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| Behavioral Health Facility Name | Firelands Counseling and Recovery Services |
| What is the form of contact? | Singular Contact |
| Department Name |  |
| Admission Notification |  |
| First Name | Michele |
| Last Name | Porter |
| Job Title | Case Management Coordinator |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | NA |
| Street Address | 1925 Hayes Ave |
| City | Sandusky |
| State | OH |
| Zip Code | 44870 |
| Secure/Encrypted Email Address | portermi@firelands.com |
| Direct Phone Number | 419-557-5046 |
| Fax Number | 419-557-5179 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet |  |
| Discharge Planning |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| County, Region, & Address Same as Above? |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address |  |
| Direct Phone Number |  |
| Fax Number |  |
| Preference for Receipt of Discharge Packet |  |

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| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Receptionist |
| Last Name | Receptionist |
| Job Title | Receptionist |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | NA |
| Direct Phone Number | 419-557-5177 |
| Fax Number | 419-557-5179 |
| Secondary Backup |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| County, Region, & Address Same as Above? |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address |  |
| Direct Phone Number |  |
| Fax Number |  |

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| Behavioral Health Facility Name | Firelands Counseling and Recovery Services |
| What is the form of contact? | Singular Contact |
| Department Name |  |
| Admission Notification |  |
| First Name | Cassandra |
| Last Name | Hetrick |
| Job Title | Program Coordinator |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | NA |
| Street Address | 675 Bartson Road |
| City | Fremont |
| State | OH |
| Zip Code | 43420 |
| Secure/Encrypted Email Address | hetricc@Firelands.com |
| Direct Phone Number | 419-557-5046 |
| Fax Number | 419-557-5179 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet |  |
| Discharge Planning |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| County, Region, & Address Same as Above? |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address |  |
| Direct Phone Number |  |
| Fax Number |  |
| Preference for Receipt of Discharge Packet |  |

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| --- | --- |
| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Receptionist |
| Last Name | Receptionst |
| Job Title | Receptionist |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | NA |
| Direct Phone Number | 419-332-5524 |
| Fax Number | 419-332-7581 |
| Secondary Backup |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| County, Region, & Address Same as Above? |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address |  |
| Direct Phone Number |  |
| Fax Number |  |

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| Behavioral Health Facility Name | Firelands Counseling and Recovery Services |
| What is the form of contact? | Singular Contact |
| Department Name |  |
| Admission Notification |  |
| First Name | Casandra |
| Last Name | Hetrick |
| Job Title | Program Coordinator |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | NA |
| Street Address | 76 Ashwood Drive |
| City | Tiffin |
| State | OH |
| Zip Code | 44883 |
| Secure/Encrypted Email Address | hetricc@Firelands.com |
| Direct Phone Number | 419-448-9440 |
| Fax Number | 419-448-5155 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet |  |
| Discharge Planning |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| County, Region, & Address Same as Above? |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address |  |
| Direct Phone Number |  |
| Fax Number |  |
| Preference for Receipt of Discharge Packet |  |

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| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Receptionist |
| Last Name | Receptionist |
| Job Title | Receptionist |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | hetricc@Firelands.com |
| Direct Phone Number | 419-448-9440 |
| Fax Number | 419-448-5155 |
| Secondary Backup |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| County, Region, & Address Same as Above? |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address |  |
| Direct Phone Number |  |
| Fax Number |  |

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| Behavioral Health Facility Name | Firelands Counseling and Recovery Services |
| What is the form of contact? | Singular Contact |
| Department Name |  |
| Admission Notification |  |
| First Name | Lauren |
| Last Name | Robinson |
| Job Title | BH Site Supervisor |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | NA |
| Street Address | 292 Benedict Avenue |
| City | Norwalk |
| State | OH |
| Zip Code | 44857 |
| Secure/Encrypted Email Address | RobinsL@Firelands.com |
| Direct Phone Number | 419-663-3737 |
| Fax Number | 419-663-5096 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet |  |
| Discharge Planning |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| County, Region, & Address Same as Above? |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address |  |
| Direct Phone Number |  |
| Fax Number |  |
| Preference for Receipt of Discharge Packet |  |

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| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Receptionist |
| Last Name | Receptionist |
| Job Title | Receptionist |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | RobinsL@Firelands.com |
| Direct Phone Number | 419-663-3737 |
| Fax Number | 419-663-5096 |
| Secondary Backup |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| County, Region, & Address Same as Above? |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address |  |
| Direct Phone Number |  |
| Fax Number |  |

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| Behavioral Health Facility Name | Firelands Counseling and Recovery Services |
| What is the form of contact? | Singular Contact |
| Department Name |  |
| Admission Notification |  |
| First Name | Roxanne |
| Last Name | King |
| Job Title | Program Coordinator |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | NA |
| Street Address | 335 Buckeye Boulevard |
| City | Port Clinton |
| State | OH |
| Zip Code | 43452 |
| Secure/Encrypted Email Address | KingRox@Firelands.com |
| Direct Phone Number | 419-734-2942 |
| Fax Number | 419-734-4922 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet |  |
| Discharge Planning |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| County, Region, & Address Same as Above? |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address |  |
| Direct Phone Number |  |
| Fax Number |  |
| Preference for Receipt of Discharge Packet |  |

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| --- | --- |
| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Receptionist |
| Last Name | REceptionist |
| Job Title | Receptionist |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | KingRox@Firelands.com |
| Direct Phone Number | 419-734-2942 |
| Fax Number | 419-734-4922 |
| Secondary Backup |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| County, Region, & Address Same as Above? |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address |  |
| Direct Phone Number |  |
| Fax Number |  |

