REFERRAL FORM

Seminole, Orange, Osceola, Brevard, Polk and Volusia Offices Fax to: General number: 321-639-1194 OR E-mail to: referrals@impowerfl.org
OR Mail to: IMPOWER; 1037 Pathfinder Way, Suite 130, Rockledge, FL 32955-3242

Targeted Case Management Referral: Fax to General number: 321-639-1194 OR E-mail to: TCM@impowerfl.org
OR Mail to: IMPOWER; 1037 Pathfinder Way, Suite 130, Rockledge, FL 32955-3242

Priority Determination: □ Routine (7 days) **Any urgent referral MUST be called into 321-639-1224**

DEMOGRAPHIC INFORMATION:

Name:_____ Social Security #:_____

Parents/Caregivers Names:_____ Relationship to Client:_____

☐ Parent/Guardian home ☐ Relative home, placed by DCF ☐ Foster Home

Address:_____ County:_____

City/State:_____ Zip:_____ Email:_____

Phone:_____ Sex:_____ Race:_____ DOB:_____ Age: _____

School:_____ Grade: _____

Client's preferred language:_____ Caregiver's preferred language:_____ Bilingual required? YES NO

DEPENDENCY/DELINQUENCY INVOLVEMENT: Parental rights terminated? ☐**Yes** ☐**No***

☐ No PS/FC/DJJ involvement ☐ Dependent (foster care) status* ☐Protective Services status ☐ DJJ Involvement

Case Manager: _____ Agency:_____ Phone:_____

***Required for Dependent children not TPR'ed**: Biological Parent/Legal Guardian:_____

Address:_____ Phone:_____

REFERRED BY:

Person completing form:_____ Referring Agency/Person:_____

Phone: _____ Fax:_____ Email:_____ Date:_____

Client is currently receiving: ☐In-home / ☐In-school / ☐Individual Therapy / ☐Medication / ☐Other:_____

Therapist Name:_____ Agency:_____ Phone:_____

FUNDING INFORMATION

Funding: Medicaid #:_____ Amerigroup/ United/ Magellan Complete Care/ AHCA/ Better Health/Integral/Molina/Prestige/First Coast Advantage/Staywell/Sunshine/Sunshine Child Welfare/Florida Department of Children's and Families

Non Medicaid cases: (Circle one) FSPT-HSA; FSPT-CHS; CMS; CBC; BFP; SAMH; Healthy Kids; Private Pay; Heartland
Authorization Number: _____ Auth period: _____

PROBLEM DESCRIPTION – ***This section must be completed in order for referral to be processed.***

SERVICES REQUESTED: ☐**Counseling** ☐**Psychiatric** ☐**Targeted Case Management**

Please describe briefly the reason for request services:

_____

_____

TCM areas of need: ___Mental Health/ Substance Abuse __Family support & Education ___Academic ___Job training/ vocational ___Housing/ Food/ Clothing/ Transportation ___Medical & Dental___Legal assistance___Establishing financial resources

History of treatment (year): _____ Previous diagnosis: _____ Developmental problem: _____

FOR IMPOWER OFFICE USE ONLY:

☐ Hx of treatment at IMPOWER: _____; Previous counselor: _____

Other Information: _____

Counselor Assigned:_____ Date Assigned:_____ LE:_____