NORTHWEST OHIO PATHWAYS HUB

Your community health worker can...

•Help navigate the healthcare system •Connect you to resources (baby items, food, etc.) •Help you understand insurance benefits and services

CLIENT INFORMATION

Full Name: _____ Date of Birth: _____ Race/Ethnicity: _____

Address: _____ City, State, ZIP: _____

Phone: _____ Email: _____

REFERRED BY

Full Name: _____ Agency: _____

Phone: _____ Email: _____

RISK FACTORS - CHECK ALL THAT APPLY

- ☐ Alcohol/Substance Abuse
- ☐ Asthma
- ☐ Childcare
- ☐ Clothing
- ☐ Depression or other mental health concern
- ☐ Developmental delay of child in family
- ☐ Domestic violence
- ☐ Education assistance
- ☐ Family history of child abuse/Neglect or involvement with CPS Family
- ☐ history of heart disease/diabetes
- ☐ Financial assistance
- ☐ Food
- ☐ Housing
- ☐ Insurance
- ☐ Job/Employment
- ☐ Legal
- ☐ Low income
- ☐ Medication Assistance
- ☐ Obesity
- ☐ Physically inactive
- ☐ Smoker/Tobacco user
- ☐ Stress
- ☐ Transportation
- ☐ Other: _____
- ☐ **Child(ren) under age 18 living in the home**
- ☐ Pregnant

Estimated due date: _____

# of Pregnancies: _____ # of Births: _____

INSURANCE STATUS - THIS MUST BE COMPLETED

- ☐ Medicaid
  - Plan Name: _____
  - Plan Number: _____
- ☐ Medicare
- ☐ Private Insurance
- ☐ Unknown
- ☐ Uninsured

ADDITIONAL INFORMATION:

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: _____

EMAIL: PATHWAYS@HCNO.ORG | FAX: 419-842-0999

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