Specialist Services Referral Form

BHA
BEHAVIORAL HEALTH ASSOCIATES, LTD.
1132 28TH AVE S, SUITE 103
MOORHEAD, MN 56560
tel 218.331.0213
fax 888.688.4095
info@bha-mn.com
www.bha-mn.com

Date: _____

Case Manager

Name: _____ Phone: _____ Email: _____

Client

Name:

_____ DOB: _____ PMI: _____

ICD-10 Code: _____ Medicaid Waiver DD ☐ CADI ☐ BI ☐ ROI signed Yes ☐ No ☐

Address:

_____ Phone: _____ Email: _____

Legal Guardian

Name:

_____ Phone: _____ Email: _____

Address:

_____

Residential Agency

Contact Person: _____ Phone: _____ Email: _____

Day Program or School

Contact Person: _____ Phone: _____ Email: _____

Other Agency

Contact Person: _____ Phone: _____ Email: _____

Reason for Referral

Initial Contact for Intake

Client ☐ Guardian ☐ Case Manager ☐ Residential Agency ☐

Clients' availability for service time (Check all that apply)

7am-11am ☐ 12pm-2pm ☐ 3pm-5pm ☐ 6pm-8pm ☐

CSP/CSSP included (Please send with Referral)

Yes ☐ No ☐