REFERRAL FORM

NEW HOPE RESIDENTIAL TREATMENT PROGRAM ELIGIBILITY SCREENING

Person Name: _____

DOB _____

SS# _____

1. Treatment Criteria:

A. Is the client 18 years of age or older? ☐ Yes ☐ No

B. What is the preferred language of the consumer or their representative?
☐ English ☐ Spanish ☐ Creole ☐ Other _____

C. Does the consumer or their representative require the use of assistive technology, auxiliary aids, or services to communicate?
☐ Yes ☐ No
i. If yes, which do they require: _____

D. To be eligible for New Hope C.O.R.P.S. the client must have a diagnosed
Mental Health Diagnosis ☐ Yes ☐ No
Substance Abuse Diagnosis ☐ Yes ☐ No
Co-occurring Diagnoses ☐ Yes ☐ No

E. Does the client have Medicaid, Private Insurance, or financial resources to pay for services?
☐ Yes ☐ No Unsure _____

F. Is this referral a U.S. Military Veteran? ☐ Yes ☐ No

F. **Referrals must include**
☐ History and Physical
☐ PPD Screening or Chest X-Ray
☐ Clinical or Biopsychosocial Assessment

Referred by South Florida Behavioral Health Network/Thriving Mind ☐ Yes ☐ No
Referred by Veteran's Administration ☐ Yes ☐ No
Referred by Ryan White Part A via In-Network Referral (Provide®) ☐ Yes ☐ No
Referred by Ryan White Part A via Out-of-Network Referral ☐ Yes ☐ No
Referred by Baptist Health S. Florida ☐ Yes ☐ No
If yes, hospital name: _____

Referred by another community agency ☐ Yes ☐ No
If yes, name of agency: _____ Address: _____
Date of referral _____ City: _____ State: _____ Zip _____
Name of person referring: _____ Tel: _____
Signature _____ Tel: _____

Referral may be made via: 1) Email: referrals@newhopecorp.org or 2) Phone: (786)243-1003 Ext. 201 or 3) Fax: (786)243-0503