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| Behavioral Health Facility Name | Firelands Counseling and Recovery Services |
| What is the form of contact? | Singular Contact |
| Department Name |  |
| Admission Notification |  |
| First Name | Dawn |
| Last Name | Kroh |
| Job Title | Site Director, BH |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | NA |
| Street Address | 6150 Park Square Drive |
| City | Lorain |
| State | OH |
| Zip Code | 44053 |
| Secure/Encrypted Email Address | KrohD@Firelands.com |
| Direct Phone Number | 440-984-3882 |
| Fax Number | 440-984-3883 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet |  |
| Discharge Planning |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| County, Region, & Address Same as Above? |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address |  |
| Direct Phone Number |  |
| Fax Number |  |
| Preference for Receipt of Discharge Packet |  |

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| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Receptionist |
| Last Name | Receptionist |
| Job Title | Receptionist |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | KrohD@Firelands.com |
| Direct Phone Number | 440-984-3882 |
| Fax Number | 440-984-3883 |
| Secondary Backup |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| County, Region, & Address Same as Above? |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address |  |
| Direct Phone Number |  |
| Fax Number |  |

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| Behavioral Health Facility Name | Firelands Counseling and Recovery Services |
| What is the form of contact? | Singular Contact |
| Department Name |  |
| Admission Notification |  |
| First Name | Casandra |
| Last Name | Hetrick |
| Job Title | Porgram Coordinator |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | NA |
| Street Address | 97 Houpt Drive, Ste W |
| City | Upper Sandusky |
| State | OH |
| Zip Code | 43351 |
| Secure/Encrypted Email Address | HetricCFirelands.com |
| Direct Phone Number | 419-294-4388 |
| Fax Number | 419-294-5788 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet |  |
| Discharge Planning |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| County, Region, & Address Same as Above? |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address |  |
| Direct Phone Number |  |
| Fax Number |  |
| Preference for Receipt of Discharge Packet |  |

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| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Receptionist |
| Last Name | Receptionist |
| Job Title | Receptionist |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | HetricC@Firelands.com |
| Direct Phone Number | 419-294-4388 |
| Fax Number | 419-294-5788 |
| Secondary Backup |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| County, Region, & Address Same as Above? |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address |  |
| Direct Phone Number |  |
| Fax Number |  |

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| Behavioral Health Facility Name | New Horizons Mental Health Services |
| What is the form of contact? | Singular Contact |
| Department Name |  |
| Admission Notification |  |
| First Name | Justine |
| Last Name | Simpson |
| Job Title | Clinical Director |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | NA |
| Street Address | 1550 Sheridan Drive |
| City | Lancaster |
| State | OH |
| Zip Code | 43130 |
| Secure/Encrypted Email Address | jsimpson@newhorizonsmentalhealth.org |
| Direct Phone Number | 740-901-3637 |
| Fax Number | 740-785-4924 |
| Contact Person is the same for both Discharge Planning and Admission Notification | No |
| Preference for Receipt of Discharge Packet | Secure email |
| Discharge Planning |  |
| First Name | Jessee |
| Last Name | Nara |
| Job Title | Community Intake Specialist |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | jnara@hewhorizonsmentalhealth.org |
| Direct Phone Number | 740-277-6166 |
| Fax Number | 740-277-6700 |
| Preference for Receipt of Discharge Packet | Secure Email |

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| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Samantha |
| Last Name | Williams |
| Job Title | CCBHC Clinic Case Manager |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | swilliams@newhorizonsmentalhealth.org |
| Direct Phone Number | 740-901-3641 |
| Fax Number | 740-785-4924 |
| Secondary Backup |  |
| First Name | Melissa |
| Last Name | Palmer |
| Job Title | Office Lead |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | mpalmer@newhorizonsmentalhealth.org |
| Direct Phone Number | 614-834-1919 Ext 3263 |
| Fax Number | 740-785-4924 |

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| Behavioral Health Facility Name | Shawnee Family Health Center |
| What is the form of contact? | Singular Contact |
| Department Name |  |
| Admission Notification |  |
| First Name | Kaitlin |
| Last Name | Colley |
| Job Title | Intake/Screener |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | NA |
| Street Address | 901 Washington Street |
| City | Portsmouth |
| State | OH |
| Zip Code | 45662 |
| Secure/Encrypted Email Address | k.colley@shawneemhc.org |
| Direct Phone Number | 740-355-8622 |
| Fax Number | 740-353-6206 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet |  |
| Discharge Planning |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| County, Region, & Address Same as Above? |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address |  |
| Direct Phone Number |  |
| Fax Number |  |
| Preference for Receipt of Discharge Packet |  |

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| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Kaitlin |
| Last Name | Colley |
| Job Title | Intake/Screener |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | k.colley@shawneemhc.org |
| Direct Phone Number | 740-355-8622 |
| Fax Number | 740-353-6206 |
| Secondary Backup |  |
| First Name | Kaitlin |
| Last Name | Colley |
| Job Title | Intake/Screener |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | k.colley@shawneemhc.org |
| Direct Phone Number | 740-355-8622 |
| Fax Number | 740-353-6206 |

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| Behavioral Health Facility Name | Hopewell Health Center |
| What is the form of contact? | Singular Contact |
| Department Name |  |
| Admission Notification |  |
| First Name | Dan |
| Last Name | Brozak |
| Job Title | Hospital Liaison |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | NA |
| Street Address | 90 Hospital Drive |
| City | Athens |
| State | OH |
| Zip Code | 45701 |
| Secure/Encrypted Email Address | dan.brozak@hopewellhealth.org |
| Direct Phone Number | 740-517-0356 |
| Fax Number | 740-593-8659 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet |  |
| Discharge Planning |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| County, Region, & Address Same as Above? |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address |  |
| Direct Phone Number |  |
| Fax Number |  |
| Preference for Receipt of Discharge Packet |  |

