ADVANCED PLACEMENT BHHS
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Intake Referral Form

Please Print Clearly **Date of Referral:** _____

Consumer Information:

Consumer Name: _____
Type: ☐Amerigroup ☐WellCare ☐Regular Medicaid / ID # _____
Date of Birth: _____ Age: _____ School _____
Gender: (Please Check) ☐Male ☐Female Primary Care Physician _____
Consumer's Address: _____
City_____ State _____ Zip _____Race: _____
Home Phone#: _____ Cell #: _____ Work #: _____
Parent/Guardian: _____

What Other Services Sought:

1. Has the child had other services (e.g. Community Support Individual-CSI, Individual and /or Family Counseling)? ☐**Yes** ☐**No** ☐**Not Sure (Upscale)**
2. Does the child have a known Serious Emotional Disturbance and/ or Substance Abuse issue/diagnosis? ☐**Yes** ☐**No** ☐**Not Sure**
3. Are child and/or family issues in need of intensive, coordinated clinical and supportive intervention? ☐**Yes** ☐**No**
4. Is the child at immediate risk of out of home placement or is currently in out of home placement and re-unification is imminent? ☐**Yes** ☐**No**
5. Has Psychological/Psychiatric Evaluation been completed? ☐**Yes** ☐**No** **If yes, please attach**

Admission Status (Please Print):

Name & Title of Person making referral: _____
Agency: _____ **Court Mandated? Yes or No County:** _____
Phone # of person making referral: _____ **Fax number:** _____
Email Address: _____

Service (s) Requested (Please Check):

☐ CORE-Medicaid Program (Individual/Family Therapy; Therapy for Substance Abuse (SA); CSI - Life Skills)
☐ Intensive Family Intervention ☐Other _____

Presenting Problem:

(List problem behaviors; include any medications for emotional and/ or behavior problems)
_____
_____
_____

For Company Use Only:

Receipt Date: _____ ***Insurance Active Yes No Medicaid Plan:*** _____

Assessed By: _____ ***Assessment Date & Time:*** _____

Assessment Completion Date: _____ ***Consumer Approved? Yes No***

If not approved, why? _____

If approved, approval date? _____ **Ref #** _____