Five County Mental Health Authority
Community Capacity
Referral Form

Client: ____________________________ **D.O.B**: ___________ **Age**: _____

Sex: M F **Phone** # (H): _______________ **SS#**: _________________

Address: ____

____

County: ________________________________ **Phone Number** (H): __________________

Family Contact/Natural Supports (*List name, relationship to client, and contact information):*

____

Primary Diagnosis: ____

☐MediCAID ☐MediCARE ☐Health Choice ☐DSS ☐Thomas S ☐CTSP ☐Self Pay INSR _____________________

Amount of Monthly Income: ___________________ Does client have a payee? Yes No (Circle Answer.)

Eligibility Criteria (Please check appropriate criteria)

Level I: _____ Olmstead Client or proposed Olmstead discharge

Level II: _____ Minimum of 3 admissions to JUH/ Cherry Hosp. or one JUH/Cherry Admission of "30" days or longer during the past fiscal year

Level III: _____ an individual shall receive at least community support services and demonstrate a need for comprehensive supportive services to reduce risk of psychiatric decompensation and to ensure housing stability community tenure. Briefly describe services provided____

____

Dates of Admissions and Discharges of State Hospitalization(s) _______________________________________

Dates of Daytime or After-Hours Emergency Contacts____

What type of service To Which Client Is Being Referred:

________ Housing (rental, utilities, etc)

________ Transportation

_______ Other

Other pertinent information: (ex: potential for violence) ____

____

Legal Involvement: Yes No ____

____

Referral Source (*Name and Agency*): ____

Referral Source telephone#:____

Signature of person making referral: ____

Send or fax Completed form to: Five County Mental Health Authority 134 S. Garnett Street Henderson, NC 27536 ATTN: J. Rice
Fax # 252-431-3467 (phone) 252-430-3073

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