DFCS Service Authorization & Referral Form

Program Area: ☐ **Intake** ☐ **Family Support** ☐ **Investigation** ☐ **Family Preservation**
☐ **Permanency** ☐ **Adoption** ☐ **Foster/Adopt**

Service Authorization ID# _____ [Not Valid if Missing]

Please Note: Service Authorization/Referral Form is **REQUIRED** prior to service provision. Provider **MUST** attach to invoice. DFCS will complete *one Service Authorization/Referral Form per UAS Code*.

Resource (Provider) Name: _____	
Resource ID: _____	**Contract #:** _____
County: _____	**Date of Referral:** _____ **Initial Referral** ☐ **Subsequent Referral** ☐
Case Name: _____	**Case ID#**: _____

Name of Person Referred for Services:	**Person ID :**	**Medicaid #**
_____	_____	_____

Marital Status:	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
Race:	☐ White	☐ Black	☐ Asian	☐ Hispanic	Other: _____

Current Street Address: _____	**City**:_____	**ZIP**:_____

Family Contact Numbers:	**Home Phone**: _____		**Cellular Phone**: _____
Case Manager Name: _____	**Phone**: _____	**Fax:** _____	**Email**: _____
CM Supervisor Name: _____	**Phone**: _____	**Fax:** _____	**Email**: _____

Family Composition : (List ALL Persons in the Home OR Involved in the Referral)

Name	**DOB**	**Relationship**	**Contact Information (If not a household member)**
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

Are Children placed with a Safety Resource? ☐ Yes ☐ No

If so, include their information (Name, Address, Phone Number, which children are placed, etc) _____

Prior DFCS History? ☐ Yes ☐ No **Length of time Current Case has been open?** _____

CPS Reasons:	☐ Neglect	☐ Physical Abuse	☐ Sexual Abuse	Other: _____

Services Authorized: (***Instructions***: *Please complete one Service Authorization/Referral Form per UAS code. Indicate which services are being authorized/referred, # units & $ amount authorized.)*

Service Authorization Period Covered : From _____	**To** _____

Comments **(Indicate reason for use of the manual service authorization form, case circumstances warranting unusual expenditures, etc.)**

☐ **UAS Code 521 (PUP) Entitlement Codes Authorized:**

PUP Eligibility Criteria:

Indicate Active Case Program Area: ☐ CPS ☐ PLC ☐ Adoptions

Choose one of the following (drop down):

1. PUP/Homestead - Immediate risk of placement

	# Units		Type of Service / Cost Per Unit	$ Auth
☐		51a	Drug Screen Collection Only - Hair Follicle ($65)	
☐		51b	Drug Screen Collection Only - Urine ($45)	
☐		51c	Drug Screen Collection Only – Oral Fluid ($45)	
☐		51g	Drug Screen Collection Only - Court Appearance and/or Testimony (Drug Screens only) ($45/hr) (Copy of Subpoena required)	
☐		51h	Drug Screen Collection Only - Drug Screen Refusal ($25 per appointment – Max 3 per family)	
☐		51i	Drug Screen Collection Only - Missed Appointments – Drug Screen ($25 per appointment – 3 per month, Max 6 per family)	
☐		51j	Drug Screen Collection Only Mileage – Mileage Reimbursed at State Rate – Max of $500 roundtrip	

UAS 521 Total Amount Authorized: _____

Reason for Referral & Services Requested: ***(Please include a brief summary of the case including risk indicators, child vulnerabilities, parental protective capacities and service needs.)*** _____

Frequency of Services – ***If counseling or parent aide services are referred, indicate frequency of services expected (for example – Counseling 2 hours once/week, Parent Aide 2 hours twice/week):*** _____

Signature of Case Manager (REQUIRED): _____ **Date:** _____

Signature of Supervisor (REQUIRED): _____ **Date**: _____

Signature of Other Designated Approver: _____ **Date**: _____

Other Designated Approver-OPTIONAL)