JOURNEY TO SUCCESSFUL LIVING
System of Care Referral Form

YOUTH/YOUNG ADULT REFERRAL INFORMATION

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:

CURRENT DIAGNOSIS (re-assessed within 12 months):

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	

If Other, please describe:

PLEASE EXPLAIN INVOLVEMENT: