CALVERT COUNTY HEALTH DEPARTMENT
LOCAL BEHAVIORAL HEALTH AUTHORITY
P.O. Box 980
Prince Frederick, Maryland 20678

Laurence Polsky, MD, MPH, F.A.C.O.G
Health Officer

Andrea McDonald-Fingland LCSW-C
LBHA Director

STATE OF MARYLAND

Phone (410) 535-5400
Washington Area (301) 855-1353
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www.calverthealth.org

Projects for the Assistance in the Transition from Homelessness (PATH)

PATH Referral Form

Today's Date: ________________

Client's Name: ____ Date of Birth: _________________

Client's Age: ____________ S.S.N. #: ________________________ Phone: ______________________

Address/Location: ____

Referral Source/Name: _______________________________ Title: ______________________________

Self Referral: _____________ Agency Referral: ________________ Consumer Referral: __________________

Email Address: ____________________________________ Phone #: _________________________________

If available, please provide a recent evaluation, treatment plan, or discharge summary, signed by a licensed mental health professional or physician, documenting applicants' diagnoses. Please include the professionals' contact information.

Please Note: All fields in this referral form are required to be completed to the best of your ability.

Is the applicant:

- ☐ Experiencing Homelessness
- ☐ At Imminent Risk of Homelessness
- ☐ Other, please describe: _________________________________

What is the client's current diagnosis? Please describe below:

- ☐ Yes: ____________________
- ☐ No
- ☐ Unsure/Other

Were additional referrals made? If so, where? Please list all additional referrals made below:

- ☐ Yes: ____________________
- ☐ No
- ☐ N/A

Client's Financial Status:

- ☐ Medical Assistance M.A. # ____________________
- ☐ Medicare M.C. # ____________________
- ☐ SSI $ Amount: ____________________
- ☐ SSDI $ Amount: ____________________
- ☐ Other Income/Benefits (Specify & Include $ Amount) ____________________

Is a follow up required/requested? ______ Yes ______ No

If Yes, when? ______ 30 Days ______ 60 Days ______ 90 Days ______ Other

What is the reason for today's referral? Please provide an explanation of need for this applicant, if possible provide background information relevant to the situation, and the reason for the referral.

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If not a provider filling out the referral form, please provide name, contact information, and any other relevant information from applicant's most recent behavioral health provider below.

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Any additional notes, or specific information that should be included to best support the applicant? Please describe below.

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(Signature's Below:)

______________________________ ______________________

Applicant's Signature: **Today's Date:**

______________________________ ______________________

Referral Source's Signature: (If different from above) **Today's Date:**

PATH Provider Use Only:

Date Referral Received: _____/_____/_______

PATH Provider Initials: _____________

Referral Received via:

- ☐ **Email**
- ☐ **Fax**
- ☐ **Hard Copy Delivered**

Date Initial Client Contact Made: _____/_____/_______ **Contacted Via: ____________________**
Second Contact Attempt Made: _____/_____/_______ **Contacted Via: ____________________**
Third Contact Attempt Made: _____/_____/________ **Contacted Via: ____________________**
Fourth Contact Attempt Made: _____/_____/_______ **Contacted Via: ____________________**
Final Contact Attempt Made: _____/_____/_______ **Contacted Via: ____________________**

NOTES:

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