

MEDICAID/MENTAL HEALTH SERVICES REFERRAL FORM

CHILD & ADOLESCENT CORE SERVICES
 ADULT CORE SERVICES

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|---|---------------------------------------|
| Date of Referral: | Name of person being referred: |
| DOB: Sex: | SSN: |
| Address: | County: |
| Telephone #: | Alternate #: |
| Parent/Guardian (if applicable): | Parent/Guardian Telephone: |
| Person making referral: | Relationship to child: |
| Referral Source Telephone: | Referral Source Email: |

Reason for Referral :

Prior Diagnosis?

Type of Insurance:

| PROVIDER | SERVICES PROVIDED | REFERRAL EMAIL | REFERRAL FAX |
|------------------|---------------------------------|--|--|
| Georgia H.O.P.E. | <i>C&A & Adult Core</i> | referrals@gahope.org | 706-301-1068 (C&A) 706-279-4190 (ADULT) |