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| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Dan |
| Last Name | Brozak |
| Job Title | Hospital Liaison |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | dan.brozak@hopewellhealth.org |
| Direct Phone Number | 740-517-0356 |
| Fax Number | 740-593-8659 |
| Secondary Backup |  |
| First Name | Dan |
| Last Name | Brozak |
| Job Title | Hospital Liaison |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | dan.brozak@hopewellhealth.org |
| Direct Phone Number | 740-517-0356 |
| Fax Number | 740-593-8659 |

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| Behavioral Health Facility Name | Franklin County Southeast Healthcare |
| What is the form of contact? | Department |
| Department Name | Clinical Leadership |
| Admission Notification |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | NA |
| Street Address | 16 West Long Street |
| City | Columbus |
| State | OH |
| Zip Code | 43215 |
| Secure/Encrypted Email Address | FranklinNotify\_Plan@southeastinc.com |
| Direct Phone Number | 614-225-0980 Ext 1137 |
| Fax Number | 614-744-8185 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet |  |
| Discharge Planning |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| County, Region, & Address Same as Above? |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address |  |
| Direct Phone Number |  |
| Fax Number |  |
| Preference for Receipt of Discharge Packet |  |

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| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Krystal |
| Last Name | McColaugh |
| Job Title | Office Liaison |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | FranklinFUNR@southeastinc.com |
| Direct Phone Number | 614-225-0980 Ext 1137 |
| Fax Number | 614-744-8185 |
| Secondary Backup |  |
| First Name | Jenifer |
| Last Name | Fraioli |
| Job Title | Chief Healthcare Officer |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | faiolij@southeastinc.com |
| Direct Phone Number |  |
| Fax Number |  |

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| --- | --- |
| Behavioral Health Facility Name | Delaware Morrow Southeast Healthcare |
| What is the form of contact? | Department |
| Department Name | Clinical Leadership |
| Admission Notification |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | NA |
| Street Address | 824 Bowtown Road |
| City | Delaware |
| State | OH |
| Zip Code | 43015 |
| Secure/Encrypted Email Address | Delaware\_MorrowNotify\_Plan@southeastinc.com |
| Direct Phone Number | 614-225-0980 Ext 1137 |
| Fax Number | 614-744-8185 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet |  |
| Discharge Planning |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| County, Region, & Address Same as Above? |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address |  |
| Direct Phone Number |  |
| Fax Number |  |
| Preference for Receipt of Discharge Packet |  |

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| --- | --- |
| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Krystal |
| Last Name | McColaugh |
| Job Title | Office Liaison |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | Delaware\_MorrowNotify\_Plan@southeastinc.com |
| Direct Phone Number | 614-225-0980 Ext 1137 |
| Fax Number | 614-744-8185 |
| Secondary Backup |  |
| First Name | Jenifer |
| Last Name | Fraioli |
| Job Title | Chief Healthcare Officer |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | fraiolij@southeastinc.com |
| Direct Phone Number |  |
| Fax Number |  |

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| --- | --- |
| Behavioral Health Facility Name | Belmont Harrison Monroe Southeast Healthcare |
| What is the form of contact? | Department |
| Department Name | Clinical Leadership |
| Admission Notification |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | NA |
| Street Address | 68353 Bannock Road |
| City | St. Clairsville |
| State | OH |
| Zip Code | 43950 |
| Secure/Encrypted Email Address | Belmont\_Harrison\_MonroeNotify\_Plan\_FUNR@southeastinc.com |
| Direct Phone Number | 740-695-9344 |
| Fax Number | 740-695-7781 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet |  |
| Discharge Planning |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| County, Region, & Address Same as Above? |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address |  |
| Direct Phone Number |  |
| Fax Number |  |
| Preference for Receipt of Discharge Packet |  |

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| --- | --- |
| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Clinical |
| Last Name | Leadership |
| Job Title | Clinical Leadership |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | Belmont\_Harrison\_MonroeNotify\_Plan\_FUNR@southeastinc.com |
| Direct Phone Number | 740-695-9344 |
| Fax Number | 740-695-7781 |
| Secondary Backup |  |
| First Name | Jenifer |
| Last Name | Fraioli |
| Job Title | Chief Healthcare Officer |
| County, Region, & Address Same as Above? | No |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | NA |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | faiolij@southeastinc.com |
| Direct Phone Number |  |
| Fax Number |  |

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| --- | --- |
| Behavioral Health Facility Name | Tuscarawas Carroll Southeast Healthcare |
| What is the form of contact? | Department |
| Department Name | Clinical Leadership |
| Admission Notification |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | NA |
| Street Address | 344 West High Avenue |
| City | New Philadelphia |
| State | OH |
| Zip Code | 44663 |
| Secure/Encrypted Email Address | Tusc\_CarrollNotify\_Plan@southeastinc.com |
| Direct Phone Number | 330-339-7850 |
| Fax Number | 740-695-7781 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet |  |
| Discharge Planning |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| County, Region, & Address Same as Above? |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address |  |
| Direct Phone Number |  |
| Fax Number |  |
| Preference for Receipt of Discharge Packet |  |

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| --- | --- |
| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Clinical |
| Last Name | Leadership |
| Job Title | Clinical Leadership |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | Tusc\_CarrollFUNR@southeastinc.com |
| Direct Phone Number | 330-339-7850 |
| Fax Number | 740-695-7781 |
| Secondary Backup |  |
| First Name | Jenifer |
| Last Name | Fraioli |
| Job Title | Chief Healthcare Officer |
| County, Region, & Address Same as Above? | No |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | faiolij@southeastinc.com |
| Direct Phone Number |  |
| Fax Number |  |

