REQUEST FOR CASE MANAGEMENT

For Clients Enrolled in STAR Kids

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| REFERRAL |
| Referral Date:           | Name of Person Making Referral:      | Name of Health Plan/Agency:      |
| Phone Number for Person Making Referral:      | Fax Number for Person Making Referral:      |
| Do you Desire Information Regarding the Status of the Referral? [ ]  YES [ ]  NO  |

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| CLIENT INFORMATION |
| Client Name:       | DOB:       | [ ]  Male [ ]  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:      |

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| ADDITIONAL INFORMATION |

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| Reason for Referral/Need for School Advocacy:      |
| FOR MORE INFORMATION: <http://www.dshs.texas.gov/caseman> |