Mental Health Bridge
Consent to Refer

Child's First and Last Name: ________________________________ Date of Birth: __________________

The purpose of the Mental Health Bridge program is to connect Ohio childcare centers, and caregivers of the children enrolled, with a state-wide network of early childhood mental health specialists who are available to provide mental health services to young children and their caregivers.

I, _____________________________ give my consent to _______________________________ to refer the

Legal Guardian Name Childcare Agency

child named above to the Mental Health Bridge Program to determine if my child is eligible to receive wellness/mental health services.

Please initial below

______ I understand that this Consent to Refer does not guarantee Mental Health/Wellness services.

______I understand that services provided through the Mental Health Bridge program will be provided either in-person or via telehealth at this childcare agency unless otherwise stated.

______I understand that at any time I have the right to withdraw my Consent to Refer or discontinue mental health/wellness services.

______I understand that if I choose to utilize the Mental Health Bridge program, I will be responsible for any insurance-related financial costs, if applicable.

______ I understand that if deemed necessary, my childcare provider may share any assessments and relevant information with the behavioral health provider.

_____________________________________ _____________________________________

Legal Guardian First and Last Name (Print) Childcare Agency Staff (Print)

_____________________________________ _____________________________________

Legal Guardian Signature Date Childcare Agency Staff Signature Date

A PROGRAM OF THE
Ohio Children's Alliance

WITH SUPPORT FROM THE
Ohio Department of Job and Family Services and the
Ohio Child Care Resource and Referral Association