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 2021 Guidelines

Family Size	Annual Income	Monthly Income
1	$19,320	$1,610
2	$26,130	$2,178
3	$32,940	$2,745
4	$39,750	$3,313
5	$46,560	$3,880
6	$53,370	$4,448
7	$60,180	$5,015
8	$66,990	$5,583
If Family Size is over 8, add $4,540 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 (ages 13 to 17)** ☐ **Counseling** ☐ **Psychiatric**

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

Please describe briefly the reason for request services:

____

____

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

Rev: 3-2021