Medicaid Funded CORE Services
Referral Form

270 Carpenter Drive * Sandy Springs, Ga 30328
678-508-3587 (O) * 678-460-0350 (F)

Referral Source

Name of referring person: _____ Date of Referral: _____

Cherokee____ Cobb___ Clayton___ Dekalb___ Douglas___ Forsyth___ Fulton___ Gwinnett____
Hall___ Kennesaw____ Rockdale____

Agency: DFCS____ School____ BHL____ PRTF____ Family____ Probation____ DJJ___ Other_____

Phone: _____ Fax: _____ Cell: _____

Email: _____Preferred Contact Method: email___phone___cell__

Supervisor: _____ Phone:_____

Is Client aware referral is being made Yes_____ No_____

Client Information

Client Name: _____ Case ID# (if applicable): _____

DOB: _____ Gender: Male ___ Female___ Ethnicity: _____

Client's School: _____ Current Grade Level: _____

Current Placement: Biological Parent _____ Foster Placement____ Group Home___

Legal Guardians Name: _____

Current Address: _____

Phone Number: _____Cell Phone: _____

Mental Health Diagnosis: _____ Medications: _____

Medicaid #: _____ Social Security Number#: _____

Type: Medicaid____ Peachstate/Cenpatico____ Amerigroup____ WellCare____*Uninsured_____

Has client had a psychological/psychiatic evaluation in the past 12 months? Yes____ No ____N/A _____

Behavior in last 3 months**:** Runaway___ Physical Aggression____ Suicidal Ideation /Attempt _____
Verbal Aggression _____ Defiance_____ ISS/OSS_____ LegalInvolvement_____ Deprived_____
Sexual Acting Out_____ Self-Harming Behaviors_____ Other_____

**Please attach psychological/psychiatric if available

Presenting Problems:

Legal:

Open/Pending Court Case ____Yes ____No Court Date: _____ Court Part_____

Name: _____County: _____ Phone_____

DFCS Involvement: *Yes ____ No _____ **DFCS** approval for services Yes ____ No____

***If child is in the custody of DFCS please complete consent form**

Caseworker: _____ Telephone #: _____

I _____, the case worker for _____ as guardian of said consumer, authorize the Foster Parent/FP Case Manager_____ For _____the authority to sign the Family Ties, Inc. legal and consent form's authorizing CORE services.

Signature: _____ Date: _____

Status of Referral: (office only)

Accept Team: _____ Case Number: _____ Date: _____

Decline Reason: _____ Date: _____