Behavioral Health Intervention Services Referral Form

Developing Strong Futures
Orchard Place

REFERRING ORGANIZATION INFORMATION (If Applicable)

Referring Person	Date
Referring Organization (If applicable)	Phone

INSURANCE INFORMATION

○ Amerigroup ○ Iowa Total Care ○ Molina Healthcare of Iowa ○ Private Insurance ○ Other (IME)

Insurance Company:	Policy Number:	Medicaid Number:
Policy Holder Name:	Group Number:	

MENTAL HEALTH INFORMATION

Current Mental Health Provider(s)	
Current Waiver(s) (if applicable)	Child's Mental Health Diagnosis

CLIENT INFORMATION

Child's Name	Date of Birth
Child's Address	Legal Sex ○ Female ○ Male
	Phone
Parent 1 Name	○ Custodial ○ Non-Custodial
Address	
Phone	Email
Parent 2 Name	○ Custodial ○ Non-Custodial
Address	
Phone	Email
Legal Guardian	○ Custodial ○ Non-Custodial
Address	
Phone	Email
Primary Language	

Additional Information (Please indicate current providers, reason for referral, etc.)

Please return this form to tcrandall@orchardplace.org or fax at (515) 697-5701