IMPOWER
Inspiring Life's Potential.

# REFERRAL FORM

**Fax to: 321-639-1194 OR E-mail to: referrals@impowerfl.org**
**OR Mail to: IMPOWER; 111 W. Magnolia Ave, Longwood, FL 32750**

**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: _____

Employer/School:_____ Grade: _____

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

**LEGAL GUARIDAN INFORMATION IF DIFFERENT THAN ABOVE:**

Name: _____ Agency:_____ Phone:_____

**EMERGENCY CONTACT**

Name: _____ Phone: _____ Relationship: _____

**REFERRED BY:**

Person completing form:_____ Referring Agency/Person:_____

Phone: _____ Fax:_____ Email:_____

Date:_____

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

Provider Name:_____ Agency:_____
Phone:_____

**FUNDING INFORMATION**

Insurance Name*: _____Medicaid #:_____
***If Medicaid, please enter Medicaid Managed Medical Assistance (MMA) name***
Non-Medicaid: (Circle One)FSPT; CMS; CBC; BFP; BNET; Private Pay; Other:_____

**TANF-FUNDED SERVICES ELIGIBILITY**

**200% of the federal poverty level 2018 Guidelines**

| Family Size | 200% Level | Monthly Income |
|---|---|---|
| 1 | $24,280 | $2,024 |
| 2 | $32,920 | $2,744 |

| | | |
|---|---|---|
| 3 | $41,560 | $3,464 |
| 4 | $50,200 | $4,184 |
| 5 | $58,840 | $4,904 |
| 6 | $67,480 | $5,624 |
| 7 | $76,120 | $6,344 |
| 8 | $84,760 | $7,064 |

1. FAMILY SIZE:_____
2. TOTAL FAMILY INCOME IS (include government assistance such as SSI, unemployment, etc.) $_____ PER _____
3. CONVERT TO A MONTHLY AMOUNT AND LIST THE FAMILY'S TOTAL MONTHLY INCOME: $_____
4. Is this **amount less than 200%** of the federal poverty level on the above chart? ☐ YES ☐ NO
5. DO YOU HAVE INSURANCE? ☐ YES ☐ NO
6. I live in the following county:(Circle One) Brevard Orange Osceola Seminole

**CERTIFICATION**

I hereby certify that all information I provided is true to the best of my knowledge and belief. I understand that in accordance with Florida Statutes Section 817.50 providing false information to defraud a health care provider for the purpose of obtaining goods and services is a second-degree misdemeanor:

_____ _____

**Client/Guardian Signature** **Date**

_____ _____ _____

**Staff Signature** **Agency/Provider Name** **Date**

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

SERVICES REQUESTED: ☐ **Substance Abuse Residential** ☐ **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: _____

Rev: 1/15/2019