CHILDREN'S CONTINUUM OF CARE

Referral for Services

___New Service ____Existing ___Reauthorized Invoice #______________

Referring Agency Name:			Address:	
Phone:			Fax:	
Care Manager's Name:			**Phone:**	
Child's Name:	ABS#:		DOB:	SS#:
Current Address:			Phone: (home	
Guardian Info:			Phone: (cell	

Billing Information:

___ Medicaid # ______________________ (Submit bill on CMS1500 to Medicaid)

___ Only CSOCI #3560 Card (Submit bill to CMO)

Service Type	Dates of Service	Authorization	Hours/ week	Reimbursement Rate	Flex Funds (Yes/ No)
Licensed Clinician					
Master's Level					
Behavioral Assistant					
Mentor					Yes
Biopsychosocial / Needs Assessment			3 Units		
Fire Evaluation *(Standard)*			3 Units		Yes
Fire Evaluation *(Comprehensive)*			TBD		Yes
Standard Psychological Evaluation			TBD		Yes
Comprehensive Psychological Evaluation			TBD		Yes
Neuropsychological Evaluation			**10-12 hrs**		Yes
Substance Abuse Evaluation			TBD		Yes
Psychosexual Evaluation					
Other – Please Specify					

Reason for referral: (Target Behaviors, Strategies and Expected Outcomes):

Care Manager Signature:_x____ Date: _____________

Supervisor Signature:____x____ Date: _____________