Gift of Hope
MHSB Service Application

Phone: 540-655-4046
Fax: 540-566-3056
www.giftofhopeservices.com

Client Demographic Information							
Name:		DOB:		Medicaid #:			
MCO:	☐ Sentara Health ☐ Aetna Better Health ☐ Anthem/Carelon	☐ United Healthcare ☐ Molina Healthcare					
Address:	Street		City		State	Zip Code	
Home Phone:		Mobile Phone:					
SSN:	- -	Gender:		Ethnicity:			

Referral Agency Information							
Name:		Organization/Agency:					
Address:	Street		City		State	Zip Code	
Phone:		Fax:		Email:			
Reason for Referral							

Please complete the ***Services Criteria Checklist*** on the next page.

Revised 06/23/2024.

Service Criteria Checklist

Diagnosis

☐ Bipolar I ☐ Major Depressive Disorder, Recurrent ☐ Other Psychotic Disorders:

☐ Bipolar II ☐ Schizophrenia ☐ Other Mental Health Diagnosis:

Basic Life Skills (Please check all that apply for the areas of the client's difficulty)

☐ Mental Health Symptom Management
☐ Physical Health Management
☐ Compliance with Medication Regimen for Psychiatric and/or Physical Health
☐ Interpersonal Communication management (including communication devices utilization)
☐ Financial Management (appropriate budgeting and spending, utilizing financial support including using coupons)
☐ Personal Hygiene Skills (personal hygiene and grooming, continence, dressing, mobility, feeding, and toileting)
☐ Food Preparation Skills (cooking and nutritious food plan and consumption)
☐ Household Management (housekeeping)
☐ Community Resources Utilization (shopping, transportation mode utilization, religious and spiritual activities and expression)
☐ Safety Procedure and Emergency Responses (ability to demonstrate safety procedures)
☐ Parenting Skills (providing basic needs for the child, having resources for the child)

History of the Following Treatment

☐ Psychiatric Hospitalization
☐ Residential or Non-Residential Crisis Stabilization Services
☐ PACT Services (Program of Assertive Community Treatment)
☐ ICT Services (Intensive Community Treatment)
☐ Psychiatric Residential Treatment Facility due to Psychiatric Reasons (including substance abuse treatment)
☐ TDO (Temporary Detention Order) for Psychiatric Evaluation

Psychotropic Medication(s) Prescribed within the past 12 Months

☐ Yes ☐ No

If the client is between the ages of 18-20, check the following item.

The client is in an independent living situation:	☐ Yes ☐ No
If **no to the above**, the client is transitioning to an independent living situation:	☐ Yes ☐ No

Signature **Title** **Date**

Please submit this referral form via **referral@giftofhopeservies.com** or fax to **540-566-3056**. Thank you.

Revised 06/23/2024.