Bridges to Wellness Referral

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

Currently serving any clients in Belmont, Tuscarawas, Guernsey, Muskingum, Coshocton, Carroll, 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:_____ **Insurance:** *Yes or No* **Insurance Company:** _____

Medicaid Insurance? (please circle): Buckeye CareSource United HealthCare Molina Paramount

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:

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