Region 1 Behavioral Health Authority
4110 Ave D
Scottsbluff, NE 69361
Phone: (308) 635-3173

**This referral form must be used on all consumers utilizing Region 1 Behavioral Health Authority funding for services**

**Consumer Referral Information:**

Name: _____ DOB: _____ Date of Referral: _____

Address/City/State/Zip: _____

Phone Number: _____ Other Phone: _____

Email: _____ Best time to contact: _____

Reason for Referral: _____

Current safety concerns: _____

Below is a list of Region 1 BHA providers and offered programs available for the consumer's referral. Please mark the provider and service of which you are referring too.

☐**CAPWN**
3350 10th Street
Gering, NE 69341
308-633-5766
308-633-9226 – fax
☐Medication Management
☐Outpatient Therapy-Mental Health-Youth/Adult
☐Outpatient Therapy-Substance Use-Youth/Adult
☐Medicated Assisted Treatment
☐Substance Use Assessment
☐Mental Health Assessment
☐Substance Use Intensive Outpatient

☐**CrossRoads Resources**
104 West 3rd Street
Chadron, NE 69337
308-747-2054
308-747-2147 – fax
☐Mental Health Assessment
☐Outpatient Therapy-Mental Health-Youth/Adult

☐**Cirrus House**
1509 1st Ave
Scottsbluff, NE 69361
308-632-3583
308-635-7880 – fax
intake@cirrushouse.com
☐Outpatient Therapy-Mental Health
☐Outpatient Therapy-Substance Use
☐Substance Use Assessment
☐Mental Health Assessment
☐Youth Transitional Services (YTS)
☐Community Support ☐MH ☐SU
☐Emergency Community Support ☐MH ☐SU
☐Day Rehabilitation
☐Day Support
☐Supported Employment
☐Recovery Support ☐MH ☐SU

☐**ESU #13** ***youth only***
4215 Ave I
Scottsbluff, NE 69361
308-635-3696
308-633-3752 – fax
☐Outpatient Therapy-Mental Health-Youth
☐Mental Health Assessment-Youth

☐**Human Services, Inc. –** ***adult only***
419 West 25th Street
Alliance, NE 69301
308-762-7177
308-762-6121 – fax
☐Short Term Residential Substance Use
☐Substance Use Assessment
☐Outpatient Therapy Substance Use
☐Intensive Outpatient-Substance Use
☐Community Support-Substance Use

☐**Independence Rising –** ***adult only***
1807 Ave A
Scottsbluff, NE 69361
308-633-7025
308- 633-7026 fax
☐Peer Support-Mental Health

☐**Region 1 Professional Partners Program**
4110 Avenue D
Scottsbluff, NE 69361
308-635-3173
308-633-2095

☐**Inner Peace Holistic & Healing Center**
229 Main Street
Chadron, NE 69337-2255
602-637-7822
Davina.borges@holisticpeace.org
☐Outpatient Therapy-Mental Health-Youth/Adult
☐Outpatient Therapy-Substance Use-Youth/Adult
☐MH ☐SUD Assessment-Youth/Adult
☐SUD Intensive Outpatient-Youth/Adult

☐**Karuna Counseling**
731 Illinois Street
Sidney, NE 69162
308-249-7853
531-248-4687 – fax
☐Outpatient Therapy-Mental Health-Youth/Adult
☐Outpatient Therapy-Substance Use-Youth/Adult
☐MH ☐SUD Assessment-Youth/Adult

☐**Mental Health Alliance**
815 Flack Ave
Alliance, NE 69301
308-225-6572
308-217-4277 – fax
☐Mental Health Assessment
☐Outpatient Therapy-Mental Health-Youth /Adult
☐Medication Management
☐Substance Use Assessment

☐**Nebraska Panhandle Counseling Center**
18 West 16th Street
Scottsbluff, NE 69361
307-237-9583
☐Outpatient Therapy-Mental Health-Youth/Adult
☐Outpatient Therapy-Substance Use-Youth /Adult
☐Medication Management-Youth/Adult
☐MH ☐SUD Assessment-Youth/Adult

☐**Sandhills Center For Hope**
2670 County Road 57
Alliance, NE 69301
308-313-5118
Sandhillstreatment21@gmail.com
☐Outpatient Therapy-Mental Health-Youth/Adult
☐Outpatient Therapy-Substance Use-Youth /Adult
☐MH ☐SUD Assessment-Youth/Adult
☐SUD Intensive Outpatient-Adult Only

☐**Western Community Health Resources**
300 Shelton Street
Chadron, NE 69337
308-432-2747
308-432-8974 – fax
☐Community Support-Mental Health
☐Youth Transition Services (YTS)
☐Emergency Community Support ☐MH ☐SU
☐Supported Employment
☐Intensive Community Service
☐Recovery Support ☐MH ☐SU
☐Mental Health Assessments-Adult
☐Mental Health Outpatient-Adult
☐PGX
☐Medication Management

I hereby authorize my name and contact information to be shared with the referring agency indicated on this form. I understand that this information will remain confidential and will be used in my treatment.

_____ _____
Patient/Client Signature Date

I hereby give my authorization for the program to which I have been referred to inform the referring program that follow-up has been completed on this referral.

_____ _____
Patient/Client Signature Date

**Referring Agency to Complete this Section**

Please list your information here in the event that the rendering provider agency needs to contact you regarding the referral.

| Name of Person Making Referral | Agency Name |
| --- | --- |
| Phone Number | Email Address |

☐ I have received verbal consent from individual to refer ☐ Individual unaware referral is being made