

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 # _____