

**COMMUNITY HOPE, INC.
Referral Form
Hope for Veterans Program**

Date: _____ Referral Contact Name: _____
 Phone: _____ Relationship to Consumer: _____
 Check here, if authorization is given to add Referral Contact's information to Community Hope mailing list.
 Complete Mailing List Contact Information Form.

Consumer Name: _____
 Address: _____
 Phone #: _____ Marital Status: _____
 D.O.B.: _____ Age: _____ Sex: _____ Social Security #: _____
 Income Source & Amount: _____ Insurance # (Medicaid/VA Pension #): _____
 Military History: _____
 Veterans/ Discharge Status: Honorably Discharged Medical Discharge Dishonorably Discharged
 Current Housing Arrangements: _____
 County of Origin (prior to hospitalization/ domiciliary admission): _____

Reason Referred: _____

Psychiatric Treatment Information (include psychiatrist): _____

 Diagnosis _____

Medical Information: _____

 Medications & Prescribing MD: _____

Personal Information (family, cultural, education, vocational, legal): _____

 Substance Use/Abuse Information: _____

FOR COMMUNITY HOPE USE ONLY (Plan of Action):
 ___ Complete Pre-Admission Evaluation– Assigned To _____ Evaluation Date _____
 ___ Meets Intake Criteria – No Resources Available – Add to Referral List
 ___ Does Not Meet Intake Criteria – Follow Up Action Taken/Date _____

FOR COMMUNITY HOPE USE ONLY (Reason for Ineligibility):

<input type="checkbox"/> Non-Psychiatric Diagnosis	<input type="checkbox"/> Consumer declined services	<input type="checkbox"/> Unable to meet Communication Needs
<input type="checkbox"/> Actively destructive or disruptive	<input type="checkbox"/> Unable to meet Medical needs	<input type="checkbox"/> Does not meet Veterans Criteria
<input type="checkbox"/> Actively Suicidal or Homicidal	<input type="checkbox"/> History of At-Risk behavior	<input type="checkbox"/> Does not meet Sobriety Criteria
<input type="checkbox"/> Consumer placed in alternative services		<input type="checkbox"/> Does not meet Homelessness Criteria

Referral Source Name (print) _____ Referral Source Signature, Credentials, & Title _____ Date _____

Community Hope Employee Name (print) _____ CH Employee Signature, Credentials & Title _____ Date _____

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The following Supporting Referral Documents are required prior to admission to the Hope for Veterans Program:

- Verification of Honorably Discharged Veterans Status (Copy of DD214)**
- Verification of Axis 1-5 Diagnosis authenticated by licensed professional (i.e. LCSW, MD, APN, etc.)**
- Complete Medical History including most recent physical and blood work analysis
- Psychiatric Treatment History
- Alcohol/ Substance Abuse Treatment History (including verification of 90 days of sobriety)
- Most recent Biopsychosocial Assessment
- Current Mental Status Exam
- History of At-Risk Behavior (i.e. Suicide Attempts, Suicidal Ideation, Homicidal Attempts, Homicidal Ideation, Criminal/ Legal History, Flight Risk/ Elopement History, Trauma History, etc.)
- 30 Day Progress Note History
- Current Financial/ Income/ Benefits Information

In the event the consumer is eligible for services at the Hope for Veterans Program, the following documentation will be required within 30 days of enrollment in the Hope for Veterans Program:

- Discharge Summary from the pre-admission service provider (i.e. VA Domiciliary, outpatient substance abuse treatment, community service provider, etc.)