Crawford County Mental Health Awareness Program, Inc.
(CHAPS)
944 Liberty Street ~ Meadville, PA 16335 ~ (814) 333-2924 ~ Fax: (814) 337-0008

CHAPS Referral Form - MERCER/VENANGO COUNTIES

Date of Referral_____

The following CHAPS service is being requested:

___ Adult Certified Peer Specialist Program (ages 18 and older).

___ Youth Certified Peer Specialist Program-COMPASS (ages 14 - 18 years old).

Individual's Name _____DOB:_____

Preferred Gender Pronoun/Name: _____Phone (Home): _____

Address :_____(Cell)_____

Best Way to Contact_____Email_____

Emergency Contact: _____Relation_____Phone:_____

SSN:_____MA #:_____Other Medical Insurance_____

Primary Care Physician (PCP) Name_____Phone:_____

Mental Health Provider:_____Diagnosis (if known):_____

Other Services/Supports Presently Receiving: _____

Alcohol and/or Substance Use (History and Current): Y/N_____

Trauma History: Y/N _____

Criminal Justice Involvement: (History and Current)_____

Reason for Referral

Please provide a brief summary of concern/need and support being requested: _____

_____

_____

_____

_____

_____ _____

Referral Signature Date Participant Signature (if present) Date

_____

Referring Agency Address & Telephone Number

Please provide any additional information:

1. Present living situation (persons in the household, etc.)?

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_____

_____

2. What activities/hobbies/clubs/sports does the individual enjoy?

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3. Please describe the individuals strengths and, if known, personal goals.

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4. Please share any additional information that may be helpful for us to know in order to best serve the individual.

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Attn: Doreen Duffy
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