**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:**       |