

Strengthening Our System, Inc.

464 Christiansburg Pike
Floyd Virginia 24091
540-585-4078
Fax 540-745-6710
info@strengtheningoursystem.com

Referral Form

DATE: _____

Referral Source Information: _____

Referral Agency Name, Address, phone number

Client Information: _____

Name, Address, 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: _____

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, phone, relationship _____

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?

(Circle 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? Circle 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?

Circle one: Yes No

If so, what type of Services? _____

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

Circle 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 _____
