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|  | State of MissouriDepartment of Mental HealthDivision of Developmental Disabilities**Southwest Missouri Autism Project** **Provider Referral Form** |

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| The *Provider Referral/Enrollment* form is only needed for a referral/enrollment with a provider the individual is not currently enrolled with (CIMOR code 52070A). Please review [Support Coordinator Roles & Responsibilities](https://dmh.mo.gov/dev-disabilities/autism/southwest/support) at <https://dmh.mo.gov/dev-disabilities/autism/southwest/support>.  |
| Name Click or tap here to enter text. | Provider Referral/Enrollment Reason Choose an item. |
| DMH IDClick or tap here to enter text. | Regional Office Choose an item. | Medicaid Number Click or tap here to enter text. |
| Referral DateClick or tap here to enter text. | Date of BirthClick or tap here to enter text. |
| Living Arrangement Choose an item. | Communication MethodChoose an item. |
| Referral/Enrollment Request for Choose an item. | Referral/Enrollment Request for Choose an item. | Referral/Enrollment Request for Choose an item. |
| Referral/Enrollment Request forChoose an item. | Referral/Enrollment Request forChoose an item. | Referral/Enrollment Request forChoose an item. |
| Referral/Enrollment Request forChoose an item. |
| **Parent/Guardian Contact Information** |
| Name Click or tap here to enter text. |
| Street Address Click or tap here to enter text. |
| City, State Zip Click or tap here to enter text. | County Click or tap here to enter text. |
| Is Guardian someone other than parent? Choose an item. If yes, explain Click or tap here to enter text. |
| Guardian’s Preferred Contact Method | Time of day to contact |
| [ ]  Home/Cell phone Click or tap here to enter text. | Click or tap here to enter text. |
| [ ]  Work phone Click or tap here to enter text. | Click or tap here to enter text. |
| [ ]  Email Click or tap here to enter text. | Click or tap here to enter text. |
| **Individual/Parent/Guardian/Designated Representative Certification & Signature(s)** I certify that I have selected the provider(s) and services(s) on this document based on identified needs. |
| Individual Signature  | Date Click or tap to enter a date. |
| Parent/Guardian/Designated Representative Signature | Date Click or tap to enter a date. |
| **Support Coordinator Certification & Signature**1. I certify that the individual/parent/guardian/designated representative has selected the provider(s) and service(s) in this document based on identified needs.
2. I certify that the need for each service has been justified in the ISP.
3. I certify any request for multiple providers for a service has been justified in the ISP.
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| Support Coordinator Name Click or tap here to enter text.  |
| Email Click or tap here to enter text. | Phone Click or tap here to enter text. |
| Support Coordinator Signature | Date Click or tap to enter a date. |