Kentucky United Methodist Children's Homes

Bringing Hope to Children Since 1871

REFERRAL FORM – Mending Point Program

Who is submitting this referral?

Name: _____ Affiliation: _____

Phone Number: _____ Email: _____

What is the best way for us to follow up on this referral?

☐ Contact referring source directly ☐ Contact person/family being referred directly

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Who is being referred? Age: _____ D.O.B. ____/_____/_____

Name: _____ Social Security# _____

Parent/Guardian's Name (for persons under age 18): _____

Address: _____

County: _____ Phone#: _____ Alternate Phone#: _____

School attending (if applicable): _____

Is substance abuse treatment court ordered? ☐ Yes ☐ No

Any substances being used or suspected of being used: _____

Please indicate source of payment for services: ☐ Anthem (Medicaid) ☐ Aetna (Medicaid) ☐ Humana (Medicaid) ☐ Passport (Medicaid) ☐ Wellcare (Medicaid) ☐ Private insurance ☐ No insurance ☐ Self-pay

Insurance ID: _____ **Company:** _____

Medicaid or Group ID: _____

Reason for referral/presenting problem:_____

_____

_____

_____

Send referrals by email to rachel.smith@kyumh.org or by fax at (859) 241-3787

For questions about Mending Point program services call (859) 523-3001