

H.E.L.P. PROGRAM REFERRAL FORM

****PLEASE FAX REFERRAL FORM TO: (770)-536-1023**

(H.E.L.P. Telephone Number Direct Line – 770-531-9173; Receptionist - 770-531-4950)

DATE OF REFERRAL: _____

OFFENDER CJIS #: _____

CLIENT INFORMATION:

NAME _____ DOB: _____ SSN#: _____

ADDRESS _____ CITY _____

ZIP _____ PHONE: (H) _____ (W) _____ (C) _____

TRANSLATION SERVICES REQUIRED? ____ YES ____ NO

MENTAL HEALTH ISSUE(S) IDENTIFIED/BASIS FOR REFERRAL: _____

CHARGES: _____

INDIVIDUAL CURRENTLY INCARCERATED? ____ YES ____ NO (IF YES, WHERE?) _____

REFERRED BY:

REFERRING AGENCY/ATTORNEY AND POINT OF CONTACT: _____

PHONE: _____ FAX #: _____ E-MAIL: _____

PROBATION:

PROBATION CHARGE(S): _____ OFFICER ASSIGNED: _____

PHONE: _____ FAX #: _____ E-MAIL: _____

DATE REFERRAL RECEIVED: _____

- _____ The referral has been forwarded to the DA for legal screening
- _____ The individual has been provided an assessment and has met H.E.L.P. Program mental health criteria.
- _____ The Team has approved entry - _____.
- _____ The individual has met mental health criteria for program services, but ***does not*** agree to participate in the HELP program.
- _____ The individual has been provided an assessment but does not meet mental health criteria for entry to program services. Referred to Linkage on _____.

TCUDS Score: _____ AUDIT Score: _____ Mental Health Screening Form III: _____

Comments: _____

Phase II Date: _____ Phase III Date: _____ Graduation: _____

Opt-Out/Terminated: _____

Provisional Diagnosis per Initial Screen: _____
