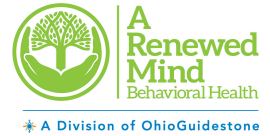


**OHIOGUIDESTONE REFERRAL & ADMISSION FORM**



**REFERRAL INFORMATION**

Referral Date \_\_\_\_\_ Urgency (select one)  Routine  Urgent  Emergency

Referral Source \_\_\_\_\_ Fiscally Responsible County: \_\_\_\_\_

Referent Name \_\_\_\_\_ Contact Phone \_\_\_\_\_

County Worker Name \_\_\_\_\_ Phone \_\_\_\_\_

Program Referred to \_\_\_\_\_ Program Level \_\_\_\_\_  
(for foster/residential only)

Managing Office \_\_\_\_\_ Service Location Preference  Office (specify) \_\_\_\_\_  School  
 Community  Home

Specific Contract Name \_\_\_\_\_ (Complete if not listed under Program)

**REASON(S) SEEKING TREATMENT (Mark all that apply):**

- Abuse  Alcohol & Drug Abuse Issue  Dual Diagnosis  Employment Services  Foster Care Needs
- Maternal Depression  Mental Health Service Needs  Parent Mentoring Needs  Pregnancy Education
- Residential Needs  Spiritual  Unknown

<b>CLIENT INFORMATION</b> <input type="checkbox"/> Former Client		Family Name: _____	
Last Name _____	First _____	Social Security# _____	
Preferred Name _____	DOB _____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____	
Address _____	County _____	City _____	State _____ Zip _____
Phone (cell) _____	<input type="checkbox"/> May Call Phone (home) _____		<input type="checkbox"/> May Call
Marital Status _____	Race _____	Other _____	Ethnicity _____
Religion _____	Other _____	Primary Language _____	Other _____
Legal Parent/Guardian Name _____	Relationship _____		
Phone (home / cell) _____	Email Address _____		
Emergency Contact Name _____	Relationship _____		
Phone number _____	Email Address _____		
Name of School _____	District _____	Grade _____	Teacher _____

**Additional Information:****FUNDER/PAYOR/CONTRACT** (Please select at least one form of funding)Permission obtained to verify benefit eligibility  Yes  No **SELF-PAY** Family Size \_\_\_\_\_ Gross Income \_\_\_\_\_ Source of Income \_\_\_\_\_ **MEDICAID**

Medicaid Managed Care Plan \_\_\_\_\_ Managed Care ID# \_\_\_\_\_

Medicaid MMIS# \_\_\_\_\_

 **PRIVATE INSURANCE**

Private Insurance Co \_\_\_\_\_ Employer \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Relationship \_\_\_\_\_ DOB \_\_\_\_\_

Social Security# \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Policy Number \_\_\_\_\_ Group \_\_\_\_\_ Customer Service Phone # \_\_\_\_\_

 **OTHER FUNDING**

Name of Funding Source \_\_\_\_\_ Contact \_\_\_\_\_

 **MEDICARE**

Medicare ID# \_\_\_\_\_ Part \_\_\_\_\_ MyCare Plan Name \_\_\_\_\_

MyCare ID# \_\_\_\_\_ Customer Service Phone # \_\_\_\_\_

**Referral Form Submission Information**

Office Locations	Fax	Phone	Email
Franklin County & Surrounding	614.928.9092	1.888.522.9174	<a href="mailto:CentralOhioIntake@OhioGuidestone.org">CentralOhioIntake@OhioGuidestone.org</a>
Stark/Portage County	330.438.1748	1.800.639.4974 x6466	<a href="mailto:StarkIntake@OhioGuidestone.org">StarkIntake@OhioGuidestone.org</a>
Lorain County	440.282.3400	440.260.6100	<a href="mailto:IntakeLorain@OhioGuidestone.org">IntakeLorain@OhioGuidestone.org</a>
Erie County	440.282.3400	440.260.6100	<a href="mailto:IntakeErie@OhioGuidestone.org">IntakeErie@OhioGuidestone.org</a>
Summit County	330.983.9310	1.800.639.4974 x2916	<a href="mailto:SummitIntake@OhioGuidestone.org">SummitIntake@OhioGuidestone.org</a>
Tuscarawas County (PFCS)	330.343.8439	330.343.8171	<a href="mailto:PFCSIntake@OhioGuidestone.org">PFCSIntake@OhioGuidestone.org</a>
Medina County	N/A	440.260.2945	<a href="mailto:IntakeMedina@OhioGuidestone.org">IntakeMedina@OhioGuidestone.org</a>
All other locations	440.260.8575	1.800.639.4974 x8300	<a href="mailto:IntakeGroup@OhioGuidestone.org">IntakeGroup@OhioGuidestone.org</a>

**For Internal Use Only**

Agency Staff processing Form \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

Scheduled with \_\_\_\_\_ Appt Date \_\_\_\_\_ Time \_\_\_\_\_