Referral Date: _____

HOPELink BEHAVIORAL HEALTH
Where Hope Meets Help

TRANSITION TO INDEPENDENCE PROCESS (TIP) REFERRAL

Young Person's Demographic Information

Please complete the form with as much information as possible. Once the form is submitted, our staff will be in contact with you.

Full name: _____ (*Last* / *First* / *M.I.*)

Phone (Cell): _____

Address: _____ (*Street address* / *Apt/Unit #*)

Phone (Other): _____

Email: _____

Date of Birth: _____ Age: _____ Sex assigned at birth: M ☐ F ☐ Identified Gender: _____

Current School Attending: (If Applicable) _____

Current School District: (If Applicable) _____

The following MUST be answered by the Young Person being referred:

Why do you want to participate in TIP? *REQUIRED*	

DSM Diagnoses

Primary Mental Health Diagnosis Code and Description:	
Additional Mental Health Diagnoses:	
Primary Medical Diagnoses: (If Applicable)	
List of Medications: (If Applicable)	

1. Self-Referral (Young Person)	Yes ☐	No ☐		
2. Natural Support (Family or Friend of Young Person)	Yes ☐	No ☐	If yes, Referring Person's Contact Info:	
3. Formal Support (Therapist, Case Manager, Teacher, School Social Worker, or Other Professional Support working with Young Person)	Yes ☐	No ☐	If yes, Referring Person's Name, Affiliation, and Contact Info:	

Additional Services

Mental Health Outpatient Involvement: (CSB Mental Health/Private Agency)	Yes ☐	No ☐	If yes, Agency Name and Provider Contact Info:	
Probation Involvement:	Yes ☐	No ☐	If yes, Jurisdiction and Probation Officer's Contact Info:	
Department of Family Services:	Yes ☐	No ☐	If yes, Agency Name and Provider Contact Info:	
Intellectual Disabilities Involvement: (CSB Intellectual Disability/Developmental Disability Agencies)	Yes ☐	No ☐	If yes, Agency Name and Provider Contact Info:	
Drug & Alcohol Treatment: (Any)	Yes ☐	No ☐	If yes, Agency Name and Provider Contact Info:	
Office of Vocational Rehabilitation: (Department of Aging and Rehabilitative Services (DARS), Other Employment Services)	Yes ☐	No ☐	If yes, Agency Name and Provider Contact Info:	
Other:	Yes ☐	No ☐	If yes, Agency name and Provider Contact Info:	

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

I understand that submitting this TIP referral does not guarantee enrollment into the TIP Program, and a staff member will contact me at the earliest convenience.

I understand my electronic signature on this form is equivalent to a written signature.

Young Person: (required) _____ Date: _____

Referring Person's Signature: (if applicable) _____ Date: _____

Mail/Fax/Secure Email to:

Central Access Team

10455 White Granite Dr., Suite 400
Oakton, VA 22124
Phone: 571-759-HOPE (571-759-4673)
Fax: 703-448-3723
Email: CentralAccess@hopelinkbh.org