

Region 1 Behavioral Health Authority  
4110 Ave D  
Scottsbluff, NE 69361  
Phone: (308) 635-3173



*\*This referral form must be used on all consumers utilizing Region 1 Behavioral Health Authority funding for services\**

**Consumer Referral Information:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date of Referral: \_\_\_\_\_

Address/City/State/Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Best time to contact: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

Current safety concerns: \_\_\_\_\_

Below is a list of Region 1 BHA providers and offered programs available for the consumer's referral. Please mark the provider and service of which you are referring to.

**CAPWN**

3350 10<sup>th</sup> Street  
Gering, NE 69341  
308-633-5766  
308-633-9226 – fax

- Medication Management
- Outpatient Therapy-Mental Health-Youth/Adult
- Outpatient Therapy-Substance Use-Youth/Adult
- Medicated Assisted Treatment
- Substance Use Assessment
- Mental Health Assessment
- Substance Use Intensive Outpatient

**CrossRoads Resources**

104 West 3<sup>rd</sup> Street  
Chadron, NE 69337  
308-747-2054  
308-747-2147 – fax

- Mental Health Assessment
- Outpatient Therapy-Mental Health-Youth/Adult

**Cirrus House**

1509 1<sup>st</sup> Ave  
Scottsbluff, NE 69361  
308-632-3583  
308-635-7880 – fax

[intake@cirrushouse.com](mailto:intake@cirrushouse.com)

- Outpatient Therapy-Mental Health
- Outpatient Therapy-Substance Use
- Substance Use Assessment
- Mental Health Assessment
- Youth Transitional Services (YTS)
- Community Support MH SU
- Emergency Community Support MH SU
- Day Rehabilitation
- Day Support

Supported Employment

Recovery Support MH SU

**ESU #13 youth only**

4215 Ave I  
Scottsbluff, NE 69361  
308-635-3696  
308-633-3752 – fax

- Outpatient Therapy-Mental Health-Youth
- Mental Health Assessment-Youth

**Human Services, Inc. – adult only**

419 West 25<sup>th</sup> Street  
Alliance, NE 69301  
308-762-7177  
308-762-6121 – fax

- Short Term Residential Substance Use
- Substance Use Assessment
- Outpatient Therapy Substance Use
- Intensive Outpatient-Substance Use
- Community Support-Substance Use

**Independence Rising – adult only**

1807 Ave A  
Scottsbluff, NE 69361  
308-633-7025  
308-633-7026 fax

- Peer Support-Mental Health

**Region 1 Professional Partners Program**

4110 Avenue D  
Scottsbluff, NE 69361  
308-635-3173  
308-633-2095

**Inner Peace Holistic & Healing Center**

229 Main Street  
Chadron, NE 69337-2255  
602-637-7822

[Davina.borges@holisticpeace.org](mailto:Davina.borges@holisticpeace.org)

- Outpatient Therapy-Mental Health-Youth/Adult
- Outpatient Therapy-Substance Use-Youth/Adult
- MH SUD Assessment-Youth/Adult
- SUD Intensive Outpatient-Youth/Adult

**Mental Health Alliance**

815 Flack Ave  
Alliance, NE 69301  
308-225-6572  
308-217-4277 – fax

- Mental Health Assessment
- Outpatient Therapy-Mental Health-Youth /Adult
- Medication Management
- Substance Use Assessment

**Sandhills Center For Hope**

2670 County Road 57  
Alliance, NE 69301  
308-313-5118

[Sandhillstreatment21@gmail.com](mailto:Sandhillstreatment21@gmail.com)

- Outpatient Therapy-Mental Health-Youth/Adult
- Outpatient Therapy-Substance Use-Youth /Adult
- MH SUD Assessment-Youth/Adult
- SUD Intensive Outpatient-Adult Only

**Karuna Counseling**

731 Illinois Street  
Sidney, NE 69162  
308-249-7853  
308-365-5122 – fax

- Outpatient Therapy-Mental Health-Youth/Adult
- Outpatient Therapy-Substance Use-Youth/Adult
- MH SUD Assessment-Youth/Adult

**Nebraska Panhandle Counseling Center**

18 West 16<sup>th</sup> Street  
Scottsbluff, NE 69361  
307-237-9583

- Outpatient Therapy-Mental Health-Youth/Adult
- Outpatient Therapy-Substance Use-Youth /Adult
- Medication Management-Youth/Adult
- MH SUD Assessment-Youth/Adult

**Western Community Health Resources**

300 Shelton Street  
Chadron, NE 69337  
308-432-2747  
308-432-8974 – fax

- Community Support-Mental Health
- Youth Transition Services (YTS)
- Emergency Community Support MH SU
- Supported Employment
- Intensive Community Service
- Recovery Support MH SU
- Mental Health Assessments-Adult
- Mental Health Outpatient-Adult
- PGX
- Medication Management

I hereby authorize my name and contact information to be shared with the referring agency indicated on this form. I understand that this information will remain confidential and will be used in my treatment.

\_\_\_\_\_  
Patient/Client Signature

\_\_\_\_\_  
Date

I hereby give my authorization for the program to which I have been referred to inform the referring program that follow-up has been completed on this referral.

\_\_\_\_\_  
Patient/Client Signature

\_\_\_\_\_  
Date

**Referring Agency to Complete this Section**

Please list your information here in the event that the rendering provider agency needs to contact you regarding the referral.

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Name of Person Making Referral

Agency Name

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Phone Number

Email Address

I have received verbal consent from individual to refer

Individual unaware referral is being made

Privacy Notice: This form contains information that is confidential, may be privileged and is intended only for the use of the individual or entity named as the recipient. If you are not the named recipient or entity, please notify the sender and do not print a hard copy of the message or save it.