THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR
COLUMBUS PUBLIC HEALTH

Ryan White Part A

Referral for Mental Health Services

Date: _____/_____/_____

1. Client Information

Client's First Name: _____ **Client's Last Name:** _____

Date of Birth: _____/_____/_____

Ryan White # *(if applicable)***:** _____ **ETO #** *(if applicable)***:** _____

Approval Date: _____/_____/_____ **Expiration Date:** _____/_____/_____

Does the client have health insurance? ☐ Yes ☐ No

If YES: **What is the client's primary type of insurance?**

☐ Private-Employer ☐ Private-Individual (ACA) ☐ Medicare ☐ Medicaid/CHIP/other private plan
☐ Indian Health Service ☐ Veteran's Health Administration (VA), military health care (TRICARE), other military care
☐ Other: _____

Client's Home Address *(including city and zip code)***:** _____

Client's Phone Number: _____ **Client's Email Address:** _____

Preferred Method of Contact: *(check all that apply)* ☐ Mail ☐ Phone ☐ Email
May confidential messages be left on voicemail? ☐ Yes ☐ No

2. Referral Information

Describe the client's circumstances and reason for the referral for mental health services:

Assessments to be included with the referral: *(check all that apply)* ☐ GAD-7 ☐ PHQ-9 ☐ DAST-20 ☐ NA

3. Ryan White Part A Approval

By signing this form, I verify that all client eligibility information has been properly reviewed and documented per Columbus Public Health policy and that the client is approved to access Columbus Ryan White Part A services.

_____ _____
Professional's Printed Name *Title*

_____ _____
Organization *Phone Number*

_____ _____/_____/_____
Professional's Signature *Date*