Reconsideration – Referral Form

Revised: February 1, 2019

Child Information			
NAME:	**MEDICAID NUMBER:**	**SOCIAL SECURITY NUMBER:**	
DATE OF BIRTH:	**GENDER:** Male ☐ Female ☐		
COUNTY OF ORIGIN:	**CIRCUIT:**	**AREA:**	
EVALUATOR:	**DATE OF LAST SUITABILITY:**	**PRIOR RECOMMENDATION:** ☐ In-Patient ☐ STGH ☐ Residential Not Recommended	

Single Point of Access (SPOA) Contact Information		
NAME:	**PHONE NUMBER:**	**EMAIL:**

Child's Current Living Arrangement			
NAME OF CURRENT LOCATION/CAREGIVER:			
PLACEMENT TYPE: ☐ In-Patient ☐ STGH ☐ Shelter ☐ Detention Center ☐ CSU ☐ Foster Parent ☐ Relative ☐ Other:			
DAYTIME PHONE NUMBER	**EVENING PHONE NUMBER**		
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**

Community Based Care Caseworker			
NAME:	**PHONE NUMBER:**	**E-MAIL ADDRESS:**	
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**

Guardian ad litem	
NAME:	E-MAIL ADDRESS:
PHONE NUMBER:	FAX NUMBER:

Attorney ad litem	
NAME:	E-MAIL ADDRESS:
PHONE NUMBER:	FAX NUMBER:

Updated Clinical Information: explanation of child's decompensation since the time of the last assessment (i.e., Baker Acts, self-injurious behaviors, etc.)

DESIRED TREATMENT OUTCOME

SUMMARY OF PERMANENCY PLAN GOALS, INCLUDING PLANNED DISCHARGE PLACEMENT

CURRENT DSM-5 DIAGNOSIS	

Note: Referral Cannot Be Processed if Information Submitted is Illegible or Incomplete.

Magellan Medicaid Administration, Inc.
To transmit request information:
Fax: 1-888-656-6823
Phone: 1-800-562-4059

CHECKLIST OF REQUIRED DOCUMENTS (MENTAL HEALTH MUST BE MARKED). THIS SECTION MUST BE FILLED OUT TO PROCESS THE REFERRAL.
☐ COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT
☐ MENTAL HEALTH TREATMENT HISTORY, INCLUDING UPDATED RECORDS SINCE THE TIME OF THE LAST ASSESSMENT
☐ COURT INFORMATION: ☐ SHELTER PETITION, ☐ SHELTER ORDER, ☐ JUDICIAL REVIEW, ☐ CASE PLAN
☐ EVALUATIONS: ☐ PSYCHOLOGICAL, ☐ PSYCHIATRIC, PSYCHOSOCIAL, ☐ PSYCHOSEXUAL EVALUATIONS
☐ TREATMENT PROVIDER DOCUMENTATION: ☐ TREATMENT PLAN, ☐ COUNSELING/MEDICATION MANAGEMENT/ABA
☐ DELINQUENCY INFORMATION (DJJ, JDC, PROBATION, ETC.)

Additional Comments or Information

I certify the referral form and package are complete and that all information will be sent to the Qualified Evaluator upon assignment.

SIGNATURE OF SPOA **DATE**

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