Region 1 Behavioral Health Authority

Today's Date: _____

Last Name (Child):_____ First Name (Child):_____ MI: _____

Date of Birth: _____ SS#:_____ Grade: _____

Mother's Name: _____ Father's Name: _____ Youth's Age: ___

Address (city /state/zip): _____ Phone: _____

_____

County of residence: _____ Ethnic Background: _____

Current Therapist: _____ Other agencies involved: _____

Who is the youth currently living with? _____

Youth's Diagnosis & Source: _____

Referred for: __x_____PPP

Brief description of reason for referral: _ _____
_____
_____
_____

Yes ___ No ___ Is youth between age 3-25 years of age?
Yes ____ No ___ Has youth been diagnosed in past with a mental illness?
Yes ___ No ____ Is the youth at risk of being placed out of the home?
Yes ____ No ___ Is the youth at risk of committing a criminal offense?
Yes ___ No ____ Is the youth currently on probation or parole?
Yes ___ No ____ Is the youth currently a state ward?
Yes ___ No ____ Has the youth ever been a state ward?
Yes ____ No ___ Is the individual or family currently receiving Medicaid assistance?
Yes ___ No ____ Does the youth have any health insurance (other than Medicaid)?

Your name and agency: _____ Phone number:_____

Thank you for your interest in Region I Professional Partner Program. The referral will be processed and you and the family will be contacted regarding their status in the program.

Date received _____ Contact with family _____ Contact with referrer _____
*Accepted*_____ *Denied*_____

PPP: 4110 Avenue D, Scottsbluff, NE 69361 or 312 Main Street, Oshkosh NE 69154
Phone: 308-635-3173 **Fax**: 308-633-2095