commUNITY cares

uniting neighborhoods - integrating through youth

REFERRAL TO ACCESS FOR ENTRANCE

Full name ____________________ Parent/Guardian ____________________

Address ____________________ City/Zip Code ____________________

Date of Birth ____________________ Social Security Number ____________________

Phone Number ____________________ Alternate Phone Number ____________________

School ____________________ Current grade level ____________________

Is this youth already receiving any services from Pine Belt Mental Healthcare Resources?
(Please circle) Y or N

(If no, please be aware that the intake process must be completed to open a new case with PBMHR.)

______PBMHR has my permission to contact me to discuss service options and schedule an appointment for my child.

______The person referring me to commUNITY cares has my permission to send this signed referral form to PBMHR.

______PBMHR has my permission to discuss possible service options with the referral source.

Parent/Guardian Signature Date ____________________ Youth Signature Date ____________________

Referral Source Signature Date ____________________ Referral Source Telephone Number ____________________

PARENT/YOUTH:

Please take this referral form to PINE BELT MENTAL HEALTHCARE RESOURCES located at 110 PATTON AVENUE OR call 601.544.4641 and ask to speak to "ACCESS" Monday-Friday from 8:00 AM-5:00 PM.

REFERRAL SOURCE:

To the Referral Source: Upon receipt of parental/legal guardian's written permission on this form, please fax this form to Sharon DeBerry at 601.582.1607. If you are a School Representative, you may also present this form to your School Based Clinician for an assessment of the youth's appropriateness for entrance into *commUNITY cares*.