



MEDICAID WAIVER REFERRAL/SCREENING FORM

SERVICE REQUESTED:

<input type="checkbox"/> Supported Employment	<input type="checkbox"/> Community Coaching	<input type="checkbox"/> Community Engagement
<input type="checkbox"/> 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: _____ Quarterly dates: _____

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

Address: _____

Reason for Request of Services:

For Community Coaching and Community Engagement: please list client's ISP goal related to pursuing vocational interests:

Please fax the following information with the referral form:

<input type="checkbox"/> Parts 1-4
<input type="checkbox"/> SIS
<input type="checkbox"/> Risk Assessment
<input type="checkbox"/> Psychological/Medical Information
<input type="checkbox"/> Documentation that no other funding is available (for supported employment services)
<input type="checkbox"/> Guardianship order (if applicable)
<input type="checkbox"/> Authorized Representative Information



THE CHOICE GROUP

For Community Coaching and Community Engagement/Office use only:

Name of screening employee: _____

Method of screening:

Screening recommendation:

Disposition of individual:

