THE MENTAL HEALTH ASSOCIATION IN BEAVER COUNTY
105 Brighton Ave.
Rochester, PA 15074
Phone: 724-775-4165 Fax: 724-775-8523

Application for Peer Support Services

Agency Application_____ Self Application_____

PARTICIPANT INFORMATION:

Name: _____ **Date of Referral:** _____

Address: _____ **Date of Birth:** _____

_____ **MA Number:** _____

_____ **Social Security #:** _____

Phone Number:_____
May we leave a message if unable to reach you? YES NO

Referred By:_____

Agency:_____

Phone Number:_____

Case Manager:_____

For MHA Use Only
Initial EVS Date: _____
Status: _____
Carrier: _____

Type of Referral: Telephone Call Fax Walk In
_____
_____
_____

Area(s) of participant's life that needs to change:
Ex: Current Living, Learning, Working, Social, Self-Maintenance (Health & Wellness):

_____
_____
_____
_____

Do you believe that you can change this? Yes or No

Please Explain: _____
_____
_____

_____ _____
Person Receiving Services Signature Date

_____ _____
Referring Person's Signature Date