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:_____

GRANT-FUNDED SERVICES ELIGIBILITY

150% of the federal poverty level 2020 Guidelines

Family Size	Annual Income	Monthly Income
1	$19,140	$1,595
2	$25,860	$2,155
3	$32,580	$2,715
4	$39,300	$3,275
5	$46,020	$3,835
6	$52,740	$4,395
7	$59,460	$4,955
8	$66,180	$5,515
If Family Size is over 8, add $6,720 to annual income for each additional member		

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 150%** 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 Glades Hendry Highlands(substance abuse only)

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** ☐ **Opioid Medication Assisted Treatment (must be 18 or older)**

Please describe briefly the reason for request services:

_____

_____

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

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