Strengthening Our System, Inc.
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Referral Form

DATE: _____

Referral Source Information:

_____ _____ _____

(Referral Agency Name, Address, and phone number)

Client Information:

_____ _____ _____

(*Name, Address, and phone number)*

Health Insurance Information:

_____ _____

Health Insurance Name and Number (Medicaid or Private)

Individual Social Security Number: _____ Individual Date of Birth: _____

Check one: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced

Financial Information:
Source of Income: _____ Monthly Income: _____

Disability Diagnosis: ☐ MH ☐ ID ☐ DD

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Medical History and Medical concerns:

Date of last physical:_____

Physician Name and Address: _____

Medications: name, dosage, reason for prescription:

Parent, Guardian or LAR Information:

_____ _____ _____

(*Name, Address, and phone number)*

Presenting Needs/situation of the Individual:

Service Requested:	**Rate/hr**	**Hours per week**
*Mental Health Support Services	83.00/unit	_____
Intensive In-Home Services (MH)	70.00	_____
Supportive In-Home ID/DD Waiver	19.85	_____
Service Facilitation (ID/DD Waiver)	rates vary	_____
Family/Care Giver Training (DD Waiver)	46.86	_____
Therapeutic Consult (ID/DD Waiver)	55.13	_____
Crisis Stabilization (ID/DD Waiver)	81.00	_____

Start Date for Services _____ Anticipated End Date for Services _____

Funding Source for Services _____

What schedule for requested services does the case manager recommend? _____

Is the individual currently receiving any Case Management Services?

(Check the type of case management) ☐ MH ☐ ID ☐ DD

Name of Case Management Agency _____

Name of Case Manager _____

Case Manager Address _____

Case Manager Phone Number _____

CSP Start and End date: _____

Quarterly Review dates: _____

Has the individual ever been hospitalized for psychiatric reasons? Check one: ☐ Yes ☐ No

If so, when and where was the most recent hospitalization?_____

Is the individual currently receiving ID or DD Waiver, or Community Rehabilitation Services?

Check one: ☐ Yes ☐ No

If so, what type of Services? _____

Is the individual and/or their LAR willing to participate in services from this agency?

Check one: ☐ Yes ☐ No

Items Below are for Agency use only:

Agency Recommendations for Services: _____

Disposition of the Referral: ❒ accepted ❒ denied ❒ pending

_____ _____

Signature of SOS, Inc. Staff Person Completing Form Date