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|  | State of Missouri  Department of Mental Health  Division of Developmental Disabilities  **Southeast Missouri Autism Project**  **Provider Referral/Enrollment Form** |

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| The *Provider Referral/Enrollment* form is only needed for a referral/enrollment with a provider the individual is not currently enrolled with (CIMOR code 52070A). Please review [Support Coordinator Roles & Responsibilities](https://dmh.mo.gov/dev-disabilities/autism/southeast/support) at <https://dmh.mo.gov/dev-disabilities/autism/southeast/support>. | | | | | | | |
| Name  Click or tap here to enter text. | | | | | Provider Referral/Enrollment Reason  Choose an item. | | |
| DMH ID  Click or tap here to enter text. | | Regional Office Choose an item. | | | Medicaid Number  Click or tap here to enter text. | | |
| Referral Date  Click or tap here to enter text. | | | | | Date of Birth  Click or tap here to enter text. | | |
| Living Arrangement  Choose an item. | | | Communication Method  Choose an item. | | | | |
| Referral/Enrollment Request for  Choose an item. | Referral/Enrollment Request for  Choose an item. | | | | | | Referral/Enrollment Request for  Choose an item. |
| **Parent/Guardian Contact Information** | | | | | | | |
| Name Click or tap here to enter text. | | | | | | | |
| Street Address Click or tap here to enter text. | | | | | | | |
| City, State Zip Click or tap here to enter text. | | | | | | County Click or tap here to enter text. | |
| Is Guardian someone other than parent? Choose an item.  If yes, explain Click or tap here to enter text. | | | | | | | |
| Guardian’s Preferred Contact Method | | | | Time of day to contact | | | |
| Home/Cell phone Click or tap here to enter text. | | | | Click or tap here to enter text. | | | |
| Work phone Click or tap here to enter text. | | | | Click or tap here to enter text. | | | |
| Email Click or tap here to enter text. | | | | Click or tap here to enter text. | | | |
| **Individual/Parent/Guardian/Designated Representative Certification & Signature(s)**  I certify that I have selected the provider(s) and services(s) on this document based on identified needs. | | | | | | | |
| Individual Signature | | | | | | | Date Click or tap to enter a date. |
| Parent/Guardian/Designated Representative Signature | | | | | | | Date Click or tap to enter a date. |
| **Support Coordinator Certification & Signature**   1. I certify that the individual/parent/guardian/designated representative has selected the provider(s) and service(s) in this document based on identified needs. 2. I certify that the need for each service has been justified in the ISP. 3. I certify any request for multiple providers for a service has been justified in the ISP. | | | | | | | |
| Support Coordinator Name Click or tap here to enter text. | | | | | | | |
| Email  Click or tap here to enter text. | | | | | | | Phone  Click or tap here to enter text. |
| Support Coordinator Signature | | | | | | | Date  Click or tap to enter a date. |