**Care Nav Referral Form**

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| ***CONTACT INFORMATION*** | | |
| ***Youth Name:*** | ***Youth DOB:*** | ***Preferred Language:*** |
| ***Youth Phone Number:*** | ***Parent/Guardian Phone Number(s):*** | ***Preferred Contact Method:***  ***Phone Call***  ***Text***  ***Email*** |
| ***Address:*** | ***Zip Code:*** | ***County/Jurisdiction:*** |
| ***Parent/Guardian Name(s) and Email(s):*** | | |
| ***Referral Source Name, Agency, Phone Number(s), and Email(s):*** | | |

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| ***REASON FOR SERVICES*** | | | |
| **Reason for Service/Service(s) Requested:** | Mental Health/Care  Substance Use Disorder (SUD)  ER/Crisis  Challenging Behaviors  Family Support  Other: | | **If checked “other”, please explain:** |
| **Is the youth currently enrolled in any other services?** | *Yes  No* | **If yes, what services?** | |
| **Has the youth used/accessed any other services in the past?** | *Yes  No* | **If yes, what services?** | |
| **Does the youth currently have health insurance?** | *Yes  No* | **If yes, what insurance?** | |
| **Is the youth currently receiving CSA funded services?** | *Yes  No* | **Where** **does the youth currently access healthcare (PCP, urgent care, emergency visits, etc.)?** | |
| **Does the youth currently have transportation?** | *Yes  No* | **If yes, what transportation utilized (Car, bus, etc.)?** | |
| **Please list any additional information/barriers:** |  | | |
| **NVFS Conexiones: Youth would benefit from services tailored for Spanish speaking immigrant families, with flexibility for home visiting and later hours.** | | | *Yes  No* |

**Connect with one of our Care Navigators**

**Phone**: 703-468-0040

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