

## Park Center Referral Application

Please email or fax referral to: Zach Harlow

Fax: 615-650-8917

Email: [referral@parkcenternashville.org](mailto:referral@parkcenternashville.org)

Phone: 615-724-6278

Individual Name: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Agency: \_\_\_\_\_

Person Making Referral: \_\_\_\_\_

Contact Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

This referral is being made to (check all that apply):	
<input type="checkbox"/> Independent Housing	<input type="checkbox"/> Psychiatric Rehabilitation (PSR) Day Program
<input type="checkbox"/> Supported Group Housing (Male & Female)	<input type="checkbox"/> Outpatient/Intensive Outpatient Program**
<input type="checkbox"/> Safe Haven Housing (Females Only)	<input type="checkbox"/> SSI/SSDI Outreach (SOAR)
<input type="checkbox"/> Emerging Adults Housing (ages 18-24)	
<input type="checkbox"/> Emerging Adults PSR Day Program (ages 18-24)	

\*\*Specifically for individuals with mental illness AND substance use/abuse

To refer an individual to our *Supported Employment Program*, please see instructions on our website:

[www.parkcenternashville.org](http://www.parkcenternashville.org) under the "Make A Referral" tab.

### Identifying Information:

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Sex: \_\_\_\_\_ Race: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Employment Status: \_\_\_\_\_ Education (last grade): \_\_\_\_\_ Degree: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_ Current Living Arrangements: \_\_\_\_\_

Is the individual a Veteran?  Yes  No If yes, what was the discharge date: \_\_\_\_\_

Emergency Contact Name/Relation: \_\_\_\_\_ Contact #: \_\_\_\_\_

Insurance/Entitlements	
Check ALL that apply:	
<input type="checkbox"/> TennCare/Medicaid	<input type="checkbox"/> Safety Net
<input type="checkbox"/> Medicare	<input type="checkbox"/> Uninsured
<input type="checkbox"/> VA Benefits	<input type="checkbox"/> Other: _____

Income (amount per month): \_\_\_\_\_ Income Source: \_\_\_\_\_ Payee: \_\_\_\_\_

Food Stamps (SNAP) Amount: \_\_\_\_\_

Does the individual have a Power of Attorney or Legal Conservator?  Yes  No

If yes, please provide name and contact number: \_\_\_\_\_

Does the individual have a case manager?  Yes  No

If yes, please provide the name, contact number, and email address: \_\_\_\_\_

Does the individual have a history of substance use/abuse?  Yes  No If yes, please describe:

Last substance(s) used: \_\_\_\_\_ Last known date of use: \_\_\_\_\_

Why are you referring this individual to Park Center at this time? \_\_\_\_\_

**Current Medications:**

Please list all Current Medications/Doses/Times Taken: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_ Agency: \_\_\_\_\_

**Diagnostic Information:**

Please include ALL diagnoses (psychiatric, substance use, development, and personality disorder diagnoses) WITH code and text. (If there are more diagnoses you'd like to add, please attach another sheet of paper.)

Diagnostic Code	Diagnostic Text

Does the individual have any developmental delays or intellectual functioning difficulties? \_\_\_ Yes \_\_\_ No

If yes, please describe: \_\_\_\_\_

Does the individual have a history of suicidal, violent, or aggressive behavior? \_\_\_ Yes \_\_\_ No

If yes, please describe: \_\_\_\_\_

Does the individual have a history of sexually inappropriate behavior? \_\_\_ Yes \_\_\_ No

If yes, please describe: \_\_\_\_\_

Has the individual had any involvement with the judicial system? \_\_\_ Yes \_\_\_ No

If yes, please describe: \_\_\_\_\_

Is the individual on probation/parole? \_\_\_ Yes \_\_\_ No

If yes, please describe (What are the terms? Are they required to attend treatment? Etc.): \_\_\_\_\_

Has the individual ever been hospitalized due to their mental illness? \_\_\_ Yes \_\_\_ No

If yes, when/where was the last instance? \_\_\_\_\_

**For ALL Housing & SOAR Programs ONLY:**

What is the individual's housing history (please provide a timeline of the last 3 years or so)? \_\_\_\_\_

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**For SSI/SSDI Outreach (SOAR) ONLY:**

Referrals for SOAR **MUST** currently meet the definition for chronic homelessness as shown below.

SOAR & HUD Definition of Homelessness: **An individual who is literally living on the streets, or in a place that isn't meant for living (for example, a car), or in an emergency shelter.**

*Has the individual:*

Been continuously homeless for the last year?  Yes  No

Experienced 4 episodes of homelessness in the last 3 years?  Yes  No

Been living on the streets, a shelter, or in an environment that is not meant for living?  Yes  No If yes, where and when? \_\_\_\_\_

Applied for benefits in the past?  Yes  No If yes, when? \_\_\_\_\_

Have an application pending (appeal or hearing)?  Yes  No

When did the individual start receiving treatment for their mental health?: \_\_\_\_\_

When was the last time the individual saw a provider?: \_\_\_\_\_

*If the individual is currently in a facility (hospital or correctional facility):*

Does the individual expect to be released within 120 days?  Yes  No

Was the individual homeless prior to entering the facility?  Yes  No

Does the individual have a stable place to go once released?  Yes  No

**For Emerging Adults Housing ONLY:**

For Emerging Adults Housing, a licensed professional's signature (or a copy of the records) is REQUIRED. We can accept signatures of most mental health licenses: LMSW, LCSW, NP, PMHNP, LPC, etc.

Licensed Professional's Signature: \_\_\_\_\_ Date: \_\_\_\_\_