



Only use this form for Medicaid beneficiaries in Medicaid fee-for-service. For beneficiaries in Medicaid managed care (STAR, STAR Kids, etc.), contact the person's health plan.

CM-Referral
04/18

REFERRAL

FOR CASE MANAGEMENT FOR CHILDREN AND PREGNANT WOMEN

REFERRAL		
Referral Date:	Name of Referral Source (List agency/company name):	Name of Person Making Referral:
Referral Source (Please check one): <input type="checkbox"/> Health Care Provider <input type="checkbox"/> Community Agency <input type="checkbox"/> School <input type="checkbox"/> ECI <input type="checkbox"/> City or County Health Department <input type="checkbox"/> Health Plan <input type="checkbox"/> Individual <input type="checkbox"/> State Agency: <input type="checkbox"/> Other		
Phone Number for Person Making Referral:		Fax Number for Person Making Referral:
Do you Desire Information Regarding the Status of the Referral? <input type="checkbox"/> YES <input type="checkbox"/> NO		

CLIENT INFORMATION			
Client Name:		DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Medicaid #:	Describe Medical/Health Condition/Risk or High-Risk Pregnancy Condition:		
Parent/Guardian Name (if client is under 18):		Language Preference:	
Residential Address:		City:	ZIP: County:
Phone Numbers-	Home:	Work:	Cell: Other:

ADDITIONAL INFORMATION
Reason for Referral/Need for case management:
Priority Status of Referral: <input type="checkbox"/> Urgent (needs to be contacted within 2 working days) <input type="checkbox"/> Standard (needs to be contacted within 7 working days)

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

FOR MORE INFORMATION ABOUT CASE MANAGEMENT, GO TO: <http://www.dshs.texas.gov/caseman/>

FOR SSU USE ONLY	
Referral Assigned To SSU CCR: _____	
Date: _____	
Date of Attempts:	Action:
1.	
2.	
3.	
Date Completed: <input type="checkbox"/> Scheduled Appointment with: <input type="checkbox"/> Successful Phone Contact/Gave provider information by phone and mailed List <input type="checkbox"/> Successful Phone Contact/Mailed Provider List <input type="checkbox"/> Successful Phone Contact/Not interested in case management <input type="checkbox"/> Successful Phone Contact/No case management needs <input type="checkbox"/> Unable to contact/Mailed provider list	
Attempts Made to contact Provider:	
Date of Attempts:	Action:
1.	
2.	
3.	

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