

Pathways LIU 18 Referral Form

Provider 50

After School Program

Partial Hospitalization

Intake Information *(Completed for all clients)*

Date of Intake _____ Completed by _____

Client _____ DOB _____ Age _____

Parent(s)/Guardians _____ Phone Number _____

Home Address _____ County _____

Client MA # _____ SSN _____

Home District _____ Grade _____ Program _____

Referring Agent _____ Agency _____

Position _____ Phone Number _____

Insurance *(select one)* MA Private Other (Please Specify) _____

Status of Evaluation *(select one)* Need to Complete Completed and will send to IU

Comments/Presenting Behaviors/Projected Services & Locations

Previous Mental Health Services

Please forward referral form to:

LIU 18 Behavioral Health Services
C/o Jennifer Davies
368 Tioga Avenue
Kingston, PA 18704-5117