OhioMHAS Sample Form

Procedures for Referral of Residents for Mental Health Evaluation and Services

Residential Care Facility
5122-30-24 (C)(8)

Facility Name: ______ License No.: ______

Residents Name: ______ Date: ______

This facility accepts persons who have a mental health diagnosis or diagnosis of mental illness. If you wish to receive mental health services or wish to speak with a mental health representative, this facility will provide the following help to you:

Call your Mental Health Board:

Board: ______

Address: ______

City: ______ Zip Code: ______

Telephone: ______ E-Mail: ______

Call the local/lead Mental Health Agency in this area:

Board: ______

Address: ______

City: ______ Zip Code: ______

Telephone: ______ E-Mail: ______

This facility will help to arrange appointments for you.
◯ Yes ◯ No

Arrange or provide transportation to appointments.
◯ Yes ◯ No

Participate in a Mental Health Plan for Care for you, should mental health services be accepted.
◯ Yes ◯ No

Cooperate with your case manager to assure you receive appropriate mental health services.
◯ Yes ◯ No

At this time, I (resident name) ______ chose:

◯ To utilize mental health services. ◯ Not to utilize mental health services.

I have received a copy of this procedure and it has been explained to me
◯ Yes ◯ No

Resident's Signature: ______ Date ______