**Referral/Request for Services**

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| --- |
| Medicaid #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Last Name:** |  | **First Name:** |  | **Middle Initial:** |  |
| **Preferred Name:** |  | **Date of Birth:** |  | **Age:** |  |
| **Gender:** |  | **Ethnicity:** |  | **Preferred Language:** |  |
| **Street Address:** |  | **Apt #:** |  |
| **City:** |  | **State:** |  | **Zip Code:** |  |
| **Legal Guardian:** |  | **Telephone #:** |  |
| **Describe reason for service request:** |  |
|  |
|  |
|  |
| **Please specify area(s) of concern:** |
| **[ ]  Housing Needs (Utilities/Rent).** | **[ ]  Family Interaction Problems.**  | **[ ]  At Risk–Residential Placement** |
| **[ ]  Academic Problems.** | **[ ]  Parenting Issues.** | **[ ]  Juvenile Delinquency** |
| **[ ]  Medical Problems.** | **[ ]  Sexual Abuse / Physical Abuse** | **[ ]  Truancy** |
| **[ ]  Need of Mental Health Services.** | **[ ]  Financial Limitations.** | **[ ]  Substance Use/Abuse** |
| **[ ]  Social Skills / Peer Relations**  | **[ ]  Medication Noncompliance.**  | **[ ]  Other:** |
| **Please specify current symptoms:** |
|

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Physical Aggression** | **[ ]**  | **Tantrums** | **[ ]**  | **Noncompliant** | **[ ]**  | **Disruptive** |
| **Verbal Aggression** | **[ ]**  | **Stealing** | **[ ]**  | **Lying** | **[ ]**  | **Impulsive** |
| **Property Destruction** | **[ ]**  | **Depressed** | **[ ]**  | **Hyperactive** | **[ ]**  | **Anxiety** |
| **Sleeping Problems** | **[ ]**  | **Eating Problems** | **[ ]**  | **Homicidal Ideations**  | **[ ]**  | **Suicidal Ideations** |

**Has the individual been hospitalized within the last 12 months? [ ]  Yes [ ]  No**  |
| **Are requested services mandated by court order? [ ]  Yes [ ]  x No**  |
| **Referring Entity/Agency:**  |  |
| **Telephone:**  |  | **Fax:** |  |
| **Person Making Referral/Title:** |  |
| **Signature:** |  | **Date:** |  |
|  |  |  |  |
| *For office use only:* **Disposition: [ ] Assigned [ ] Referred to other services:** |  |
|  |  | **Date:** | **/    /** |
|  | **Signature of Targeted Case Management Supervisor** |  |  |