**REFERRAL FORM**

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| **Identifying Information** |

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| Date:  |
| Client Name:  | DOB: |
| Address:  | SS#: |
| Parent/Legal Guardian(s):  | Parent/Legal Guardian Phone:  |
| Parent/Legal Guardian E-mail: | Parent/Legal Guardian Alt. Phone: |
| Referral Source:  | Referral E-mail:  |

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| **Insurance Information** |

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| Medicaid MCO:  | Toll Free Number (on back of card): |
| Medicaid Member ID: | Medicaid # (12 digits): |
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| Tricare/Private Insurance Co. Name: | Toll Free Number (on back of card): |
| Policy Holder’s Name: | Policy Holder Birthdate: |
| Policy member #: | Policy Group #: |

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| **Waiver Information** |
| Does the individual have the ID/DD waiver? [ ]  No [ ]  Yes, please provide information below. |
| Case Manager Name: | Case Manager Phone Number: |
| Case Manager Email: |
| **Diagnosis Information** |
| Primary Diagnosis: | Secondary Diagnosis: |
| Reason for Referral: (intense behaviors (list and describe), limited communication, social skills, or adaptive living skills (list and describe) |

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| **Office Use ONLY:****Date Referral Was Received by Intercept:****Projected Start of Services Provided:** |