THE CHOICE GROUP

Revised 9/26/2019

MEDICAID WAIVER REFERRAL/SCREENING FORM

SERVICE REQUESTED:

☐ Supported Employment ☐ Benefits Planning ☐ Therapeutic Behavior Consultation

REFERRAL SOURCE:

Referral Agency: _____ Case Manager: _____

Email: _____ Telephone/ Fax: _____

CLIENT DATA:

Name: _____ S.S. #: _____

Address: _____

Telephone: _____ Date of Birth: _____

Medicaid number: _____ Other insurance (if applicable): _____

Primary diagnosis and code: _____

Secondary diagnosis and code: _____

ISP dates: _____ Client's Status with DARS: _____

Does the client have a legal guardian? If so, please provide name and address: Name:_____

Address:_____

Reason for Request of Services:

_____

_____

For Supported Employment: Please list client's ISP goal related to pursuing vocational interests:

_____

_____

Please fax the following information with the referral form:

☐ Parts 1-4
☐ SIS
☐ Risk Assessment
☐ Psychological/Medical Information
☐ Documentation that no other funding is available (for supported employment services)
☐ Guardianship order (if applicable)
☐ Authorized Representative Information

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