Rice Counseling and Associates, Inc.

CASE REFERRAL/SERVICE AGREEMENT

Client Name:_____**Medicaid #:**_____ **Client #**_____
DOB:_____**SSN:**_____**Race:**_____**Gender:**_____**Marital Status:**_____
Current Residence:_____**Phone:**_____
Parent/Guardian:_____ **Work Phone:** _____
Address:_____ **Relationship:**_____
Referring Agency:_____ **Worker:**_____
Address:_____ **Phone:**_____

Reason For Referral (Include Presenting Concerns): _____

Goals Outlined by Referring Agency:_____

Funding Source: **___FAPT/CPMT Funded** **___Medicaid** **___294 Funded**
___VJCCC **___Other**_____

Billing Agency/Address: _____
Attention:

The above named agency authorizes Rice Counseling & Associates to provide Intensive In-Home Services to the above named client, and is responsible for payment of these services. Rice Counseling & Associates agrees to provide the following services throughout the contract period unless a revised agreement is negotiated.

SERVICES REQUESTED	UNITS/PER	COST PER UNIT	STAFF ASSIGNED

Case Start Date:_____ **Case End Date:**_____
Rice Counseling & Associates will 1)provide a written assessment 2)provide an Individual Service Plan 3) provide therapeutic services as deemed appropriate 4)attend scheduled meetings 5)provide regular client/family updates to the referring agency.

Verbal Request by:_____ **Date:**_____ **Time:**_____

_____ **Date:**_____ **Time:**_____
Rice Counseling & Associates Staff Member

Funding Authorization:_____ **Date:**_____