

***JOURNEY TO SUCCESSFUL LIVING***

***System of Care Referral Form***

**Youth/Young Adult Referral Information**

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| --- | --- | --- |
| Last Name: | First Name: | Middle Initial: |
| Address: | | |
| SSN (Required): | | |
| DOB (Required): | Gender: Choose one | Race/Ethnicity: Choose one |
| Cell #: | Email: | |

**INSURANCE INFORMATION**

|  |  |
| --- | --- |
| **Medicaid:**  Choose one | Ohio Medicaid # |
| If pending, explain: |
| **Shares #:** |
| **Private Insurance** | Company: |
| Policy #: |

**CURRENT LIVING SITUATION**: Choose one

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| --- |
|  |

**If other, please describe:**

**CAREGIVER INFORMATION (Required if applicable):**

|  |  |  |
| --- | --- | --- |
| Name: | Mailing Address: | |
| ☐Parent(s): | ☐Foster Parent(s): | ☐Guardian – Relationship to youth: |
| Home #: | Work #: | Cell #: |
| Email#: | |  |

**Projected Enrollment Date:**

**MHAP Authorization Date: **

**REASON FOR REFERRAL:**

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**CURRENT DIAGNOSIS (re-assessed within 12 months):**

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**DOES CLIENT HAVE A CURRENT DAF or PDE (within 12 Months)? ☐Yes ☐No**

**MULTI-SYSTEM INVOLVEMENT:**

|  |  |
| --- | --- |
| ☐ Juvenile Court | ☐ Self/Family |
| ☐ Adult Court System | ☐ Education (High School or College) |
| ☐ Job and Family Services | ☐ Workforce/Employment |
| ☐ Mental Health and Recovery Services | ☐ Other Involvement |
| ☐ Developmental Disabilities Services |

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**If Other, please describe:**

**PLEASE EXPLAIN INVOLVEMENT:**

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