SD EForm - 2473 V1 Complete and use the button at the end to print for mailing. HELP

Department of Social Services
Division of Behavioral Health
605-773-3123

HIGH INTENSITY REFERRAL FORM

TO BE COMPLETED BY REFERRAL AGENCY

All fields are REQUIRED. Incomplete forms will be returned

Client's First and Last Name: _____

STARS ID: _____

DOB _____ **Last 4 of Social Security #** _____ **Mother's First Name** _____
Street Address _____
City _____ **State** _____ **Zip Code** _____ **County** _____
Home Phone # _____ **Cell Phone #** _____

Date Approval Form Completed: _____ **Date Assessment Completed:** _____
Agency Submitting the request: _____
Agency Contact Person: _____
Email Address: _____

Provider Recommended ASAM Level of Care: Please Choose
Provider Recommended Placement: Please Choose

Please check boxes if the following applies: ☐ IVC County: _____
☐ Pregnant (EDD date: _____) Medicaid Number _____

☐ Currently on probation/parole **JCA/CSO/Parole Agent/:** _____
☐ Pending legal charges ☐ Currently incarcerated County of charges _____
List of pending legal charges

☐ IV drug use in the last 30 days ☐ IV Drug use lifetime
☐ Current Heroin Drug Use ☐ Current Prescription (Opioid) Drug Use

Level of Motivation to change

- All referrals must include:
  - ☐ Release of information signed by the client
  - ☐ Financial means form
  - ☐ Completed integrated assessment which matches the recommended level of care being made on this form

- Medicaid funded referrals must include a physician referral that medical necessity exists
- Pregnant Women or Pregnant Adolescent referrals must also include a Physicians Letter verifying pregnancy with estimated due date (EDD).

Please send completed forms to the Division of Community Behavioral Health via fax at (605)367-5239 or email at: DSS.DCBHTNANotifications@state.sd.us.

PRINT FOR MAILING CLEAR FORM
