Community Integrated Health Services

Peer Bridger Referral Form

Peer Bridger's will be using their lived experience to provide support, guidance and hope to those discharging from the State Hospital. A Peer Bridger develops a relationship of trust with the participant. In developing this trust, the Peer Bridger may function as a role model, peer support, a mentor, a teacher, an advocate, and an ally as he or she communicates hope and encouragement. Peer Bridger's help set the stage and lay the ground work for independence. Peer Bridger's work with the peer in identifying their skills and assisting in the development of skills that are needed to succeed in the community. Peer Bridger's support the peer in establishing a wider circle of support .This is a voluntary program for individuals who are eligible for Medicaid, who have a primary behavioral health diagnosis, and who meet program eligibility standards.

Instructions:

- Please complete this referral form and attach a copy of your insurance card and any additional information if available.
- Submit this referral form and any attachments in person or via:
  - Email Scheduling@cihealthservices.com
  - Fax: (844) 554-3370 or (360) 748-448
  - Postal Mail (see last page for mailing addresses.)
- CIHS will confirm receipt of the referral and will contact you within one (1) business day of receipt of request.
- Check the county where you anticipate services being provided:
  - ☐ Lewis ☐ Grays Harbor
- How did you hear about us? ______________________________

Referent Information

Are you Self Referring? ☐ Yes ☐ No (if yes skip to next section)

Agency Name:______________________________Date:______________

Contact Name:______________________________Phone:______________

Contact Email Address: ______________________________

Individual Requesting Services

First & Last Name/Avatar ID:______________________________Date: ______________

Birthdate:______________Preferred Gender Pronoun: ______________

Home Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Email Address: ____________________

Cell Phone: ____________________ Home Phone: ____________________

Reason for Referral

(Examples: homicidal and/or suicidal ideations, substance use/abuse, depression, trauma stressors, multi-system involvement, family functional difficulties, etc.)

Benefits/Income

SSI $ ____________ SSDI $ ____________ ABD $____________

None/Other $$____________ HCS Care Assessment Completed: ☐ Yes ☐ No

Housing Plan

☐ Independent ☐ AFH ☐ ESF ☐ Assisted Living/Skilled Nursing Facility

GOSH: ☐ Yes ☐ No Where do you want to live? ____________________

What do you like to do for fun?

Community Integrated Health Services Mailing Addresses:
Grays Harbor County: 618 W. Market Street, Aberdeen, WA 98520
Lewis County: 1707 Cooks Hill Road, Centralia, WA 98531

Phone: (360) 261-6930 or (855) 303-4834 | Fax: (360) 748-4480 or (844) 554-3370
Website: www.cihealthservices.com

For Office Use Only:

Received By: ____________________ Date: ____________________

Received Via: ☐ Email ☐ Fax ☐ Mail ☐ In-Person ☐ Other____________________

Provider One # ____________________