




**Mental Health America of Montana**  
**Family Peer Support Services Referral Form**

 Date of Referral: \_\_\_\_\_

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**SECTION 1: Referring Party Information**

- **Name:** \_\_\_\_\_
  - **Agency/Organization (if applicable):** \_\_\_\_\_
  - **Phone Number:** \_\_\_\_\_
  - **Email Address:** \_\_\_\_\_
  - **Relationship to Family (if not self-referral):** \_\_\_\_\_
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**SECTION 2: Family Information**

- **Parent/Guardian Name(s):** \_\_\_\_\_
  - **Phone Number:** \_\_\_\_\_
  - **Email Address:** \_\_\_\_\_
  - **Best Time to Contact:** \_\_\_\_\_
  - **Address:**  
Street: \_\_\_\_\_  
City: \_\_\_\_\_  
ZIP Code: \_\_\_\_\_
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**SECTION 3: Child(ren) Information**

**Name Age School/Program Diagnosed Conditions/Concerns**

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#### **SECTION 4: Reason for Referral**

Please check all that apply:

- ☐ Emotional/behavioral challenges
  - ☐ Special education/IEP support
  - ☐ Family stress or trauma
  - ☐ Help navigating systems (mental health, school, etc.)
  - ☐ Need for advocacy or empowerment
  - ☐ Peer-to-peer connection
  - ☐ Other (please specify): \_\_\_\_\_
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#### **SECTION 5: Additional Notes or Context**

Please describe any additional information that would help us support this family:

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#### **SECTION 6: Consent to Contact**

I give permission for Mental Health America of MT to contact me and provide family peer support services.

**Signature of Parent/Guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_