The Georgia Collaborative ASO

PRTF/CBAY Referral Document Checklist

All items listed plus the checklist must be uploaded into ProviderConnect. Requests that do not contain all items as described will not be processed. Care Managers may only speak with the referring provider. No discussions may occur with collateral providers/agencies or family members.

Individual's Name:	DOB: / / Gender: ☐ Male ☐ Female ☐ Unknown
Referring Provider's Name:	Referring Contact Person's Name:
Referring Contact Person's E-Mail:	Referring Provider's Phone #:
Individual's Current Placement/Treatment Type: (ie. Core, RBWO, Crisis Bed, CSP, IFI, Group Home, etc):	Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic Please complete both Race and Ethnicity
Race: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other	
Individual is 18 years old or older? ☐ Yes ☐ No If yes, the individual must sign all forms Total annual family income in past year: $	Individual is 18 years old or older and has a court appointed Legal Guardian? ☐ Yes ☐ No If yes a copy of the court order must be submitted
Is this a referral due to a change in funding source? (ie. consumer is already in your facility under different funding source) ☐ Yes ☐ No	***If yes what is the change:***
Consumer currently admitted to CBAY Waiver Services and this is a request for brief stabilization in a PRTF facility? ☐ Yes ☐ No	***If yes, who is the CME:***
Is this a PRTF/CBAY lateral transfer? ☐ Yes ☐ No	If yes, select referral to: ☐ PRTF ☐ CBAY
DJJ Involvement? If yes, **must** select type & submit **Court Order** to support selection ☐ Yes ☐ No	If yes ***must select and include a copy of the Court Order*** ☐ Commitment ☐ Custody ☐ Probation

Required Documents to be Included in the Referral	Date of the Document
Psychiatric Evaluation (within 60 days or 30 days for a lateral transfer) Must be legible and dated within 60 days for a new referral, 30 days for a lateral transfer or funding change. Must include the following: current medication(s) with dosage and times given; current diagnosis; current symptoms and behaviors; and signed and dated by the MD, ARNP, CNS or PA.	
Psychosocial Evaluation (within 60 days) This evaluation must be dated within 60 days of the date the Admission Review is submitted. This evaluation must include the following: consumer's historical information (past placements, hospitalizations, treatment history, developmental history, medical history, family history, etc); presenting behaviors; and signed and dated by the clinician. This document must be legible. APS will accept an evaluation that is older than 60 days with an addendum that includes current information within 60 days. This evaluation can be initiated by a previous treatment setting (such as hospital, educational setting, etc) as long as it includes the above listed information and is within timeframe.	
Psychological Evaluation (within 2 years) This evaluation must be dated within 2 years of the date the referral submission. This evaluation must include the following: IQ score; recommendations; and signed and dated by the Licensed Psychologist. This evaluation can be initiated by a previous treatment setting (such as hospital, educational setting, etc) as long as it includes the above listed information and within timeframe.	
Psychosexual Evaluation (if available and applicable)	
Treatment Choice Form (TCF) *(**must be included**, see Stakeholder Memo 11-15-2011)*	
Copy of Medicaid Portal showing type (if any) of Medicaid coverage	

CBAY Referrals ***must*** include:

CBAY BIP Packet: ☐ Overview & Consent ☐ Unified Release of Information

CBAY MFP Packet:

☐ MFP Unified Release ☐ MFP Overview and Consent ☐ MFP CBAY Referral

☐ MFP Informed Consent ☐ MFP Authorization for Use or Disclosure of Health Information