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Medicaid CORE Services Referral Form

Referral Source

Name of referring person: _____ Date of Referral: _____
Cherokee___ Cobb___ Clayton___ Dekalb___ Douglas___ Forsyth___ Fulton___ Gwinnett___ Hall___ Henry___ 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: _____ Language Spoken _____
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___
***For uninsured , families must apply for Peachcare - www.peachcare.org**
Has client had a **psychological evaluation in the past 12 months? Yes___ No___ Unknown___
Has client had a **psychiatric evaluation in the past 12 months? Yes___ No___ Unknown___
Behavior in last 6 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: _____