

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

CHAPS Referral Form for Transition Age Youth/Family Services

Date of Referral _____

The following CHAPS service(s) are being requested:

- Pathfinders - Site Based Psychiatric Rehabilitation Program (ages 14-17 years old, or 18 if currently enrolled in high school)**
- Compass - Certified Peer Specialist Program (ages 14-18 years old)**
- Youth Housing (ages 18-24)**

Individual's/Family'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): _____

If currently attending school, which school and what grade/level?: _____

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/School/Program & Telephone Number

Please provide any additional information:

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

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

3. Please describe the individual's/family's strengths and, if known, personal goals.

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

CONTACT INFO:

PATHFINDERS/COMPASS

Doreen Duffy
Phone: 814-373-5078
Fax: 814-337-0008
Email: dduffy@chapsinc.org

YOUTH HOUSING

Sandy Farkas
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Email: cfarkas@chapsinc.org