Referral for Family Peer Support Services

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

Email: referrals@autismdelaware.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 #: _____

TO BE COMPLETED BY REFERRAL AGENT:

Clinical Information

Reason for Referral: _____

Has this child had an autism evaluation? ___Yes ___No
Has this child been diagnosed medically with autism spectrum disorder? ____ Yes ___No
Does this child have an educational classification of autism? ____ Yes ___ No

Current Diagnoses: _____

_____

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Treatment Plan

Which of the following goals 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 Information – Professional Completing this Referral

Name: _____

REQUIRED:

Type of Professional License: _____

(physician, nurse practitioner, physician assistant, licensed psychologist, LCSW, LPCMH)

Agency/Practice: _____ Phone: _____

Email: _____

_____ _____

Referral Agent 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 send it to 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.

_____ _____

Parent/Guardian Signature Date

_____

Printed parent/Guardian Name