

***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

|  |
| --- |
|  |

**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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