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| Behavioral Health Facility Name | Darke County Recovery Services dba: Recovery and Wellness Centers of Midwest Ohio – Mental Health /Darke County |
| What is the form of contact? | Singular Contact |
| Department Name |  |
| Admission Notification |  |
| First Name | Vickie |
| Last Name | Martin |
| Job Title | Clinical Director - MH Darke County |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | Darke County |
| Street Address | 212 East Main St |
| City | Greenville |
| State | OH |
| Zip Code | 45331 |
| Secure/Encrypted Email Address | VMartin@rwcohio.org |
| Direct Phone Number | 937-548-1635 |
| Fax Number | 937-548-1500 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet | Fax |
| Discharge Planning |  |
| First Name | Vickie |
| Last Name | Martin |
| Job Title | Clinical Director- MH Darke County |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | VMartin@rwcohio.org |
| Direct Phone Number | 937-548-1635 |
| Fax Number | 937-548-1500 |
| Preference for Receipt of Discharge Packet |  |

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| --- | --- |
| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Receptionist |
| Last Name | Receptionist |
| Job Title | Receptionist |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | NA |
| Direct Phone Number | 937-548-1635 |
| Fax Number | 937-548-1500 |
| Secondary Backup |  |
| First Name | Rhonda |
| Last Name | Fields |
| Job Title | Out Patient Therapist/ Team Lead |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | rfields@rwcohio.org |
| Direct Phone Number | 937-548-1635 |
| Fax Number | 937-548-1500 |

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| Behavioral Health Facility Name | Darke County Recovery Services dba: Recovery and Wellness Centers of Midwest Ohio – MH & SUD Miami County |
| What is the form of contact? | Singular Contact |
| Department Name |  |
| Admission Notification |  |
| First Name | Cindy |
| Last Name | Holloway |
| Job Title | Clinical Director - MH & SUD Miami County |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | Miami County |
| Street Address | 1483 West Main St |
| City | Tipp City |
| State | OH |
| Zip Code | 47371 |
| Secure/Encrypted Email Address | cholloway@rwcohio.org |
| Direct Phone Number | 937-335-0361 |
| Fax Number | 937-667-5001 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet | Fax |
| Discharge Planning |  |
| First Name | Cindy |
| Last Name | Holloway |
| Job Title | Clinical Director - MH & SUD Miami County |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | cholloway@rwcohio.org |
| Direct Phone Number | 937-335-0361 |
| Fax Number | 937-667-5001 |
| Preference for Receipt of Discharge Packet |  |

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| --- | --- |
| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Receptionist |
| Last Name | Receptionist |
| Job Title | Receptionist |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | NA |
| Direct Phone Number | 937-335-0361 |
| Fax Number | 937-667-5001 |
| Secondary Backup |  |
| First Name | Tina |
| Last Name | Supinger |
| Job Title | Performance Improvement Coordinator |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | tsupinger@rwcohio.org |
| Direct Phone Number | 937-335-0361 |
| Fax Number | 937-667-5001 |

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| Behavioral Health Facility Name | Darke County Recovery Services dba: Recovery and Wellness Centers of Midwest Ohio – MH & SUD Preble County |
| What is the form of contact? | Singular Contact |
| Department Name |  |
| Admission Notification |  |
| First Name | Jerri Lynn |
| Last Name | Stanley |
| Job Title | Clinical Director- MH & SUD Preble County |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | Preble Co |
| Street Address | 228 North Barron St |
| City | Eaton |
| State | OH |
| Zip Code | 45320 |
| Secure/Encrypted Email Address | jlstanley@rwcohio.org |
| Direct Phone Number | 937-456-7694 |
| Fax Number | 937-456-7752 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet | Fax |
| Discharge Planning |  |
| First Name | Jerri Lynn |
| Last Name | Stanley |
| Job Title | Clinical Director- MH & SUD Preble County |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | jlstanley@rwcohio.org |
| Direct Phone Number | 937-456-7694 |
| Fax Number | 937-456-7753 |
| Preference for Receipt of Discharge Packet |  |

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| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Receptionist |
| Last Name | Receptionist |
| Job Title | Receptionist |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | NA |
| Direct Phone Number | 937-456-7694 |
| Fax Number | 937-456-7753 |
| Secondary Backup |  |
| First Name | Debra |
| Last Name | Hater |
| Job Title | Out Patient Therapist/Team Lead |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | dhater@rwcohio.org |
| Direct Phone Number | 937-456-7694 |
| Fax Number | 937-456-7753 |

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| Behavioral Health Facility Name | Ravenwood Health |
| What is the form of contact? | Department |
| Department Name | Emergency Services |
| Admission Notification |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address | 12557 Ravenwood Dr |
| City | Chardon |
| State | Ohio |
| Zip Code | 44024 |
| Secure/Encrypted Email Address | n/a |
| Direct Phone Number | (440) 285-3568 |
| Fax Number | (440) 285-4552 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet | Fax |
| Discharge Planning |  |
| First Name | Emergency |
| Last Name | Services |
| Job Title | Hospital Discharges |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | n/a |
| Direct Phone Number | (440) 285-3568 "Emergency Services" |
| Fax Number | (440) 285-4552 |
| Preference for Receipt of Discharge Packet |  |

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| --- | --- |
| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Emergency |
| Last Name | Services |
| Job Title | Hospital Discharges |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | n/a |
| Direct Phone Number | (440) 285-3568 "Emergency Services" |
| Fax Number | (440) 285-4552 |
| Secondary Backup |  |
| First Name | Amanda |
| Last Name | Naso |
| Job Title | Emergency Services Coordinator |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | nasoa@ravenwoodhealth.org |
| Direct Phone Number | (440) 285-3568 x331 |
| Fax Number | (440) 285-4552 |

