

CREATIVE FAMILY SOLUTIONS, INC.

Referral/Admission Form

Date of Referral: _____

Referring Staff Name: _____ Referring Agency: _____

Referral Address: _____ City, State, Zip: _____

Referral Phone Number: _____ Referral Fax Number: _____

Client Name: _____

Client Address: _____ City, State, Zip: _____

Client Phone Number: _____ Client Soc. Sec. #: _____

Client Birth Date: _____ Client Age: _____ Client Race: _____ Client Gender: _____

Client Health Insurance (Medicaid) Name: _____

Health Insurance Number: _____

Legal Guardian Name: _____ Relationship to Client: _____

Guardian Address: _____ City, State, Zip: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

Emergency Contact other than guardian: _____ Relationship to Client: _____

Address: _____ City, State, Zip: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

Location of service delivery (check all that apply): Home _____ Community _____ Other _____

Table with 3 columns: Family Members Living in the Home, Age/DOB, Relationship

Immediate Family Members not living in the home: _____

Non-Relatives in the home: _____

Type of service requested: check all that apply

- Formal Assessment = \$300.00
Residential Support (Waiver) _____ Hours per week recommended = Billed to Medicaid
Crisis Stabilization (Waiver) _____ Hours per week recommended = Billed to Medicaid
Intensive In-Home II (Clinician) _____ Hours per week recommended = \$70.00/hr or billed to Medicaid
Client Behavior Intervention (CBI) _____ Hours per week recommended = \$43.00/hr
Intensive In-Home I (Mentor) _____ Hours per week recommended = \$23.00/hr
Mental Health Supports _____ Hours/Units recommended = Billed to Medicaid

If the child has Medicaid and meets program criteria, we can bill for Intensive In-home II. There are a variety of other funding agreements including FAPT funds, insurance and private pay by families. Call us to discuss your case further.

Referral Form

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CFS, Inc.

Reason for referral including presenting needs and preferences:

Directions to Family Home:

Signature of Person completing form

Date

For CFS Inc. office use only;

SCREENING: List dates of screenings

_____ Telephone Consult or Screening Based on DMAS/CFS Inc. Criteria for the following:

_____ Mental Health Supports; _____ Intensive In-home
_____ In home Services _____ Other Program

Disposition of Client: _____ Approved for Services

_____ Not approved for services and referred to other agency
listed: _____

Reason for referral to other program:

Recommended Start Date: _____

Anticipated End Date: _____

CFS, Inc. Staff