Referral Form

BHA
BEHAVIORAL HEALTH ASSOCIATES, LTD.
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MOORHEAD, MN 56560
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Date: _____

Specialist Services ☐
Self Advocacy ☐

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 ☐