

REFERRAL FORM

MEDICAID WAIVER:

SERVICE:

<input type="checkbox"/> Medicaid Waiver (indicate type: _____) <input type="checkbox"/> DARS <input type="checkbox"/> Private Pay <input type="checkbox"/> CSB Local Funding	<input type="checkbox"/> Supported Employment (Individual) API # 0784901289 <input type="checkbox"/> Benefits Planning API # 0706401392
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REFERRAL SOURCE:

Referral Agency: _____ Case Manager: _____

Email: _____ Telephone/ _____
Fax: _____

INDIVIDUAL DATA:

Name: _____ S.S. #: _____

Address: _____

Telephone: _____ Date of Birth: _____

Medicaid number: _____ Other insurance (if applicable): _____

Primary diagnosis and code: _____

Secondary diagnosis and code: _____

ISP dates: _____ Quarterly dates: _____

Does the client have a legal guardian? If so, please provide name and address: _____

Notes: _____

Please fax the following information with the referral form:

<input type="checkbox"/> SIS (Waiver) <input type="checkbox"/> Risk Assessment (Waiver) <input type="checkbox"/> VIDES (Waiver) <input type="checkbox"/> Psychological Report/Medical Information (All) <input type="checkbox"/> Applicable protocols (if applicable) including behavior support plan (Waiver) <input type="checkbox"/> Documentation that no other funding is available for supported employment services (All) <input type="checkbox"/> Guardianship order (if applicable) (All)
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Office Use: Case # _____	Counselor: _____	Signature: _____	Date: _____
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