OHIOGUIDESTONE REFERRAL & ADMISSION FORM

OhioGuidestone
WHERE NEW PATHS BEGIN

A Renewed Mind Behavioral Health
An OhioGuidestone Organization

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

CLIENT INFORMATION ☐ Former Client Family Name:

Last Name_____First_____Social Security# _____

Preferred Name _____ DOB _____Gender ☐ Male ☐ Female ☐ Other _____

Address_____County_____City_____ State_____ Zip _____

Phone (cell)_____ ☐ May Call Phone (home)_____☐ 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	CentralOhioIntake@ohioguidestone.org
Stark/Portage County	330.438.1748	1.800.639.4974 x6466	StarkIntake@OhioGuidestone.org
Lorain County	440.282.3400	440.260.6100	IntakeLorain@ohioguidestone.org
Erie County	440.282.3400	440.260.6100	IntakeErie@Ohioguidestone.org
Summit County	330.983.9310	1.800.639.4974 x2916	SummitIntake@OhioGuidestone.org
Tuscarawas County (PFCS)	330.343.8439	330.343.8171	PFCSIntake@OhioGuidestone.org
All other locations	440.260.8575	1.800.639.4974 x8300	Intakegroup@OhioGuidestone.org

For Internal Use Only

Agency Staff processing Form _____ Date_____
Printed Name

Scheduled with _____ Appt Date _____ Time _____