

Name: _____ Medicaid# _____

Date of Referral: _____ Medicaid County: _____

Date of Birth: _____ Social Security: _____ Sex: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

Referral Source: ☐ Self/No Referral ☐ LME ☐ Hospital ☐ DSS ☐ Schools ☐ Doctor

☐ Family/Relative/Friend ☐ Other: List _____

Referral Source's Name: _____ Phone #: _____

Reason for Referral: _____

☐ Housing/Residential ☐ Financial ☐ Legal ☐ Transportation ☐ Family Conflicts

☐ Emotional/Mental Health Tx ☐ Social ☐ Medical/Health Issues ☐ Safety Issues ☐ Day Program

☐ Other(s): List _____

DIAGNOSIS: DSM-V Code and Description and/or Clinical Impression

F Code: _____ F Code: _____

F Code: _____ G Code: _____

F Code: _____ M Code: _____

LEGAL STATUS (Check all that apply):

☐ Competent ☐ Incompetent ☐ Minor ☐ Denies legal history ☐ On Probation/Parole

☐ Juvenile Court ☐ In Jail ☐ Legal history/prior charges (list) _____

GUARDIANSHIP/LEGALLY RESPONSIBLE PERSON/EMERGENCY INFORMATION

Who is Legally Responsible Party? ☐ Self ☐ Guardian ☐ Parent ☐ LRP ☐ Other _____

Name of Guardian/LRP/Emergency Contact: _____

(Circle all that apply)

Address of Guardian/LRP/Emergency Contact: _____

(Circle all that apply)

Home #: _____ (Work) _____ (Cell) _____

What services does person currently have, if any? _____

What services are you requesting? _____