Request for Family Peer Support Services

TYPE OF FAMILY PEER SUPPORT REQUESTED *(CHECK ALL THAT APPLY)*		
☐ **Mental Health** ***Please specify age of loved one:*** ☐ Early Childhood (birth to 5 years old) ☐ School-Aged Child(ren) ☐ Adult (18+ years old)	☐ **Substance Use** ***Please specify age of loved one*:** ☐ less than 18 years old ☐ 18 – 26 years old ☐ Adult (27+ years old)	☐ **Problem Gambling**

REFERRAL INFORMATION	
Source of Referral ***(please check only one)***	
☐ Self-referral (caregiver is referring themselves)	☐ Referral is made on behalf of a family or caregiver
Name of person referring on behalf of family	**Referring Org. Phone**
Name of Referring Organization	**Referring Org. Email**
REQUIRED: Is caregiver aware this referral has been made on their behalf?	☐ Yes ☐ No

FAMILY INFORMATION		
Caregiver Name	**Position as Caregiver**	
Home Address (Street, City, State, Zip Code)		**County**
Family/Caregiver Phone	**Family/Caregiver Email**	**Languages Spoken in Home**
Name of Loved One(s) with behavioral health challenges		**Date of Birth**

Does Caregiver have legal custody? ☐ Yes ☐ No ☐ N/A

Caregiver Race:

☐ African American or Black ☐ Multi-racial ☐ White
☐ Asian ☐ Native American ☐ Unknown
☐ Middle-Eastern ☐ Native Hawaiian/other Pacific Islander ☐ Decline to self-identify
☐ Other, specify:

Ethnicity:

☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown ☐ Decline to self-identify

ADDITIONAL INFORMATION
Please include any additional information you feel would be useful to help us provide the best support:

When completed, please email referral form to: Referral@mdcoalition.org