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:

SUBMIT