

# OHI GUIDESTONE 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 _____ Homeroom# _____	
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>
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 \_\_\_\_\_