Mahoning Valley Pathways HUB
100 Westchester Dr., Youngstown, Ohio 44515
Phone: 330-270-2855 ext. 174
Email: hub@mahoninghealth.org

OhioPathwaysHub.org

Mahoning Valley Pathways HUB Referral Form

Date: _____

Please complete the requested information below and fax to **330-918-1729** or email this form to HUB Coordinator at **hub@mahoninghealth.org**.

Referred by (agency and/or name):

_____ Phone: _____

Client's Name: _____

Gender: _____ Race/Ethnicity _____

Address: _____ City: _____ Zip: _____

Phone: _____ Email: _____

Date of Birth: _____ Due Date If Pregnant: _____

Medical Provider: _____

Do you have insurance? **Yes / No** (circle one) If yes, what is the provider and card number?

_____

Do you have any children under 18 years? **Yes / No** (circle one) If yes, how many? _____

Reason For Referral (Check all that apply)

- ☐ Addiction/Substance Use
- ☐ Depression/Anxiety
- ☐ Stroke
- ☐ Diabetes
- ☐ Pregnancy
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ COPD
- ☐ Other: _____

Additional Needs (Check all that apply)

- ☐ Tobacco Cessation
- ☐ Housing
- ☐ Transportation
- ☐ Food
- ☐ WIC
- ☐ Other: _____

By signing here, I consent to have _____ (agency/representative) share the above information with the Mahoning Valley Pathways HUB and its partner agencies for the purposes of enrollment into the Pathways Program which includes home visits with a community health worker.

_____

Print name | Sign name | Date

_____

Print name of parent/guardian | Sign name of parent/guardian | Date

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