



# Mental Health Association in Passaic County Community Advocates / Peer Outreach Support Team Referral Form

REFERRAL SOURCE/NAME (self, family member, case manager, etc.)

DATE

## Community Advocate services requested for:

NAME:

ADDRESS:

TELEPHONE:

## Identifying Information

DATE OF BIRTH

AGE:

Male  Female

GENDER

SOCIAL SECURITY

Caucasian  African-American  Latino/Hispanic  Asian/Pacific Islander  Native American  Other

RACE / ETHNICITY

RELIGIOUS AFFILIATION (if any)

Lives Independently  With Family  Supervised Residence  Boarding Home  Other

LIVING SITUATION

DIAGNOSIS / EXPLAIN MENTAL ISSUES

TYPE OF SERVICE REQUESTED

## Emergency Contact

NAME

ADDRESS

TELEPHONE

RELATIONSHIP



**Mental Health Association in Passaic County  
Community Advocates / Peer Outreach Support Team  
Referral Form**

**Release of Information**

I, \_\_\_\_\_, authorize \_\_\_\_\_  
**CLIENT'S NAME** **REFERRAL SOURCE**

to release the above information to the Mental Health Association Community Advocates program. I understand that a representative of the Mental Health Association will contact me prior to my participation in this program. All of the information contained here is accurate.

\_\_\_\_\_  
**CLIENT'S SIGNATURE** **DATE**

\_\_\_\_\_  
**SIGNATURE OF PERSON MAKING REFERRAL** (if other than client) **NAME OF PERSON MAKING REFERRAL** (please print)

\_\_\_\_\_  
**DATE**

**Please mail or fax to:**  
Mental Health Association in Passaic County  
404 Clifton Avenue  
Clifton, NJ 07011  
Phone: (973) 478-4444  
Fax: (973) 478-0941