|  |  |  |
| --- | --- | --- |
| **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**