Southeast Missouri State University Autism Center
Request for Services / **Referral Form- DDD Contract**
PLEASE FAX TO: (573) 986-4994
Call for questions or verification of receipt of referral: (573) 986-4985
Serving the Counties Supported by Sikeston and Poplar Bluff Regional Offices.

Client Full Name _____ DOB _____ DMH# _____

Parent/Legal Guardian Name _____ Primary Phone: _____

Client Address _____
Street City Zip Code

Other Contact Information: (second phone; email; etc) _____
SPECIFY TYPE OF CONTACT

Primary Diagnosis_____ Other Diagnoses: _____

Referring Official (Name/Title): _____ Email: _____

Referring Official Phone: _____ Regional Office/ SB40 Board: _____

Has the Utilization Review been completed? ***NO*** ***YES*** ***(Please enclose meeting notes or confirmation)***

Please check the category and provide a brief description of the service requested or attach treatment plan/ meeting notes
Date faxed _____

Service (CIMOR waiver code/non waiver code)

- ☐ Behavior Analyst Services
  (H2019 HO/491611 – Sr Behavior Consultant)
  (H2019/491621- Behavior Intervention Specialist)
- ☐ Functional Behavior Assessment
  (H0002/ 491601)
- ☐ Behavior Therapy
  (H0004/ none listed)
- ☐ Counseling (Provided by Psychologist)
  (H0004 TG/ 35A00H)
- ☐ Parent/ Care Giver Training
  (none listed/ 9200H)
- ☐ Psychological Evaluation
  (none listed/ 1200H)
- ☐ Speech Therapy (includes Social Cognition Therapy)
  (92507/73000H)
- ☐ Speech/Language Evaluation
  (none listed/ 15000H)
- ☐ Outreach Services : Information/Education
  (none listed/ 94000H,940001]

Specify / Describe services requested or other relevant information regarding this referral:

Client Treatment Plan or other documentation verifying services must be received **before** being added to the wait list.

Funding Source(s) Identified:
☐ Medicaid Waiver ☐ Partnership for Hope Waiver ☐ Autism Waiver ☐ SE PAC Funds ☐ None

☐ Other _____