Community Support Services Referral Form

Gneral Information:

Name of person being referred: ______________________________________

Address of person referred: ____

Phone number of person referred: _______________________________

Social Security Number: ____________ Date of Birth: _____________

Date of Referral: ____________________

Application completed by: Self Case Manager

Referring agent:

Referring person: ____

Agency: ______________________ Phone: __________________________

Address:_____________________ Email address:_____________________

Insurance Information:

Medicaid Number:_____________________

MCO: ______________________ MCO ID number: _______________

Diagnosis (please provide ICD-10 code)

Primary Diagnosis: __________________ Secondary Diagnosis: _________________

Guardianship Status:

☐ Member is their own guardian; please enter guardian information, as needed.

Name: ____

Address: ____

Phone number: (home)___________________________(work)_____________________

Payee Information:

☐ Member is their own payee: please enter payee information, as needed.

Agency name: ____

Address:____

Phone number:____

Legal Information:
Is this person currently involved in any pending civil or criminal legal action? : ______
If yes, please describe:
____
____

Other Information that is needed:
Social history - as current as possible
History and Physical if available
Legal Documents e.g. Guardianship papers