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| Behavioral Health Facility Name | Community Counseling & Wellness Centers |
| What is the form of contact? | Singular Contact |
| Department Name |  |
| Admission Notification |  |
| First Name | Brittany |
| Last Name | Massey |
| Job Title | Director of Human Resources |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | Crawford, Marion |
| Street Address | 320 Executive Drive |
| City | Marion |
| State | OH |
| Zip Code | 43302 |
| Secure/Encrypted Email Address | bmassey@ccscrawford.org |
| Direct Phone Number | 7403875210 |
| Fax Number | 7403823713 |
| Contact Person is the same for both Discharge Planning and Admission Notification | No |
| Preference for Receipt of Discharge Packet | Fax |
| Discharge Planning |  |
| First Name | Courtney |
| Last Name | A |
| Job Title | Intake Specialist |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | courtneya@maccsite.com |
| Direct Phone Number | 7403875210 |
| Fax Number | 7403823713 |
| Preference for Receipt of Discharge Packet |  |

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| --- | --- |
| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Courtney |
| Last Name | A |
| Job Title | Intake Specialist |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | courtneya@maccsite.com |
| Direct Phone Number | 7403875210 |
| Fax Number | 7403823713 |
| Secondary Backup |  |
| First Name | Amy |
| Last Name | Billa |
| Job Title | Director of Programming and Clinical Operations |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | abilla@ccscrawford.org |
| Direct Phone Number | 7403875210 |
| Fax Number |  |

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| Behavioral Health Facility Name | The Nord Center |
| What is the form of contact? | Singular Contact |
| Department Name |  |
| Admission Notification |  |
| First Name | Vera |
| Last Name | McGuinness |
| Job Title | System Administrator |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | NA |
| Street Address | 6140 S Broadway |
| City | Lorain |
| State | Ohio |
| Zip Code | 44053 |
| Secure/Encrypted Email Address | vmcguinness@nordcenter.org |
| Direct Phone Number | 440.204.4347 |
| Fax Number | 440.233.5552 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet | Secure Email |
| Discharge Planning |  |
| First Name | Brooke |
| Last Name | Sherman |
| Job Title | Director of Counseling Services |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | bsherman@nordcenter.org |
| Direct Phone Number | 440.204.4215 |
| Fax Number | 440.233.5552 |
| Preference for Receipt of Discharge Packet |  |

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| --- | --- |
| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Brooke |
| Last Name | Sherman |
| Job Title | Director of Counseling Services |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | bsherman@nordcenter.org |
| Direct Phone Number | 440.204.4215 |
| Fax Number | 440.233.5552 |
| Secondary Backup |  |
| First Name | Dana |
| Last Name | Santo |
| Job Title | Chief Clinical Officer |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | dsanto@nordcenter.org |
| Direct Phone Number | 440.204.4333 |
| Fax Number | 440.233.5552 |

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| Behavioral Health Facility Name | Appleseed Community Mental Health Center Inc. |
| What is the form of contact? | Singular Contact |
| Department Name |  |
| Admission Notification |  |
| First Name | Amy |
| Last Name | Adams |
| Job Title | Emergency Services and Quality Improvement Coordinator |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | NA |
| Street Address | 2233 Rocky Lane |
| City | Ashland |
| State | OH |
| Zip Code | 44805 |
| Secure/Encrypted Email Address | aadams@appleseedcmhc.org |
| Direct Phone Number | 419-281-3716 |
| Fax Number | 419-281-4605 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet | Fax |
| Discharge Planning |  |
| First Name | Amy |
| Last Name | Adams |
| Job Title | Emergency Services and Quality Improvement Coordinator |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | aadams@appleseedcmhc.org |
| Direct Phone Number | 419-281-3716 |
| Fax Number | 419-281-4605 |
| Preference for Receipt of Discharge Packet |  |

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| --- | --- |
| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Madyson |
| Last Name | Ringer |
| Job Title | Health Officer |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | mringer@appleseedcmhc.org |
| Direct Phone Number | 419-281-3716 |
| Fax Number | 419-281-4605 |
| Secondary Backup |  |
| First Name | Madyson |
| Last Name | Ringer |
| Job Title | Health Officer |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | mringer@appleseedcmhc.org |
| Direct Phone Number | 419-281-3716 |
| Fax Number | 419-281-4605 |

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| --- | --- |
| Behavioral Health Facility Name | Butler Behavioral Health |
| What is the form of contact? | Singular Contact |
| Department Name |  |
| Admission Notification |  |
| First Name | Trish |
| Last Name | Haas |
| Job Title | Office Manager |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | Butler, Clinton, Warren |
| Street Address | 1490 University Boulevard |
| City | Hamilton |
| State | Ohio |
| Zip Code | 45011 |
| Secure/Encrypted Email Address | thaas@bbhs.org |
| Direct Phone Number | 513-896-7887 |
| Fax Number | medicalrecords@bbhs.org |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet | Secure Email |
| Discharge Planning |  |
| First Name | Trish |
| Last Name | Haas |
| Job Title | Office Manager |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | thaas@bbhs.org |
| Direct Phone Number | 513-896-7887 |
| Fax Number | medicalrecords@bbhs.org |
| Preference for Receipt of Discharge Packet |  |

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| --- | --- |
| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Trish |
| Last Name | Haas |
| Job Title | Office Manager |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | thaas@bbhs.org |
| Direct Phone Number | 513-896-7887 |
| Fax Number | medicalrecords@bbhs.org |
| Secondary Backup |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| County, Region, & Address Same as Above? |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address |  |
| Direct Phone Number |  |
| Fax Number |  |

