## Ryan White HIV/AIDS Program Part B (Area 7)

# Mental Health Referral Form: Initial

*This form shall be completed by the client's case manager and faxed to the mental health provider. The referring agency and the mental health provider shall maintain a copy in the client's record. The referring agency shall submit a new Initial Referral form to the mental health provider at the beginning of each contract year for clients requiring continued care.*

This referral is valid for up to 15 visits in the contract year for uninsured clients. Insured clients could be eligible for co-pay assistance.

**Client Name:** _____ **DOB:** _____ **Phone:** _____

**Agency:** _____ **NOE Exp.:** _____ **Acuity Level:** ☐ **1** ☐ **2**

**Insurance Status:**

☐ **Insured***

☐ Medicare ☐ Tricare ☐ Magellan ☐ Aetna

☐ Cigna ☐ UHC/Optum ☐ Blue Cross Blue Shield

*Attach copy of insurance card to confirm coverage

☐ **Uninsured**

**Service Requested:** ☐ Counseling ☐ Psychiatry

**Reason for Referral:**

☐ Active crisis occurring

☐ Current or past history of mental illness or symptoms

☐ Condition impacting adherence to HIV care

☐ Need for continued medication management

**Case Manager:** _____ **Date:** _____

## This referral expires on the 31st of March of the current contract year.

Additional visits must be requested by the mental health provider based on the client's treatment plan and authorized by the case management agency.

Case conferencing is required in order to request an additional 11 visits and shall be documented in a case note. The request shall be documented with the completion of the Follow-Up Referral Form.