



REFERRAL FORM - ACCESS TO SERVICES

Hope Horizon Mental Health

327 S. "K" Street, Tulare CA 93274

Phone: 559.688.2043

Fax: 559.624.1991 or Email: intake@hopehorizon.org

Date of Referral:

Referring Party:

Phone:

Contact Person:

Phone:

Fax:

Name of Consumer:

Gender: Male Female

DOB: Age: Grade: School:

Teacher: SS#:

Parent/Guardian:

Court/Custody Orders: Yes (if yes, required paperwork is needed to begin services) **No**

Address: City: Phone:

Parent Primary Language: **Contacted: Yes No Date:**

Ethnicity: Caucasian Hispanic African Am. S.E. Asian Other:

Dr:

Medications:

Funding: Medi-Cal/Tulare Co. #: Medi-Cal/Other Co. #:

Insurance Company Name: #:

No Insurance/No Medi-Cal Other Funding:

(Attach a copy of Medi-Cal Card or Insurance Card)

Reason for Referral/Concerns:

Social Worker/Probation Officer:

Phone:

Previous Counseling: No Yes Where/Who:

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