|  |
| --- |
| **Client Information**  |
| **Name:**  | **Date of Birth:**  | **Phone:**  |
|  |  | **Alternate Phone/Email:** |
| **Address:** | **Gender:** [ ]  Female [ ] Male | **Client Type:** [ ]  Pregnant [ ]  Adult [ ]  Pediatric |
| **Primary Language Spoken in the Home:** |
| **Does client have insurance?**  | [ ]  Yes | [ ]  No |
| **(If Yes)** Is insurance Medicaid? | [ ]  Yes | [ ]  No |
| **(If Medicaid)** Please specify Medicaid MCO: |
| [ ] Buckeye [ ]  AmeriHealth-Caritas [ ]  Molina [ ]  Anthem [ ]  UnitedHealthcare ☐ Humana |
| **(If Medicaid)** Medicaid Identification Number:Member ID (# on card):  |
| **(If non-Medicaid insurance):** |
| Non-Medicaid Insurer:Non-Medicaid Identification Number: |
| **Is client currently receiving services from a home visiting program (e.g., Bright Beginnings, Help Me Grow, Nurse Family Partnership)?** **(If Yes) Which home visiting program?** | [ ]  Yes | [ ]  No [ ]  Unknown |
| **Any other info that may be helpful:** |

|  |
| --- |
| **Referred By:** |
| Name:  | Phone:  |
| Email: |
| Agency: |  |

By signing here, I consent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Referring Agency) to share the above information with the Better Health Pathways HUB for the purpose of enrollment.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Fax Referral Form to 216-957-0436**

**Or Call HUB at 216-778-7525**