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| Behavioral Health Facility Name | The Centers |
| What is the form of contact? | Department |
| Department Name | Rapid Access |
| Admission Notification |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address | 4400 Euclid Ave |
| City | Cleveland |
| State | OH |
| Zip Code | 44103 |
| Secure/Encrypted Email Address | rapidaccessteam@thecentersohio.org |
| Direct Phone Number | 216-314-2730 |
| Fax Number | 216-325-9223 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet | Fax |
| Discharge Planning |  |
| First Name | Evelin |
| Last Name | Rivera |
| Job Title | Practice Manager |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | rapidaccessteam@thecentersohio.org |
| Direct Phone Number | 216-314-2730 |
| Fax Number | 216-325-9223 |
| Preference for Receipt of Discharge Packet |  |

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| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Evelin |
| Last Name | Rivera |
| Job Title | Practice Manager |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | rapidaccessteam@thecentersohio.org |
| Direct Phone Number | 216-314-2730 |
| Fax Number | 216-325-9223 |
| Secondary Backup |  |
| First Name | Colleen |
| Last Name | Ptak |
| Job Title | Director |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | colleen.ptak@thecentersohio.org |
| Direct Phone Number | 216-218-9091 |
| Fax Number | 216-325-9223 |

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| Behavioral Health Facility Name | Allwell Behavioral Health Services |
| What is the form of contact? | Singular Contact |
| Department Name |  |
| Admission Notification |  |
| First Name | Bonnie |
| Last Name | Taylor |
| Job Title | Acute Care Services Director |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | Muskingum, Guernsey, Coshocton, Perry, Morgan, Noble |
| Street Address | 2845 Bell Street |
| City | Zanesville |
| State | Ohio |
| Zip Code | 43701 |
| Secure/Encrypted Email Address | btaylor@allwell.org |
| Direct Phone Number | 740-252-6067 |
| Fax Number | 740-455-5322 |
| Contact Person is the same for both Discharge Planning and Admission Notification | No |
| Preference for Receipt of Discharge Packet | Fax |
| Discharge Planning |  |
| First Name | Amy |
| Last Name | Green |
| Job Title | Hospital Liason |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | agreen@allwell.org |
| Direct Phone Number | 740-454-4615 |
| Fax Number | 740-455-5322 |
| Preference for Receipt of Discharge Packet |  |

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| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | April |
| Last Name | Nichols |
| Job Title | Office Manager |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | anichols@allwell.org |
| Direct Phone Number | 740-454-9766 |
| Fax Number | 740-588-6452 |
| Secondary Backup |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| County, Region, & Address Same as Above? |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address |  |
| Direct Phone Number |  |
| Fax Number |  |

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| Behavioral Health Facility Name | Community Counseling Center of Ashtabula, Ohio |
| What is the form of contact? | Department |
| Department Name | Receptionist |
| Admission Notification |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | Ashtabula |
| Street Address | 2801 C Court |
| City | Ashtabula |
| State | OH |
| Zip Code | 44004 |
| Secure/Encrypted Email Address | receptionists@cccohio.com |
| Direct Phone Number | 440.998.4210 |
| Fax Number | 440.998.6489 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet | Secure Email |
| Discharge Planning |  |
| First Name | Receptionists (Jennifer, Wendy, Diana, Grace, Missy) |
| Last Name | Receptionists (Peyton, Charles, Hoplight, Wimbs, Colucci) |
| Job Title | Receptionists |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | receptionists@cccohio.com |
| Direct Phone Number | 440.998.4210 |
| Fax Number | 440.998.6489 |
| Preference for Receipt of Discharge Packet |  |

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| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Receptionists (Jennifer, Wendy, Diana, Grace, Missy) |
| Last Name | Receptionists (Peyton, Charles, Hoplight, Wimbs, Colucci) |
| Job Title | Receptionists and Qualifications Specialists |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | receptionists@cccohio.com |
| Direct Phone Number | 440.998.4210 |
| Fax Number | 4409.998.6489 |
| Secondary Backup |  |
| First Name | Joleen |
| Last Name | Sundquist |
| Job Title | Chief Clinical Officer |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | joleen.sundquist@cccohio.com |
| Direct Phone Number | 440.990.3418 |
| Fax Number | 440.998.6489 |

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| Behavioral Health Facility Name | The Counseling Center of Wayne and Holmes Counties |
| What is the form of contact? | Department |
| Department Name | Health Information Management Services |
| Admission Notification |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | NA |
| Street Address | 2285 Benden Drive |
| City | Wooster |
| State | OH |
| Zip Code | 44691 |
| Secure/Encrypted Email Address | rhess@ccwhc.org |
| Direct Phone Number | 330-264-9029 |
| Fax Number | 330-263-7251 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet | Secure Email |
| Discharge Planning |  |
| First Name | Robin |
| Last Name | Hess |
| Job Title | Director, Health Information Services |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | rhess@ccwhc.org |
| Direct Phone Number | 330-264-9029 |
| Fax Number | 330-263-7251 |
| Preference for Receipt of Discharge Packet |  |

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| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Billie |
| Last Name | Schlund |
| Job Title | Intake Secretary |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | bschlund@ccwhc.org |
| Direct Phone Number | 330-264-9029 |
| Fax Number | 330-2637251 |
| Secondary Backup |  |
| First Name | Diane |
| Last Name | DeRue |
| Job Title | Vice President/ Chief of Recovery Services |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | dsderue@ccwhc.org |
| Direct Phone Number | 330-264-9029 |
| Fax Number | 330-263-7251 |

