|  |
| --- |
| **Eligibility:**   * Existing Approval by OPWDD & Active Medicaid coverage   **Required documents:**  current Insurance identification cards (front and back),  Current Life Plan, IEP, and any OTHER PLANS of care,  signed authorization of Disclosure consenting to the release of PHI to:   1. Presence Counseling Services (Social Work Service) **and/ or** 2. Presence Developmental Services (Behavioral Support, Psychology, Sexuality assessment and training, specialty services, Occupational, Physical Therapy, or Speech Language Pathology services).   **Additional documents for PT, OT & SLP service requests:**  Individual signed authorization CONSENTING TO the release of PHI between PDS & the individual’s primary care physician &  script for PT, OT or SLP services |

## Please do not leave any blanks.

**Referred Individual Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Street Address, City, State & Zip code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Insurance Coverage Information **including** Medicare advantage plans & Medicaid Managed Care: **­­­­­­­­­­**

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Check if Private pay agreement is needed

## Legal guardian/representative information if the referral individual is a minor or has authorized representative:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address, City, State, & Zip code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Select the requested service:

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| --- | --- |
| Social Work Services | Occupational Services include script and Primary Care Physician Authorization |
| Applied Behavioral Services | **Speech Language Services** include script and Primary Care Physician Authorization |
| Psychology/Harrison | **Physical Therapy Services** include script and Primary Care Physician Authorization |
| Sexuality Assessment and Training | **Specialty Services** |
| Preferences (i.e. Provider, In-person, Telehealth, or both) & describe known safety risks: | |

## Care Coordination Agency

**Care Coordinator Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address & Zip code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**