Bridges to Wellness Referral

Fax to: 330-365-9221 **Scan to: coordinator@accesstusc.org**

Currently serving participants in: Belmont, Carroll, Coshocton, Guernsey, Harrison, Holmes, Monroe, Muskingum, Noble, Tuscarawas, and Washington counties

Referring Agency:_____ Phone # _____

Referring Staff Member:_____ Date:_____

Staff Member Email:_____ Fax #_____

Is the participant aware of this referral ☐ *Yes* ☐ *No*

(Care coordination is a voluntary program, if possible please ensure referral has been made.)

Client Name:_____ **Phone #** _____

Address:_____ **City:**_____ **Zip:**_____ **County:** _____

Date of Birth:_____ **Insured:** *Yes or No* **Insurance Company:** _____

Medicaid Insurance? (please circle): AmeriHealth Buckeye CareSource Humana Molina United Healthcare Anthem

Pregnant? *Yes or No* **If yes, due date:**_____ **OB Provider** _____

Please check off the following areas the client may need assistance with:

☐ Health Insurance/Medicaid Application
☐ Housing
☐ Food
☐ Clothing
☐ Utilities
☐ Access to Medication
☐ Taking Medication Correctly
☐ Frequent ER Visits
☐ Smoking Cessation
☐ Substance Use
☐ Medical Appointments/Doctor
☐ Transportation
☐ Dental
☐ Behavioral Health
☐ Legal
☐ Adult Education
☐ GED/Graduation
☐ Specialty Care
☐ Domestic Violence
☐ Pregnancy Assistance
☐ Other: _____

Any additional information regarding client that may be helpful: