____

Years of Military Service: _____ Military Discharge Date: ___/___/___

Married: ___ Single: ___ Divorced: ___ Separated: ___ Widow/Widower: _____

Number of children: _____ Ages of Children: _____

Does client have D&A Diagnosis? Yes: ____ No: ____

Is client currently under D&A treatment? Yes: ____ No: ____

Please continue next page

Compeer United Way

NREPP Included in SAMHSA's National Registry of Evidence-based Programs and Practices

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(Please give information that will help in making a good friendship connection with a volunteer.)

Current Hobbies or Special Interests: _____

_____

_____

Social Functioning/Personality: _____

Positive Attributes: _____

The CompeerCORPS Program provides mental health wellness through camaraderie, Trust and Support with "Vet to Vet" connections

Stability & willingness to participate in the **CompeerCORPS** Program:_____

Suggestions to guide the **CompeerCORPS** volunteer in developing a friendship: _____

_____

Preference to: Age: ____ Race: ____ Smoker: Yes: ____ No: ____

Client Availability: Daytime: ____ Evening: ____ Week-end:_____ Anytime: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Physical Limitations / Medical Conditions: _____

Referral submitted by: _____

Title: _____ Provider/Agency: _____

Address: _____ Zip: _____

Telephone: ( ) _____ Best time to call: _____

Primary Therapist (if different from above): _____

Agency/Provider: _____

Address: _____ Zip: _____

Telephone: ( ) _____

It is understood by the Referring Provider Agency that the applicant will be placed on a waiting list because volunteers from the community may not be immediately available to complete a "vet to vet" connection. All information on this referral form is held confidential with HIPAA compliance.

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Date of Referral: _____/_____/____

RELEASE OF INFORMATION: CompeerCORPS Program

Mental Health Association in Butler County
140 North Elm Street, Suite A
Butler, Pennsylvania 16001

Phone: (724) 287 - 4083
Fax: (724) 287 - 7090

I, _____, do hereby consent to and Authorize _____ to disclose to the

_____ Mental Health Association
_____ CompeerCORPS Program Coordinator / Volunteer
_____ Mental Health Advocate
_____ Other: _____

Information from my case records. I understand the reason for this ***Release of Information*** is to facilitate program guidelines, and to allow program coordinators and advocates to discuss information with collaborative agencies, providers, or others for the purpose of helping with a specific problem or complex situation.

I understand that information discussed in consultation and networking with services could include:

Social Services _____ Therapy Notes _____ Medication Maintenance _____
CompeerCORPS _____ Substance Abuse (Drug/Alcohol) _____ Housing _____
VA Recovery _____ other (please explain): _____

This statement must be signed upon entering the CompeerCORPS Program or programs at the Mental Health Association and may be revoked at any time. This Release of Information will remain confidential and in compliance with the Mental Health Association's HIPAA policy guidelines. This Release of Information will remain in force for a reasonable period of time and may be updated periodically.

Signed: _____

Witness: _____

Date: _____

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