

Medicaid Funded CORE Services

Referral Form

270 Carpenter Drive \* Sandy Springs, Ga 30328

678-460-0345 (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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_