PATHWAY TO HOPE COUNSELING SERVICES, INC.
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Intake Referral Form

Please Print Clearly

Date of Referral: _____

Consumer Information:

Consumer Name: _____

Type: ☐Peachstate ☐Amerigroup ☐ Wellcare ☐Reg Medicaid - Medicaid#_____

Date of Birth: _____ Age: _____ SS#_____ Grade Level_____

Gender: (Please Check) ☐Male ☐Female Race: _____

Consumer's Address: _____

City_____ State _____ Zip _____

Home Phone#: _____ Cell #: _____ Work #: _____

Parent/Guardian: _____

What Other Services Sought:

1. Has the client had other services (e.g. Community Support Individual-CSI, Individual and /or Family Counseling)? ☐**Yes** ☐**No** ☐**Not Sure**
2. Does the client have a known Serious Emotional Disturbance and/ or Substance Abuse issue/diagnosis? ☐**Yes or** ☐ **No** ☐**Not Sure**
3. Are client and/or family issues in need of intensive, coordinated clinical and supportive intervention? ☐**Yes** ☐**No**
4. Does the client have stable housing? ☐**Yes or** ☐**No**
5. Has Psychological/Psychiatric Evaluation been completed? ☐**Yes** ☐**No** **If yes, please attach**

Admission Status (Please Print)

Name & Title of Person making referral: _____

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

Phone # of person making referral: _____ **Fax number:** _____

Service (s) Requested (Please Check)

☐CORE-Medicaid Program (Indiv/Family Therapy; Therapy for Substance Abuse (SA); CSI - Life Skills)
☐Intensive Family Intervention ☐Other _____

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:*** _____

Assigned to: _____ ***Date Assigned:*** _____

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

If not approved, why? _____

If approved, approval date? _____ **Ref #** _____