Eminent Behavioral Health, LLC

Mental Health Skill-Building Services (MHSS) Referral Form

This form is for providers, case managers, hospitals, community agencies, and self-referrals requesting Mental Health Skill-Building Services.

SECTION 1: REFERRAL INFORMATION

Referral Date:
Referral Source / Agency Name:
Contact Person Name:
Phone Number:
Email Address:
Relationship to Individual:
☐ Case Manager ☐ Therapist ☐ Hospital ☐ Community Agency ☐ Self ☐ Family Member ☐ Other: _____

SECTION 2: INDIVIDUAL INFORMATION

Full Name:
Date of Birth:
Age:
Gender:
Phone Number:
Email (if applicable):
Current Address:
City / State / Zip Code:

Preferred Method of Contact:
☐ Phone ☐ Email ☐ Text

SECTION 3: INSURANCE INFORMATION

Primary Insurance Provider:
☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ Uninsured

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Medicaid ID Number (if applicable):

Managed Care Organization (if Medicaid):

☐ Anthem HealthKeepers Plus

☐ UnitedHealthcare Community Plan

☐ Sentara Medicaid

☐ Fee-for-Service (Acentra)

☐ Other: _____

SECTION 4: CLINICAL INFORMATION

Primary Mental Health Diagnosis (if known):
Secondary Diagnosis (if applicable):

Current Symptoms (check all that apply):

☐ Depression

☐ Anxiety

☐ Mood Instability

☐ Psychotic Symptoms

☐ Trauma-Related Symptoms

☐ Difficulty with Daily Living Skills

☐ Social Withdrawal

☐ Medication Non-Adherence

☐ Other: _____

Has the individual had a recent psychiatric hospitalization?

☐ Yes ☐ No

If yes, date(s): _____

SECTION 5: FUNCTIONAL SKILL DEFICITS

(Required for MHSS eligibility – be specific)

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Please indicate areas where the individual requires skill-building support:

☐ Medication management and adherence
☐ Symptom recognition and coping strategies
☐ Personal hygiene and self-care
☐ Money management and budgeting
☐ Meal planning and food preparation
☐ Time management and organization
☐ Social skills and communication
☐ Use of community resources
☐ Crisis prevention and stabilization skills

Describe current level of functioning and specific challenges:
(Include frequency, severity, and duration where possible)

SECTION 6: RISK & SAFETY CONSIDERATIONS

Current safety concerns:
☐ Suicidal ideation
☐ Homicidal ideation
☐ History of self-harm
☐ Aggressive behavior
☐ Housing instability
☐ Substance use concerns
☐ None reported

If any checked above, please explain:

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SECTION 7: CURRENT SERVICES

Is the individual currently receiving other behavioral health services?

☐ Yes ☐ No

If yes, please list:

☐ Therapy ☐ Psychiatry ☐ Case Management ☐ Crisis Services ☐ Other: _____

How will MHSS complement (not duplicate) current services?

SECTION 8: STRENGTHS & SUPPORTS

Individual strengths, interests, or motivators:

Natural supports (family, friends, community, faith, etc.):

SECTION 9: CONSENT & ACKNOWLEDGMENT

I confirm that the information provided is accurate to the best of my knowledge and that the individual (or legal guardian) is aware of and consents to this referral.

Referrer Name:
Signature:
Date:

SUBMISSION INSTRUCTIONS (Website Footer Text)

Please submit this referral form online.
For questions or urgent concerns, contact **Eminent Behavioral Health, LLC** directly.

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Submission of this form does not guarantee eligibility. All referrals are reviewed in accordance with DMAS and DBHDS guidelines.