northwest ohio

pathways HUB

Client Information		
Name:	|Date of Birth:	|Race/Ethnicity:
Address:	|City, State, Zip:	
Home Phone:	Phone:	
Referred By:		
Name:	Agency:	
Phone:	Email:	

Please check all factors that apply:

Risk Factors	
☐ Alcohol/Substance Abuse:	☐ Legal
☐ Asthma	☐ Low Income
☐ Childcare	☐ Medication Assistance
☐ Clothing	☐ Obese
☐ Depression or Other Mental Health Concern	☐ Physically Inactive
☐ Developmental Delay of Child in Family	☐ Poor Diet
☐ Domestic Violence	☐ Smoker/Tobacco User
☐ Education Assistance	☐ Stress
☐ Family History of Child Abuse/Neglect or involvement with CPS	☐ Transportation
☐ Family History of Heart Disease/Diabetes	☐ Other:
☐ Financial Assistance	
☐ Food	☐ **Child under age 18 living in the home**
☐ Housing	☐ **Pregnant** Estimated Due Date: _____
☐ Insurance	Gravida/Para: ___/___
☐ Job/Employment	

Insurance Status: *this must be completed*

☐ Medicaid:
Medicaid #: _____
☐ Medicare

☐ Uninsured
☐ Private

☐ CareNet
☐ Unknown

Please provide any additional information that may be helpful: _____

*By signing here, I consent for _____ (Referring Agency) to share the above information with the Northwest Ohio Pathways HUB for the purposes of enrollment into the Pathways Program.

Print Name: _____Signature: _____ Date: _____

Fax Referral to 419-842-0999 or email: pathways@hcno.org