Greater Reading Mental Health Alliance

Referral/Intake for Peer Support Services

MEDICAL ASSISTANCE/CCBH REQUIRED FOR THIS SERVICE

Today's Date: _____

Referring Agency: _____

Person Making Referral: _____

Individual's Information

Name: _____ Male: _____ Female: _____

Social Security #: _____ **MA #:** _____

Address: _____

_____

Home Phone #: _____ Cell Phone #: _____

Marital Status: **S M W D SEP**

Type of living situation (Family, independent, Personal Care Home, Shelter, Homeless, Other):

_____

Case Management Agency: _____ Contact Person: _____

Address and Phone Number: _____

Family Physician: _____ Phone: _____

Therapist and Agency: _____ Phone: _____

Significant Health Problems/Special needs: _____

_____

Are you a smoker? Yes _____ No _____

Drug & Alcohol History: Yes ____ No _____ Legal History: Yes ____ No _____

Probation/Parole (Type/Probation officer and Phone): _____

_____

Medical Advance Directive: Yes ____ No ____ Psychiatric Advance Directive: Yes ____ No _____

WRAP: Yes ____ No ____ Safety/Crisis Plan: Yes ____ No _____

Emergency Contact Name and Phone Number: _____

_____

Relationship to Emergency Contact: _____

Additional Information: _____

_____

Consumer Signature: _____ Date: _____

Signature/Person Completing Form: _____ Date: _____

Please **FAX** the completed form to the Greater Reading Mental Health Alliance: 610-775-4000, or scan to Brittany Millard: brittanymillard@grmha.org.

If you have any further questions, please call us at 610-775-3000.

Revised: 5/19