DATE:

ADULT, CHILD & FAMILY SERVICES, LLC

CTSS REFERRAL FORM

REFERRAL SOURCE (AGENCY/PERSON):_____

Phone: _____ Fax: _____ Email Address:_____

Clients Name: _____ DOB: _____ GENDER: _____

Phone Number:_____ SOC. SEC. # _____

Address: _____

Parent/ Guardian Name:_____if Guardian, explain relationship_____

Phone Number:_____

Case Manager ? Yes____ No____

Name:_____ Email address/Phone:_____

Therapist? Yes____ No____

Agency:_____ Email address/Phone:_____

Other Providers? Yes____ No____

Agency:_____ Email address/Phone:_____

PLEASE ATTACH THE MOST RECENT DIAGNOSTIC ASSESSMENT WITH THIS FORM

If there is no current DA, does ACFS need to complete one? _____

DA completed? If so, Date completed _____ Is Client SED?_____ CTSS Recommendation in DA?_____

TYPE OF SERVICE(S) DESIRED (CHECK ALL THE APPLY)

☐ INDIVIDUAL SKILLS ☐ GROUP SKILLS ☐ FAMILY SKILLS

BRIEF DESCRIPTION OF PROBLEM (attach separate sheet if necessary. please forward medical & behavioral information, court reports, social summaries, previous DA's, etc.)

_____

_____

_____

Does client know of this referral? _____ Release of information completed for therapist and Case worker? _____

Billing Information (MUST be MA or have a PMAP to qualify for services)

primary Insurance _____ Policy/ PMI # _____ Group # _____

Please fax this completed form to 507.344.1726 or email to kcooper@acfsmankato.org