Re-Entry Program (Mercer, Venango, Crawford Counties) Referral Form
Referrals and questions email to astright@fsnwpa.org and lswartz@fsnwpa.org

Date of Referral:			
Client Name:		**Social Security Number:**	
Date of Birth:	**Gender:**	**Ethnicity/Race:**	
Address:			
Phone Number:		**Alt. Phone Number:**	
Referral Source:	**Agent:**	**Referral Source Email:**	
DOC #:	**PBPP #:**	**County Probation #:**	
Detention Location: ☐ Mercer County Jail	☐ Venango County Jail	☐ Crawford County Jail	☐ Lawrence County Jail
☐ Other County Jail	☐ SCI – Cambridge Springs	☐ SCI - Mercer	☐ SCI - Albion
☐ Other SCI	☐ Community Corrections Center	☐ N/A – Client not currently detained	
Probation/Parole Type: ☐ Special Probation	☐ Parole	☐ Intermediate Punishment Program	☐ Probation
☐ Other level of supervision not listed			
MAX date for any form of Parole/Probation Supervision:		**Approved Home Plan:** ☐ Yes ☐ No	
Address after release (if different from above):			

Risk assessment rated at Moderate or High: ☐ Yes ☐ No	
If rated as High, please list which domains and any safety concerns:	
Mental Health and/or SUD Diagnosis:	**Disabilities or Medical Diagnosis:**
Currently Employed/Work Schedule:	**Receiving SSI/SSDI:**

Reason for Referral:

Please check all that apply to the client being referred:			
☐ Mental Health Diagnosis	☐ History of Suicidal Ideation	☐ History of Homicidal Ideation	☐ Drug/Alcohol Involvement
☐ Criminal Activity	☐ Incarceration	☐ Additional Pending Charges	☐ Sex Offender
☐ At-Risk of Homelessness	☐ Child Welfare Involvement	☐ ID Diagnosis	☐ Other:

Previous and Current Treatment	**Provider/Facility**	**Dates**
☐ MH/D&A Case Management		
☐ Outpatient MH		
☐ Partial		
☐ Psychiatric Hospitalization		
☐ Outpatient Drug/Alcohol		
☐ Inpatient Drug/Alcohol		
☐ Medication Management		

Has the client had a Drug and Alcohol evaluation within the past 30 days? ☐ Yes ☐ No (If Yes, list Facility providing treatment and Recommendations)	
Name of Facility:	**Recommendations:**
Date of Evaluation:	**Date of Graduation (if completed):**

For internal FSNWPA use only	
Date Received:	**Date Caseworker Assigned:**
Supervisor Initials:	**Client ID #:**