Referral and Authorization Form

Name of Requesting Agency: ____

☐ New referral ☐ Change in Service ☐ 2 hours for LCSW, Treatment Plan

Case Manager: ______________________ **CM's Phone #:** ____________________

Client's Name: ______________________ **DOB:** __________ **Gender:** __________

Medicaid #: ______________________ **ABS#:** ______________________

Parent's Name: ______________________ **SS#:** ______________________

Home Address: ____

Phone: ______________________ **Alt#:** ______________________

Behaviors/Special Needs: ____

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Type of Service: ☐ Behavioral Assistant ☐ Intensive In-Community (BA)
☐ Intensive In-Community (MA,MS) ☐ Intensive In-Community (Lisc)
☐ Needs Assessment

Service Delivery: ☐ Child's Home ☐ Foster Home ☐ Residential ☐ School
☐ Other: ____

Service Auth. Dates: from_______to_______ **Authorized # of hours per week:** ____________
Total # of Authorized hours: ________ ☐ **Medicaid** ☐ **Non-medicaid**

Authorization # : ______________________

Special Training/Certification: ____

Gender Preference: ______________________ **Ethnic/Race Preference:** ______________

JO# - _______________ Client# - _______________ Taker - _______________ Given to - _______________ LOA - Yes / No

Source: Active Marketing Bulk Meeting Call-in