Fax Cover Sheet
Mental Health Referral
Request for Service

From: Head Start

Center: _____

FA: _____

Phone: _____

Email: _____

To: __ **Kairos/Jackson Services** -Access Coordinator
Phone: 541-772-0127 **Fax: 541-772-0966**

__ **Options/Jackson County** -CRT-Intake Coordinator
Phone: 541-476-2373 **Fax: 541-770-4686**

__ **Options/Josephine County** -CRT Intake Coordinato
Phone: 541-244-3103 **Fax: 541-479-2450**

To be completed by Family Advocate or EHS Specialist with parent:

Person requesting services:
Date:
Child's Name:
Medicaid Number (optional):
Birth Date:
Mother's Name:
Address:
Phone Number:
Reason for Referral:

Mental Health Office to complete below:

Eligibility Check:
Client Checked in MMIS:
OHP:
County Enrolled In:
Eff Dates of Service:
Checked by:
Date:

FA or EHS Specialist to Fax MH Packet to the attention of Access or Intake Coordinator (see information above): this cover sheet, Head Start MH-2 ROI, Behavior Checklist (Options or the MH-3 for Kairos), copy of ASQ-SE, and Individual Observation (if available).

A copy of the MH Packet goes to Head Start MH Dept, copy in child file, then enter data in SHINE.

MH-4

or