**Advanced Placement BHHS**

206 Pitcarin Way, Suite A, Augusta, GA 30909

Office: (706) 955-8647 Fax: (706) 955-8839

Email: [augadmin@aplacement.org](mailto:augadmin@aplacement.org)

**Intake Referral Form**

**Please Print Clearly Date of Referral:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consumer Information:**

Consumer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type: Amerigroup 🞏WellCare 🞏Regular Medicaid / ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: (Please Check) Male 🞏Female Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consumer’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What Other Services Sought:**

1. Has the child had other services (e.g. Community Support Individual-CSI, Individual and /or Family

Counseling)? 🞏**Yes** **No** **Not Sure (Upscale)**

2. Does the child have a known Serious Emotional Disturbance and/ or Substance Abuse

issue/diagnosis? **Yes** **No** **Not Sure**

3. Are child and/or family issues in need of intensive, coordinated clinical and supportive intervention?

**Yes** **No**

4. Is the child at immediate risk of out of home placement or is currently in out of home placement and

re-unification is imminent? **Yes** **No**

5. Has Psychological/Psychiatric Evaluation been completed? **Yes** **No If yes, please attach**

**Admission Status (Please Print):**

**Name & Title of Person making referral:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Agency:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Court Mandated? Yes or No County:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone # of person making referral:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Fax number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Service (s) Requested (Please Check):**

 CORE-Medicaid Program (Individual/Family Therapy; Therapy for Substance Abuse (SA); CSI - Life Skills)

 Intensive Family Intervention Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Presenting Problem:**

(List problem behaviors; include any medications for emotional and/ or behavior problems)

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***For Company Use Only:***

***Receipt Date: \_\_\_\_\_\_\_\_\_\_\_\_ Insurance Active Yes No Medicaid Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Assessed By: \_\_\_\_\_\_\_\_\_\_\_ Assessment Date & Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Assessment Completion Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Consumer Approved? Yes No***

**If not approved, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If approved, approval date? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ref # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**