



THE CHOICE GROUP

MEDICAID REFERRAL FORM

SERVICE (Please check one):

The Choice Group		Robin Metcalf
<input type="checkbox"/> MR Waiver	<input type="checkbox"/> DD Waiver	<input type="checkbox"/> MR Waiver <input type="checkbox"/> DD Waiver
<input type="checkbox"/> 60 Day Assessment	<input type="checkbox"/> Supported Employment	<input type="checkbox"/> LPC
<input type="checkbox"/> Day Support	<input type="checkbox"/> Family Care Giving&Trng.	<input type="checkbox"/> Therapeutic Consultation

REFERRAL DATA

Referral Agency/Address: _____ Case Manger: _____

Email: _____ Telephone/Fax: _____

DMAS 122(225)Co-Pay (1 time/year): _____ Status Code: _____ Psych./ Med/ ICAP Records: _____

Social Assessments: _____ Level of Functioning: _____ Other Insurance: _____

Information from school/DRS – that says Special Ed funds or DRS not funding? Must have for our file.	_____	Case Manager’s Waiver Plan Dates: (start date of plan – needs to be on I-SAR form and submit 10 days ahead of time)	_____
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CONSUMER DATA:

Name (first/middle/last): _____ S.S. # _____

Address: _____ Medicaid # (copy card): _____

Telephone: _____ Date of Birth: _____

Primary Diagnosis and Code: _____

Secondary Diagnosis and Code: _____

*Notes: _____

Office Use: Case #	Counselor	Signature	Date
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