# STARK COUNTY PATHWAYS COMMUNITY HUB REFERRAL

Referral Date: _____

NAME: _____

ADDRESS: _____

CITY: _____ ZIP CODE: _____

PHONE NUMBER: _____ ALT. NUMBER: _____

BIRTH DATE: _____

Are you or another family member involved in any home visiting program? _____YES _____NO

Are you currently working with a mental/behavioral health agency: _____YES _____NO

If yes, please name the agency: _____

Name of insurance plan:

____ Buckeye ____ CareSource ____ Molina ____ Paramount ____ United Healthcare

____Uninsured ____Other: Please list Provider Name_____

| **BRIEF SUMMARY REGARDING CONCERNS/REASON FOR REFERRAL:** |
|---|
| |
| **SAFETY HAZARDS/CONCERNS:** ☐ **Y** ☐ **N** |
| **If "YES, please explain:** |

*Client has given _____ (name/agency) consent to share the above information with the STARK COUNTY HUB for the purposes of enrollment into the care coordination program.*

Client Signature: _____

Agency/Provider referring: _____

Agency Contact (name): _____ Number: _____

Supervisor: _____ Number: _____

**Email this form to Stark County Community Action Agency Pathways HUB at mary.martell@sccaa.org or by Fax: 330-454-6850**

**Please contact Mary Martell, HUB Director at 330.454.1676 ext. 133 with any questions or concerns.**