BCDBH CHILD/YOUTH SYSTEM OF CARE REFERRAL/MANAGED CARE AUTHORIZATION (MCA)

Date of Referral/MCA: ☐ Referral Other:

Client Name: Client DOB: Client ID:

Agency/Program: Clinician Name/ID:

Parent/Guardian Name: Parent/Guardian Phone Number:

Parent/Guardian Address:

Referring Party Name: Referring Party Phone:

Current Service(s) (Check all services client is currently receiving):

☐ HAP ☐ IHP ☐ SMHS/SBC ☐ TFC ☐ YES ☐ None
☐ HEART ☐ Med Support ☐ Strong Starts ☐ VOCS ☐ YIP
☐ IHBS ☐ PCIT ☐ TBS ☐ WRAP ☐ 6th Street

Requested Service(s) (Choose only ONE program per form):

☐ HAP ☐ Med Support ☐ Strong Starts ☐ YES
☐ HEART ☐ PCIT ☐ VOCS ☐ 6th Street
☐ IHP ☐ SMHS/SBC ☐ WRAP

Services requiring prior authorization: ☐ IHBS ☐ TBS ☐ TFC

Please provide clinical rationale for service request:

☐ I have reviewed this referral/MCA with my supervisor

(Name of Supervisor)

Provider of Services (Name & Credentials): Date

For Quality Management Use Only

For IHBS, TBS, TFC services only:

Service Authorized From:

To:

For Referrals:

Referral Approved:

Assigned To:

Quality Management Clinician Signature: