**Instructions: Please complete all sections of the form and include all required documentation listed below when submitting the referral or processing of the referral will be delayed.**

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| Referred Name:       Date of Birth:  Address, City, State, & Zip Code:  Telephone:       Email address:  **Insurance Coverage Information:**  Medicaid ID#       Managed Care Plan:  Third-Party Insurance Name*:*  Primary Subscriber Name:       Subscriber Date of Birth:  Relationship to Insured:  ***Please include copies of all insurance cards.***  Indicate if a Private pay agreement is needed: Y N |

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| If the referred individual is a minor or has an authorized representative, please include contact information below.  Name & Relationship:  Phone #:       Email address:  Street Address, City, State, & Zip Code: |

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| **The following documents are required for all referrals:**   * OPWDD Notice of Decision * Medicaid Identification Card * Copy of insurance cards – including managed care plans, Medicare advantage plans, third-party or private insurance plans. * Copy of Life plan. * Copy of IEP (for school-aged referrals) * Signed authorization of consent to disclose or release PHI to:  1. Presence Counseling – Social Work service 2. Presence Developmental-Behavioral Support, Psychology, Sexuality Assessment & Training, Occupational Therapy, Physical Therapy, Speech-Language Pathology, or Specialist services.   **Select all applicable services:**  Social Work Services Behavioral Services Psychology/Harrison Sexuality Assessment & Training  Occupational Therapy Speech-Language Pathology Physical Therapy Specialty Services:  **NOTE: If Physical Therapy, Occupational Therapy, or Speech-Language Pathology is selected above additional referral documents are required.**   * Valid script for the PT, OT, SLP referral. * Signed authorization of consent to disclose or release PHI to  1. Primary Care Physician 2. School District (if school aged)   **Service Delivery Preference:** Select all that apply.  In-person  Telehealth Office Community  **Recommended Provider:**  **Identify the need for the referral:** Describe needs and safety risks. |

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| **Care Coordinator Name:**  **Address, City, State & Zip Code:**  **Phone #:**       **E-mail Address:** |