Georgia Health Partners, LLC

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INTAKE/REFERRAL FORM

(MEDICAID ADULTS ONLY - PHOTO ID IS REQUIRED)

Date of Referral:							
Individual Name:							
Insurance Type:	☐ Amerigroup ☐ CareSource ☐ Medicaid ☐ Peachstate ☐ Medicare						
Medicaid#		SS#		Date of Birth:			
Age:		Gender:		Race:			
Address:		City:		State:	GA	Zip:	
Parent/Guardian Name:							
Parent/Guardian Phone Number(s):							
Parent/Guardian Email Address:							
Emergency Contact Name:							
Emergency Contact Phone Number(s):							
Has the individual consented to this referral being made?	■ YES ☐ NO						
Is individual/family open to telehealth services?	■ YES ☐ NO						
Is a translator/interpreter needed for services?	☐ YES ■ NO						
Is the individual currently receiving counseling services?	☐ YES ■ NO If YES, name of service provider:_____						

REFERRAL SOURCE INFORMATION:

Name and title of person making referral:	
Agency/Organization:	
Referral source type:	☐DFCS ☐Foster Parent ☐MH Prof ☐School ☐Parent ☐Self ☐Juvenile Court/Justice ☐ Hospital ☐ Counseling Agency ☐Other
Phone number of person making referral:	
Email address of person making referral:	
Is individual mandated to participate in services?	☐ YES ■ NO

SERVICE(S) REQUESTED:

■ Non-Intensive Outpatient Services (Individual, Family, and Skills 1-3 sessions per week) (NIOP)
☐ Peer Support (Adults only)
☐ Psychiatric Evaluation and Treatment/ Medication Management (must be in conjunction with NIOP, IFI, or Peer Support)
☐ Intensive Family Intervention (Individual, Family, and Skills at least 3 sessions per week) (IFI) (Child and Adolescent Only)

REASON FOR REFERRAL:

☐ History of Counseling	☐ Suicidal/Homicidal/Self-Harming	☐ Substance Abuse/Dependence	☐ Legal Involvement	☐ Psychosis
☐ Risk/History of Homelessness	☐ Medication Use	☐ Hospitalization	☐ Out of Home Placement	☐ DFCS Involvement
☐ History of Abuse/Trauma	☐ Psychological/Psychiatric Eval completed (please attach to referral)			
☐ Other:				