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| Behavioral Health Facility Name | Pathways Counseling Center Inc. |
| What is the form of contact? | Department |
| Department Name | Administration |
| Admission Notification |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | NW |
| Street Address | 835 North Locust Street |
| City | Ottawa |
| State | Ohio |
| Zip Code | 45875 |
| Secure/Encrypted Email Address | dkonst@pathwaysputnam.org |
| Direct Phone Number | 419-523-4300 |
| Fax Number | 419-523-6188 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet | Secure Email |
| Discharge Planning |  |
| First Name | Kesha |
| Last Name | Scott |
| Job Title | Clinical Director |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | kscott@pathwaysputnam.org |
| Direct Phone Number | 419523-4300 |
| Fax Number | 419-523-6188 |
| Preference for Receipt of Discharge Packet |  |

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| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Kesha |
| Last Name | Scott |
| Job Title | Clinical Director |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | kscott@pathwaysputnam.org |
| Direct Phone Number | 419-523-4300 |
| Fax Number | 419-523-6188 |
| Secondary Backup |  |
| First Name | Donna |
| Last Name | Konst |
| Job Title | Ex. Director |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | dkonst@pathwaysputnam.org |
| Direct Phone Number | 419-523-4300 |
| Fax Number | 419-523-6188 |

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| Behavioral Health Facility Name | The Counseling Center |
| What is the form of contact? | Department |
| Department Name | Crisis Center |
| Admission Notification |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address | 1311 2nd Street |
| City | Portsmouth |
| State | OH |
| Zip Code | 45662 |
| Secure/Encrypted Email Address | jbrashear@thecounselingcenter.org |
| Direct Phone Number | 740-354-1010 |
| Fax Number | 740-981-3592 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet | Secure Email |
| Discharge Planning |  |
| First Name | Jonathan |
| Last Name | Brashear |
| Job Title | Director of Mental Health/Crisis Services |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | jbrashear@thecounselingcenter.org |
| Direct Phone Number | 740-464-2553 |
| Fax Number | 740-981-3590 |
| Preference for Receipt of Discharge Packet |  |

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| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Jonathan |
| Last Name | Brashear |
| Job Title | Director of Mental Health/Crisis Services |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | jbrashear@thecounselingcenter.org |
| Direct Phone Number | 740-354-1010 |
| Fax Number | 740-981-3590 |
| Secondary Backup |  |
| First Name | Jonathan |
| Last Name | Brashear |
| Job Title | Director Mental Health/Crisis Services |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | jbrashear@thecounselingcenter.org |
| Direct Phone Number | 740-354-1010 |
| Fax Number |  |

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| Behavioral Health Facility Name | Appleseed Community Mental Health Center |
| What is the form of contact? | Singular Contact |
| Department Name |  |
| Admission Notification |  |
| First Name | Amy |
| Last Name | Adams |
| Job Title | Emergency Services & Compliance Coordinator |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | Ashland County |
| Street Address | 2233 Rocky Lane Dr |
| City | Ashland |
| State | OH |
| Zip Code | 44090 |
| Secure/Encrypted Email Address | aadams@appleseedcmhc.org |
| Direct Phone Number | 419-281-3716 |
| Fax Number | 419-281-4605 |
| Contact Person is the same for both Discharge Planning and Admission Notification | No |
| Preference for Receipt of Discharge Packet | Fax |
| Discharge Planning |  |
| First Name | Intake |
| Last Name | Intake |
| Job Title | Intake |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | aadams@appleseedcmhc.org |
| Direct Phone Number | 419-281-3716 |
| Fax Number | 419-281-4605 |
| Preference for Receipt of Discharge Packet |  |

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| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Emma |
| Last Name | Fowler |
| Job Title | Intake |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | efowler@appleseedcmhc.org |
| Direct Phone Number | 419-281-3716 |
| Fax Number | 419-281-4605 |
| Secondary Backup |  |
| First Name | Receptionist |
| Last Name | Receptionist |
| Job Title | Receptionist |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address |  |
| Direct Phone Number |  |
| Fax Number |  |

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| Behavioral Health Facility Name | CommQuest Services Inc |
| What is the form of contact? | Singular Contact |
| Department Name |  |
| Admission Notification |  |
| First Name | Katrina |
| Last Name | McCole |
| Job Title | Office Manager, Cleveland Ave |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | N/A |
| Street Address | 625 Cleveland Ave NW |
| City | Canton |
| State | OH |
| Zip Code | 44709 |
| Secure/Encrypted Email Address | katrina.mccole@commquest.org |
| Direct Phone Number | 330-445-2680 |
| Fax Number | 330-455-2101 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet | Secure Email |
| Discharge Planning |  |
| First Name | Katrina |
| Last Name | McCole |
| Job Title | Office Manager, Cleveland Ave |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | katrina.mccole@commquest.org |
| Direct Phone Number | 330-445-2680 |
| Fax Number | 330-455-2101 |
| Preference for Receipt of Discharge Packet |  |

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| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Katrina |
| Last Name | MCole |
| Job Title | Office Manger, Cleveland Ave |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | katrina.mccole@commquest.org |
| Direct Phone Number | 330-445-2680 |
| Fax Number | 330-455-2101 |
| Secondary Backup |  |
| First Name | Theresa |
| Last Name | Kennedy |
| Job Title | Office Manager, Massillon |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | theresa.kennedy@commquest.org |
| Direct Phone Number | 330-833-0234 x5504 |
| Fax Number | 330-837-7705 |

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| Behavioral Health Facility Name | Family Resource Center |
| What is the form of contact? | Singular Contact |
| Department Name |  |
| Admission Notification |  |
| First Name | Maria |
| Last Name | Cool |
| Job Title | Crisis Manager |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | NW Ohio/Hancock County |
| Street Address | 1918 North Main Street |
| City | Findlay |
| State | OH |
| Zip Code | 45840 |
| Secure/Encrypted Email Address | maria.cool@frcohio.org |
| Direct Phone Number | 567-271-3040 |
| Fax Number | 419-423-6464 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet | Secure Email |
| Discharge Planning |  |
| First Name | Maria |
| Last Name | Cool |
| Job Title | Crisis Manager |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | maria.cool@frcohio.org |
| Direct Phone Number | 567-271-3040 |
| Fax Number | 419-423-6464 |
| Preference for Receipt of Discharge Packet |  |

