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> |