Presence Counseling and Developmental Services Referral Form

Instructions: Please answer each question on the form and include <u>all</u> documentation listed below to be considered a complete referral or processing of the referral will be delayed. Indicate NONE or NA if applicable.

Referred Name: Email address:

Street Address, City, State, & Zip Code:

Telephone:

Insurance Coverage Information: Date of Birth:

Please include copies of all insurance cards.

Medicaid ID# Managed Care Plan:

Third-Party Insurance Name:

Primary Subscriber Name: Primary Subscriber Date of Birth:

Relationship to Referred:

☐ Check here if a Private pay agreement is needed.

If the referred individual is a minor or has an authorized representative, please include contact information below.

Name & Relationship: Email address:

Phone #:

Street Address, City, State, & Zip Code:

The following documents must be attached for complete referral:

- OPWDD Approval Notice of Decision
- Medicaid Identification Card
- Other insurance cards such as a managed care plans, Medicare advantage plans, third-party or private insurance plans.
- Copy of Life plan.
- Copy of IEP (for school-aged)
- Signed authorization of consent to disclose and release PHI to:
  - ☐ Presence Counseling Services – for Social Work service **OR**
  - ☐ Presence Developmental services- for Behavioral Support, Psychology, Sexuality Assessment & Training, Occupational Therapy, Physical Therapy, Speech-Language Pathology, or Specialist services.

Reason for Referral:

☐ Social Work Services ☐ Behavioral Services ☐ Psychology/Harrison ☐ Sexuality Assessment & Training

☐ Occupational Therapy ☐ Speech-Language Pathology ☐ Physical Therapy ☐ Specialty Services:

NOTE: For a Physical Therapy, Occupational Therapy, or Speech-Language Pathology referral, the referral must also include the following:

- Script for the PT, OT, SLP therapy
- Signed authorization of consent to disclose and release PHI to:
  - ☐ Primary Care Physician
  - ☐ School District (if school aged)

Service Delivery Preference: Select all that apply. ☐ In-person ☐ Telehealth ☐ Office ☐ Community

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PDS or PCS therapist preference:

Please describe reasons for referral, including any known diagnoses, to support an effective case assignment

Care Coordination Agency and Coordinator Name:
E-mail Address:
Address, City, State & Zip Code:
Phone #: