A NEW WAY OF LIFE

A Rising Hope Company

Referral for Services

20 S. Third St. Columbus OH 43215
Phone: 678-89 ◆ Fax: 877-564-4386

Date of Referral:

(Please Print)

Name & Title Of Person Making Referral:

Agency: _____ County: _____ Court Mandated? ☐ Yes ☐ No

Phone # Of Person Making Referral: _____ Fax Number: _____

Consumer Information:

Consumer Name: _ _____ Medicaid# Date Of Birth: Age: _ SS#_____
Gender: (Please Check) ☐Male ☐Female Race: _ ____

Address: City_ _____ State _ ___ Zip _ _

Home Phone#: _____ Cell #: 404-956-8917 Work #: _____

Services Background:

1. Has the person had other services (e.g. Community Support Individual-CSI, Individual and /or Family Counseling)?
   ☐ **Yes** ☐ **No** ☐ **Not Sure**
2. Does the individual have a known Serious Emotional Disturbance and/ or Substance Abuse issue/diagnosis?
   ☐ **Yes** ☐ **No** ☐ **Not Sure**
3. Does the person currently take medications? ☐**Yes** ☐**No** **If so, please list the medications if known.**
4. Has a Psychological/Psychiatric Evaluation been completed? ☐**Yes** ☐**No** **If yes, please attach.**

Service (s) Requested:

Presenting Problem: (List problem behaviors; include any medications for emotional and / or behavior problems)

For Company Use Only:

Receipt Date: ____ ***Insurance Active*** ☐***Yes*** ☐***No*** ***Medicaid Plan:***

Screening and Consents:

BHA/Service Plan Assigned To: _____ ***Date Assigned:*** _____

Assessment Completion Date: _____ ***Consumer Approved?*** ☐***Yes*** ☐***No***

If Not Approved, Why? _____

If Approved, Approval Date? _____ **Prior Approval #** _____