



# Crossroads Counseling Centers

a branch of Children's Services of Virginia, Inc.  
Strengthening Individuals and Families

- Harrisonburg**  
Phone: 540.801.0885  
Fax: 540.801.8221
- Luray**  
Phone: 540.843.2509  
Fax: 540.843.2512
- Manassas**  
Phone: 703.361.1525  
Fax: 703.361.3395
- Winchester**  
Phone: 540.662.7007  
Fax: 540.662.1311
- Woodstock**  
Phone: 540.459.9003  
Fax: 540.459.9015

## REFERRAL/INTAKE APPLICATION

**I. Service Type:**  EI  IIH  Mentoring (BSS)  ISBSS  OP  MHS  TDT  TILS  Group: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip + 4: \_\_\_\_\_

SSN#: \_\_\_\_\_ DOB: \_\_\_\_\_  M  F Grade/Occupation: \_\_\_\_\_

Parent (s)/Foster Parent/Legal Guardian (circle one): \_\_\_\_\_

Phone (H) and (C): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip + 4: \_\_\_\_\_

Medicaid #: \_\_\_\_\_

**II. Presenting Needs:** \_\_\_\_\_

Past and Current Therapy: \_\_\_\_\_ Medications: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Name of School/Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Contact Person School/Employer: \_\_\_\_\_ Permission to Contact:  Yes  No

Current Living Arrangements: \_\_\_\_\_

Family Functioning: \_\_\_\_\_

Referral Agency: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Requested hours of service per week: \_\_\_\_\_ Requested hours of service per month: \_\_\_\_\_

### FOR OFFICE USE ONLY

Date Medicaid Checked: \_\_\_\_\_ Verification #: \_\_\_\_\_ Medicaid/MCO \_\_\_\_\_ Code: \_\_\_\_\_

Eligibility Dates: \_\_\_\_\_ Weeks/Unit Available: \_\_\_\_\_

90801 in last 12 months: \_\_\_\_\_ Copy of Card  Other Insurance: \_\_\_\_\_

**Diagnosis and Code:** Axis I \_\_\_\_\_

Clinical Director's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Staff person taking call:** \_\_\_\_\_

Service Fee (per unit): \_\_\_\_\_  EI  IIH  Mentoring (BSS)  ISBSS  OP  MHS  TDT  TILS  Group: \_\_\_\_\_

Original Funding Source: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Assigned Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Transfer of Service/Funding:**  EI  IIH  Mentoring (BSS)  ISBSS  OP  MHS  TDT  TILS  Group: \_\_\_\_\_

New Funding Sources: \_\_\_\_\_ Effective Date: \_\_\_\_\_

New Assigned Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Client Discharge From:**  EI  IIH  Mentoring (BSS)  ISBSS  OP  MHS  TDT  TILS  Group: \_\_\_\_\_

Discharge Date: \_\_\_\_\_ Discharge Summary Completed:  Yes  No