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

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

RELIGIOUS AFFILIATION (if any)

❑ Lives Independtly ❑ 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
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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