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| --- | --- |
| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Maria |
| Last Name | Cool |
| Job Title | Crisis Manager |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | maria.cool@frcohio.org |
| Direct Phone Number | 567-271-3040 |
| Fax Number | 419-423-6464 |
| Secondary Backup |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| County, Region, & Address Same as Above? |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address |  |
| Direct Phone Number |  |
| Fax Number |  |

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| Behavioral Health Facility Name | Westwood Behavioral Health Center |
| What is the form of contact? | Singular Contact |
| Department Name |  |
| Admission Notification |  |
| First Name | Niki |
| Last Name | Gearhart |
| Job Title | QMHS-Crisis |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | Van Wert and Paulding Counties |
| Street Address | 1158 Westwood Dr. |
| City | Van Wert |
| State | OH |
| Zip Code | 45891 |
| Secure/Encrypted Email Address | ngearhart@westwoodbehavioral.com |
| Direct Phone Number | 419-238-3434 |
| Fax Number | 419-238-1356 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet | Fax |
| Discharge Planning |  |
| First Name | Mandy |
| Last Name | Thomas |
| Job Title | QMHS-Crisis |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | mthomas@westwoodbehavioral.com |
| Direct Phone Number | 419-238-3434 |
| Fax Number | 419-238-1356 |
| Preference for Receipt of Discharge Packet |  |

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| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Niki |
| Last Name | Gearhart |
| Job Title | QMHS-Crisis |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | ngearhart@westwoodbehavioral.com |
| Direct Phone Number | 419-238-3434 |
| Fax Number | 419-238-1356 |
| Secondary Backup |  |
| First Name | Mandy |
| Last Name | Thomas |
| Job Title | QMHS-Crisis |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | mthomas@westwoodbehavioral.com |
| Direct Phone Number | 419-238-3434 |
| Fax Number | 419-238-1356 |

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| Behavioral Health Facility Name | Mental Health Services for Clark and Madison Counties, Inc. |
| What is the form of contact? | Singular Contact |
| Department Name |  |
| Admission Notification |  |
| First Name | Jill |
| Last Name | Sokolnicki |
| Job Title | COO |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | Clark, Madison and Greene counties |
| Street Address | 474 N. Yellow Springs Street |
| City | Springfield |
| State | OH |
| Zip Code | 45504 |
| Secure/Encrypted Email Address | jill.sokolnicki@mhscc.org |
| Direct Phone Number | 937-399-9500 |
| Fax Number | 937-342-4242 |
| Contact Person is the same for both Discharge Planning and Admission Notification | Yes |
| Preference for Receipt of Discharge Packet | Secure Email |
| Discharge Planning |  |
| First Name | Mari |
| Last Name | Boswell |
| Job Title | Support Services Manager |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | Mari.Boswell@mhscc.org |
| Direct Phone Number | 937-399-9500 |
| Fax Number | 937-342-4242 |
| Preference for Receipt of Discharge Packet |  |

|  |  |
| --- | --- |
| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Mari |
| Last Name | Boswell |
| Job Title | Support Services Manager |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | mari.boswell@mhscc.org |
| Direct Phone Number | 937-399-9500 |
| Fax Number | 937-342-4242 |
| Secondary Backup |  |
| First Name | Jessica |
| Last Name | Capers |
| Job Title | jessica.capers@mhscc.org |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | jessica.capers@mhscc.org |
| Direct Phone Number | 937-399-9500 |
| Fax Number | 937-342-4242 |

|  |  |
| --- | --- |
| Behavioral Health Facility Name | Crossroads Health |
| What is the form of contact? | Department |
| Department Name | Intake |
| Admission Notification |  |
| First Name |  |
| Last Name |  |
| Job Title |  |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) | Lake County, NE |
| Street Address | 9220 Mentor Ave. |
| City | Mentor |
| State | Ohio |
| Zip Code | 44060 |
| Secure/Encrypted Email Address | intakelinesupport@crossroadshealth.org |
| Direct Phone Number | 440.354.9924 |
| Fax Number | 440.205.2417 |
| Contact Person is the same for both Discharge Planning and Admission Notification | No |
| Preference for Receipt of Discharge Packet | Fax |
| Discharge Planning |  |
| First Name | Aaron |
| Last Name | Burko |
| Job Title | Senior Director |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | aburko@crossroadshealth.org |
| Direct Phone Number | 440.255.1700 ext. 800 |
| Fax Number | 440.205.2417 |
| Preference for Receipt of Discharge Packet |  |

|  |  |
| --- | --- |
| Follow-Up Appt Scheduling for EstablishedPatients and New Referral |  |
| First Name | Lauren |
| Last Name | Hartmeyer |
| Job Title | Supervisor of Access |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | Lhartmeyer@crossroadshealth.org |
| Direct Phone Number | 440.255.1700 ext. 591 |
| Fax Number | 440.205.2417 |
| Secondary Backup |  |
| First Name | Jessica |
| Last Name | Jones |
| Job Title | Intake Care Coordinator Team Lead |
| County, Region, & Address Same as Above? | Yes |
| If County or Region specific, please specify County/Counties or Region (C, NW, NE, SE, SW) |  |
| Street Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Secure/Encrypted Email Address | Jjones@crossroadshealth.org |
| Direct Phone Number | 440.255.1700 ext. 619 |
| Fax Number | 440.205.2417 |