



Referral for Family Support Services

To make a referral, please complete **\*AND SIGN\*** this form and send it to our statewide Intake Coordinator at:

Email: [referrals@delautism.org](mailto:referrals@delautism.org)

924 Old Harmony Road, Suite 201, Newark, DE 19713

Phone: 302-224-6020

Fax: 302- 224-6017

**Child's Information**

Child Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Gender:  Male  Female Resides with: \_\_\_\_\_

**Parent/Legal Guardian Information**

Parent Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Email address: \_\_\_\_\_

**Insurance Information**

Medicaid?  Yes  No Medicaid MCO: \_\_\_\_\_

MCO ID #: \_\_\_\_\_

Private Insurance Company: \_\_\_\_\_ ID #: \_\_\_\_\_

**Referral Agent Information – Professional Completing this Referral**

Name: \_\_\_\_\_

Type of Professional License: \_\_\_\_\_

(physician, nurse practitioner, physician assistant, licensed psychologist, LCSW, LPCMH)

Agency/Practice: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

**Clinical Information**

Has this child been diagnosed medically with autism spectrum disorder?

Yes: diagnosed by: \_\_\_\_\_ License type: \_\_\_\_\_

No. If no, please list other diagnoses below.

Current Diagnosis:	DSM-5 Code:	Diagnosed by:



Referral for Family Support Services, page 2

Reason for Referral to Family Support Services: \_\_\_\_\_

Which of the following family support needs are included in your treatment plan for this family? (One or more will be necessary for insurance coverage)

<input type="checkbox"/> Outreach and Information	<input type="checkbox"/> Bridging & Coordination of Services
<input type="checkbox"/> Advocacy and Empowerment Coaching	<input type="checkbox"/> Parent/Guardian/Caregiver Psychoeducation
<input type="checkbox"/> Community Connections and Natural Supports	

\_\_\_\_\_  
**\*\*\* Referral Agent/Provider Signature \*\*\***

\_\_\_\_\_  
Date

**Parent/Legal Guardian Consent**

As the legal guardian of this child, I understand that we have certain rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including right to privacy regarding the child’s protected health information, including information shared in this referral.

I agree for the “Referral Agent” listed above to complete this form and share the information with Autism Delaware for the purposes of referring my child for Family Peer Support Services, including the ACT Program. *I further agree that Autism Delaware Family Support Services staff may contact and speak with the listed referral agent in order to coordinate the referral.*

This consent to share information will be effective for 6 months from the date of my signature below, or until \_\_\_\_\_. I understand that I have the right to revoke this consent at any time and no further information will be shared as of that time.

Como el tutor legal de este niño/a, entiendo que tenemos ciertos derechos bajo la Ley de Portabilidad y Responsabilidad de Seguros de Salud (HIPAA por sus siglas en ingles), incluyendo el derecho a privacidad sobre la información de salud protegida, incluyendo la información compartida con este referido.

Estoy de acuerdo que el “agente que está refiriendo” que esta listado previamente llene este formulario y comparta información con Autism Delaware con el propósito de referir a mi hijo/a para los Servicios de Apoyo de Familia, incluyendo el programa ACT. Incluso estoy de acuerdo que el personal de Servicio de Apoyo para Familias de Autism Delaware podrá contactar y hablar con el agente listado en esta referencia para poder coordinar el referido.

Este permiso para compartir información será efectivo por 6 meses desde la fecha de la firma de abajo, o hasta \_\_\_\_\_. Entiendo que tengo derecho de revocar este permiso en cualquier momento y desde esa fecha no se compartirá más información.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Parent/Guardian Name