St. Clair County Community Mental Health Authority

PORT OF HOPES INC.

Drop-In Center Eligibility Verification

Only adults with a mental illness diagnosis are eligible to attend the Port of Hopes Drop-In Center.

Individual: _____
(Print name)

Case #: _____ Date of birth: _____

Other Name(s) Used: _____ Date: _____

To become a member of the Port of Hopes Inc.

Take this form to your **CMH Mental Health Provider** for completions. (Only one name and phone number are required.)
Take completed form to Port of Hopes along your picture ID.

TO BE COMPLETED BY MENTAL HEALTH PROFESSIONAL

****Authorized Mental Health Professional who can verify Drop-In Center eligibility.**

1. Case Manager Name: _____ Phone: _____
2. Clinician/Therapist Name: _____ Phone: _____
3. Mental Health Assistant Name: _____ Phone: _____
4. Peer Support Specialist Name: _____ Phone: _____
5. Registered Nurse Name: _____ Phone: _____
6. Psychiatrist Name: _____ Phone: _____

FOR NON-CMH MENTAL HEALTH PROVIDERS

**The Port of Hopes Inc. Director needs a letter from your Mental Health Provider on their business letterhead. Letter must include name of agency, address and phone number, email address, practitioner's name, title, and phone number, so that the Port of Hopes Director can contact your Mental Health Provider and or representative to verify that you have a mental health diagnosis.

**I give permission through the following signature to allow Port of Hopes to verify my eligibility to attend the Drop-In Center by contacting the person indicated on this form or letter received from my mental health representative.

_____
Signature of Individual Requesting Membership

Picture ID verified by Port of Hopes Staff. ☐ Yes ☐ No Sign: _____