

Rice Counseling and Associates, Inc.
CASE REFERRAL/SERVICE AGREEMENT/MEDICAID PRESCREENING
Identifying Information

Referral Date: _____
 Referrral Source: _____

| | |
|-------------------------------|------------------------------------|
| Name: | Client #: |
| DOB: | SSN: Marital Status: Gender: Race: |
| Current Residence | |
| Parent/Guardian | |
| Home Phone: | Work Phone: |
| School: | Grade: |
| Special Education: — yes — no | |
| Probation/Parole Officer: | |
| DSS Caseworker: | |
| Primary Care Physician: | |
| Psychiatrist: | |
| Medication(s)/Dosage: | |

Medicaid Information

| | | |
|--|-------------------------------------|-----------|
| Medicaid Recipient # | Recipient Eligibility: Yes/No | End Date: |
| Service Availability: (weeks) | Date Verified: | |
| Has recipient received Medicaid In-Home this year: | YES/NO Approximate Duration (weeks) | |

Clinical Screening

| | | |
|---|--------------------------------------|------------------------------|
| ___ Sadness/Depression | ___ Parent/Child Problems | ___ Physical/Emotional Abuse |
| ___ Anxiety/Phobias | ___ Behavior Problems/School Failure | ___ Sexual Abuse/Molestation |
| ___ Substance Abuse | ___ Truancy/Drop Out/Expulsion | ___ Chronic Medical |
| ___ Problems Eating/Sleeping Disturbances | ___ Suicide Attempt(s) # _____ | ___ Legal Concerns |
| ___ Physical Aggressiveness | ___ Danger to Self/Others | ___ Runaway Potential |
| ___ Sexually Inappropriate Behaviors | ___ Outpatient TX | ___ Death/Loss Issues |
| ___ Peer Relationship Challenges | ___ Hospitalization(s) # _____ | ___ Foster Placement |

___ At least one parent is willing to participate in IIHS. Name: _____

___ Child/Adolescent is at risk of/being transitioned from an out-of-home placement due to a mental health DX: _____

Provisional Diagnosis: _____

___ Child/Adolescent has significant relationship/behavioral or cognitive concerns: _____

___ A minimum of 5 hours/week of Intensive In-Home Services is necessary to successfully stabilize the child/adolescent in the family:

Medicaid Disposition

| | | |
|--|----------------|-------------|
| Initial Plan: Client is eligible and recommended for Intensive In-Home Services: | YES | NO |
| Case Start Date: | Case End Date: | Hours/Week: |
| Prescreening Completed By: | Date: | |
| Staff Assigned: | Date: | |
| Clinical Supervisor/Reviewer | Date: | |