



# 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: \_\_\_\_\_

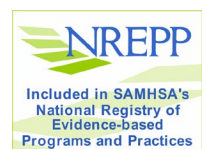
Does client have D&A Diagnosis? Yes: \_\_\_\_ No: \_\_\_\_

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

**Please continue next page**



"Thank you for your Service"  
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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.

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: \_\_\_\_\_