# 1915(i) Services Referral Form

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| First Name |  |
| Middle Name |  |
| Last Name |  |
| Social Security # |  |
| Medicaid # |  |
| Copy of Medicaid ID Attach copy |  |
| Copy of License or ID Attach copy |  |
| Who Are They With (CCNH, Trillium, Partners, Other) |  |
| County of Residence |  |
| Address |  |
| Caretaker Information |  |
| HIPAA Letter Signed? |  |
| Services Requested |  |
| Who Referred You? |  |
| Additional Notes |  |
| Contact Information:  Email |  |
| Telephone Number: |  |

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| ***Office Use Only:*** |
| ***Intake Coordinator:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** |
| ***Location of Referral:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** |
| ***Contact person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** |
| ***Medicaid Verified: Yes \_\_\_\_\_ or No\_\_\_\_\_ Eligible for 1915(I) Services:\_\_\_\_\_\_\_\_\_\_*** |
| ***Assessment needed: Yes \_\_\_\_ or No:\_\_\_\_\_\_\_*** |
| ***Accepted in RAS INC: yes\_\_\_\_\_ or NO:\_\_\_\_\_\_*** |
| ***Authorization Start Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** |
| ***Approved by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** |

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