SOURCE Referral Form

SOURCE Member _____ Date _____

Social Security No._____ Medicaid No._____

Address_____ Phone No._____

_____ Medicare No._____

_____

Diagnosis Code _____

SOURCE **Service Prior Authorization Number** _____

Service Prior Authorization Effective Date _____ Expiration Date _____

Directions to home_____

Primary Contact and Relationship_____

Primary Contact Phone Number _____

Primary Contact Address _____

Services Requested:

Adult Day Health_____

Provider _____Frequency_____

Level 1 Full Day_____ Level II Full Day_____
Level 1 Partial Day_____ Level II Partial Day_____
Physical Therapy_____
Speech Therapy_____

Alternative Living Service_____ Provider_____

Group Model_____ Family Model_____

Respite Services_____

Provider _____Frequency_____

Out of Home Respite (12 hours) _____
Out of Home Respite (8 hours maximum, 3 hours minimum)_____

Structured Family Caregiving _____

Provider _____

Member Medicaid Number _____

Personal Support Services (PSS) _____**Extended Personal Support Services (EPS)**_____

Provider _____

PSS Frequency_____

EPS Frequency _____

Emergency Response System_____

Provider_____

Installment_____ Monitoring Monthly_____

Home Delivered Meals_____

Provider _____ Frequency _____

Comments: _____

Medicaid Home Health (75 units of service)_____

Provider _____

Skilled Nursing Visit_____
Physical Therapy Visit_____
Occupational Therapy Visit_____
Medical Social Services_____
Home Health Aide_____

Level of Care is approved through _____

Services to Begin: _____

Member is under administrative review. Please continue services until: _____

Comments:

SOURCE Site _____
Case Manager Signature/Title_____ Date_____