Referral for Family Support Services

To make a referral, please complete ***AND SIGN*** this form and send it to our statewide Intake Coordinator at:

Email: referrals@delautism.org 924 Old Harmony Road, Suite 201, Newark, DE 19713
Phone: 302-224-6020 Fax: 302- 224-6017

Child's Information

Child Name: ____ DOB: ______________________

Gender: ___ Male ___ Female Resides with: ____

Parent/Legal Guardian Information

Parent Name: ____ Phone: ___________________________

Relationship to Child: ___________________________________ Alternate Phone: ___________________

Address: ____

Email address: ____

Insurance Information

Medicaid? ___Yes ___No Medicaid MCO: ____

MCO ID #: ____

Private Insurance Company: _________________________________ ID #: ______________________________

Referral Agent Information – Professional Completing this Referral

Name: ____

Type of Professional License: ____
(physician, nurse practitioner, physician assistant, licensed psychologist, LCSW, LPCMH)

Agency/Practice: ____ Phone: ___________________________

Email: ____

Clinical Information

Has this child been diagnosed medically with autism spectrum disorder?

_____ Yes: diagnosed by:_________________________________ License type: __________________________

_____ No. If no, please list other diagnoses below.

Current Diagnosis:	DSM-5 Code:	Diagnosed by:

Reason for Referral to Family Support Services: ____
Which of the following family support needs are included in your treatment plan for this family? (One or more will be necessary for insurance coverage)

☐ Outreach and Information	☐ Bridging & Coordination of Services
☐ Advocacy and Empowerment Coaching	☐ Parent/Guardian/Caregiver Psychoeducation
☐ Community Connections and Natural Supports	

____ ______________

***** Referral Agent/Provider Signature ***** Date

Parent/Legal Guardian Consent

As the legal guardian of this child, I understand that we have certain rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including right to privacy regarding the child's protected health information, including information shared in this referral.
I agree for the "Referral Agent" listed above to complete this form and share the information with Autism Delaware for the purposes of referring my child for Family Peer Support Services, including the ACT Program. *I further agree that Autism Delaware Family Support Services staff may contact and speak with the listed referral agent in order to coordinate the referral.*

This consent to share information will be effective for 6 months from the date of my signature below, or until ____________.
I understand that I have the right to revoke this consent at any time and no further information will be shared as of that time.

Como el tutor legal de este niño/a, entiendo que tenemos ciertos derechos bajo la Ley de Portabilidad y Responsabilidad de Seguros de Salud (HIPAA por sus siglas en ingles), incluyendo el derecho a privacidad sobre la información de salud protegida, incluyendo la información compartida con este referido.
Estoy de acuerdo que el "agente que está refiriendo" que esta listado previamente llene este formulario y comparta información con Autism Delaware con el propósito de referir a mi hijo/a para los Servicios de Apoyo de Familia, incluyendo el programa ACT. Incluso estoy de acuerdo que el personal de Servicio de Apoyo para Familias de Autism Delaware podrá contactar y hablar con el agente listado en esta referencia para poder coordinar el referido.

Este permiso para compartir información será efectivo por 6 meses desde la fecha de la firma de abajo, o hasta _______ .
Entiendo que tengo derecho de revocar este permiso en cualquier momento y desde esa fecha no se compartirá más información.

____ ______________

Parent/Guardian Signature Date

____

Printed Parent/Guardian Name