Georgia Health Partners, LLC

ATLANTA: 100 Crescent Centre Pkwy Suite #650 Tucker, GA 30084
OFFICE: (678) 389-4856 FAX: (470) 575-6099

SAVANNAH: 5302 Frederick Street Suite 100 Savannah, GA 31405 OFFICE: (912) 225-3883 FAX: (912) 335-5655

EMAIL: referrals@gahealthpartners.com INTAKE/REFERRAL FORM

(MEDICAID ADULTS ONLY - PHOTO ID IS REOUIRED)

Date of Refer	ral:							
Individual Na	ame:							
Insurance Type: Amerigroup CareSource Medicaid Peachstate Medicare								
Medicaid#	pe.		SS#		realeara Teachstate	Date of I		
							DII tii.	
Age:			Gender:			Race:		
Address:		City:		State:		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			eing made?		YES NO			
Is individual/family open to telehealth services?				s?		YES	1	NO
Is a translator/interpreter needed for services?						YES		NO
Is the individual currently receiving counseling service					If YES, name of service pr	YES ovider:	1	NO
REFERRAL SOURCE INFORMATION:								
			REFER	RAL SOUR	CE INFORMATION:			
Name and tit	le of perso	n making re		RAL SOUR	CE INFORMATION:			
Name and tit		n making re		RAL SOUR	CE INFORMATION:			
	nization:	n making re		DI	CS Foster Parent MF			
Agency/Orga	nization:		eferral:	DI				
Agency/Orga Referral sour	nnization: ce type: er of perso	n making re	eferral:	DI	CS Foster Parent MF			
Agency/Orga Referral sour Phone numb	er of persons of persons	n making re making ref	eferral: eferral: Ferral:	□DI □Ju	CS Foster Parent MF			
Agency/Orga Referral sour Phone numb Email address	er of persons of persons	n making re making ref	eferral: eferral: Ferral:	DI DI U	CS Foster Parent MF venile Court/Justice Hosp	oital	nseling Ag	
Agency/Orga Referral sour Phone numb Email address Is individual	er of person mandated	on making re making ref to participa	eferral: eferral: Gerral: te in servic	es?	CS Foster Parent MF venile Court/Justice Hosp CE(S) REQUESTED:	yes	nseling Ag	
Agency/Orga Referral sour Phone numb Email address Is individual Non-Intensi	er of person mandated	n making re making ref to participa	eferral: eferral: Gerral: te in servic	es?	CS Foster Parent MF venile Court/Justice Hosp	yes	nseling Ag	
Agency/Orga Referral sour Phone numb Email address Is individual Non-Intensi Peer Suppor Psychiatric	er of person mandated ve Outpatier t (Adults onl	on making ref to participa at Services (Ind y)	eferral: eferral: ferral: te in servic lividual, Fami	es? SERVICIBLE SERVICIBLE SERVICIBLE SERVICIBLE SERVICIBLE SERVICIBLE SERVICE	CS Foster Parent MF venile Court/Justice Hosp E(S) REQUESTED: -3 sessions per week) (NIOF	YES NIOP, IFI, or	NO NO	gency Other Opport)
Agency/Orga Referral sour Phone numb Email address Is individual Non-Intensi Peer Suppor Psychiatric	er of person mandated ve Outpatier t (Adults onl	on making ref to participa at Services (Ind y)	eferral: eferral: ferral: te in servic lividual, Fami	es? SERVICIBLE SERVICIBLE SERVICIBLE SERVICIBLE SERVICIBLE SERVICIBLE SERVICE	CS Foster Parent MF renile Court/Justice Hosp E(S) REQUESTED: -3 sessions per week) (NIOF	YES NIOP, IFI, or	NO NO	gency Other Opport)
Agency/Orga Referral sour Phone numb Email address Is individual Non-Intensi Peer Suppor Psychiatric	er of person mandated ve Outpatier t (Adults onl	on making ref to participa at Services (Ind y)	eferral: eferral: ferral: te in servic lividual, Fami	es? SERVIC: ily, and Skills: Management (r nd Skills at lea	CS Foster Parent MF venile Court/Justice Hosp E(S) REQUESTED: -3 sessions per week) (NIOF	YES NIOP, IFI, or	NO NO	gency Other Opport)
Agency/Orga Referral sour Phone numb Email address Is individual Non-Intensi Peer Suppor Psychiatric I Intensive Fa	er of persons of persons of persons mandated ve Outpatient (Adults onle Evaluation at mily Interve	on making ref to participa at Services (Inc. y) and Treatment/ ntion (Individent)	eferral: eferral: erral: te in servic dividual, Fami Medication Mual, Family, a	es? SERVIC: ily, and Skills: Management (r nd Skills at lea REASON Harming	E(S) REQUESTED: -3 sessions per week) (NIOF must be in conjunction with st 3 sessions per week) (IFI) FOR REFERRAL: Substance Abuse/Dependen	YES NIOP, IFI, or (Child and A	NO NO	pport) Only) Psychosis
Agency/Orga Referral sour Phone numb Email address Is individual Non-Intensi Peer Suppor Psychiatric I Intensive Fa	er of persons of persons of persons mandated ve Outpatier t (Adults onle Evaluation and mily Interversions of Homeles	on making refit to participant Services (Indext) and Treatment/ ntion (Individual) Suicidal/Hosness Media	eferral: eferral: eferral: terral: dividual, Fami Medication Mual, Family, a	es? SERVIC: ily, and Skills: Management (r nd Skills at lea REASON Harming Hospitalizat	E(S) REQUESTED: -3 sessions per week) (NIOF must be in conjunction with st 3 sessions per week) (IFI) FOR REFERRAL: Substance Abuse/Dependen	YES NIOP, IFI, or (Child and A	NO NO	pport) Only) Psychosis