Client ID:____________________Assigned Assessor:______________________ Class:____________

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Behavioral Support Services, Inc.

315 North Lakemont Avenue, Suite B, Winter Park, Florida 32792
Phone: 407-830-6412 Fax: 407-479-3827
E-Mail: Referral@BSSOrlando.com

Referral Form

Client Information (Please print): ***Date of Referral*: ___________**

Last Name: ______________________ First Name: ______________________ Middle Initial: ________

SSN: ______________ Sex: ☐ M ☐ F DOB: __________ Race: ____________ County: ______________

Home Address: ____ City: ________________ Zip: ________

Parent/Guardian: ____ Phone: ______________________

Work: ________________ Cell: ________________ Bilingual Needed: ☐ Yes ☐ No ________________

School: ____ Grade: __________ ESE: ☐ Yes ☐ No

List of Medication(s): ____

Current Treatment:

Previous Treatment:

Primary Reason for Referral: (e.g. Anxiety, Depression, Inappropriate Sexual Behavior, Noncompliance, Stealing, Substance Abuse, Trauma, Verbal Aggression, etc.)

Services Required: (e.g. Behavior Analysis, Case Management, Mentor, Psychiatric Evaluation, Therapy, etc.)

Please list ALL insurance coverage for the client being referred:

☐ Amerigroup	☐ Children's Home Society (CHS)	☐ Med-Waiver (Developmental Disability)
☐ Amerigroup HK	☐ Children's Medical Services (CMS)	☐ HSA/Family Services Planning Team (HSA/FSPT)
☐ Beacon/Prestige	☐ Community Based Care (CBC)	☐ Human Services Association/Title 21 (HSA/Title 21)
☐ Cenpatico	☐ United Healthcare	☐ Other (please specify): ________________
☐ Magellan	☐ United Healthcare HK	☐ Mental Health Network (Autism)
☐ Magellan HK	☐ Vocational Rehab	☐ United Behavioral Health (Autism)
☐ Aetna (Autism)	☐ Humana (Autism)	☐ Cigna (Autism)

Medicaid #: ________________ Other ID #: ________________ Support Plan Effective Date: ____________

I understand that I must disclose all insurance coverage. If failure to disclose results in a denied claim, I will be financially responsible. ____ (Signature of parent/caregiver)

Referral Source Information: (Please Print)

Name: ________________________________ Agency: ______________________

Email: ________________________________ Phone: ______________________

Fax: __________________________ Requested Therapist: ______________________

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Confidential & Privileged Information for Professional Use Only