CompeerCORPS
Camaraderie • Support • Friendship

Program Referral Form
"Vet2Vet" 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

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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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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: ______________________________