TEXAS Health and Human Services

Case Management for Children and Pregnant Women

CM- 01A
11/23

REFERRAL & INTAKE FORM

REFERRAL				
Referral Date:	**Name of Referral Source (List agency/company name):**		**Name of Person Making Referral:**	
Phone Number for Person Making Referral:		**Fax Number for Person Making Referral:**		

CLIENT INFORMATION				
Client Name:		**DOB:**	☐ **Male** ☐ **Female**	
Medicaid #:		**Language Preference:**		
Parent/Guardian Name (if client is under 18):				
Residential Address:		**City:**	**ZIP:**	**County:**
Phone Numbers:	**Home:**	**Work:**	**Cell:**	**Other:**

Health Condition/Health Risk (Child) or High-Risk Condition (Pregnant Woman) / Case Management Needs Per Referral Source:

Referral section completed by:

INTAKE (completed by case manager with client/parent/guardian)	
Date of Intake:	**Information provided by:**

☐ **Information same as provided by referral source**

☐ **Additional information provided by client/parent/guardian; Include expected date of delivery if pregnant:**

Outcome of Referral:

☐ **Eligible needs. Submit initial prior authorization request for case management services.**
☐ **Routine medical and dental needs. Refer to Texas Health Steps Hotline or MCO.**
☐ **Routine medical transportation needs. Refer to Medical Transportation Program.**
☐ **Basic needs only. Refer to 2-1-1 or other community resource.**
☐ **Not interested in case management services and/or no needs identified.**
☐ **Other**

Attempts to Contact Client/Parent/Guardian	
Date of Attempts:	**Action:**
1.	
2.	
3.	
Intake completed by:	

FAX TO: THSTEPS SPECIAL SERVICES UNIT FAX # (512) 533-3867