2695 South Jersey Street Denver, CO 80222 | 303.759.1192 | Fax 303.759.1194 | info@fireflyautism.org | www.fireflyautism.org

NEW CLIENT REFERRAL FORM

Date ___________________ **Date Recv'd_____________**
(Office Use)

CLIENT INFORMATION

Full Legal Name:_______________________________________ Preferred/Nickname?: _________________________

Address: ____

City: ________________________________ State: ____________ Zip: ___________ County: _________________________

Date of Birth: _________________________ Gender: ______________ Race: _________________________________

Autism Spectrum Disorder (ASD) diagnosis? Y / N Intellectual Disabilities Diagnosis (IDD)? Y / N

Any other relevant diagnosis(es) or condition(s)?: ____

PROGRAM OF INTEREST FOR CLIENT

Please indicate which of the following services you are interested in enrollment with at this time:

______ **Center Based <u>Early Childhood</u>** (Clients who are between the ages of 2-5 in need of center-based therapy)
_____ Full-day _____ Half-day

______ **Center Based <u>School Age or Young Adult</u>** (Clients who are between the ages of 6-21 and in need of center-based therapy.)
**Pending authorization by the child's school district*

______ **Home-Based Services** (Clients who could benefit from ABA (applied behavior analysis) therapy in the home and/or community)
Availability: Mon: AM_____ Tues: AM_____ Wed: AM_____ Thurs: AM_____ Fri: AM_____ Sat: AM_____ Sun: AM_____
PM_____ PM_____ PM_____ PM_____ PM_____ PM_____ PM_____

______ **Social Skills Groups** (Clients who could benefit from brief regular social interaction with peers 1-2 times a week)

______ Additional Services:

_____ Speech and Language Pathology
_____ Occupational Therapy
_____ Other (Please explain) ____

REFERRAL INFORMATION

Who referred you to Firefly Autism?

Name: ____ Phone: ( ) ____________________________

Title: ____ Organization/Agency: ____________________________________

PARENT/LEGAL GUARDIAN INFORMATION 1

Name of Parent/Legal Guardian: ____

Relationship to child: ___**MOTHER** ___**FATHER** ___**OTHER (Specify):**___________________________

___Biological ___Adoptive ___Step-Parent ___Foster ___Grandparent ___ Other (Specify):____________

Address: ____

Home Phone: ( ) ____________ Work Phone: ( ) ____________ Cell: ( ) ____________

Email: ____

PARENT/LEGAL GUARDIAN INFORMATION 2

Name of Parent/Legal Guardian: ____

Relationship to child: ___**MOTHER** ___**FATHER** ___**OTHER (Specify):**___________________________

___Biological ___Adoptive ___Step-Parent ___Foster ___Grandparent ___ Other (Specify):____________

Address: ____

Home Phone: ( ) ____________ Work Phone: ( ) ____________ Cell: ( ) ____________

Email: ____

SIBLINGS OF CLIENT

Sibling Name: ______________________ Age: _______ Gender: ____________
Lives in same home as client? Y / N
Anything else you would like to share about this sibling?: ______________________

Sibling Name: ______________________ Age: _______ Gender: ____________
Lives in same home as client? Y / N
Anything else you would like to share about this sibling?: ______________________

Sibling Name: ______________________ Age: _______ Gender: ____________
Lives in same home as client? Y / N
Anything else you would like to share about this sibling?: ______________________

CURRENT PRIMARY CARE PHYSICIAN OF CLIENT

Physician's Name: ______________________ Clinic/Office: ______________________

Address: ____

Phone: ( ) ______________________ Fax: ( ) ______________________

CURRENT/PREVIOUS THERAPY INFORMATION

Type of service: ___________________________________ Date range of treatment (MM/YYYY): ____________________________

Name of provider: ____ Phone: ( ) ________________________________

Type of service: ___________________________________ Date range of treatment (MM/YYYY): ____________________________

Name of provider: ____ Phone: ( ) ________________________________

Type of service: ___________________________________ Date range of treatment (MM/YYYY): ____________________________

Name of provider: ____ Phone: ( ) ________________________________

Anything else you would like to share about this person's current or previous therapies?:

____

CURRENT SCHOOL, TREATMENT FACILITY, PRESCHOOL, OR OTHER

Name of facility: ____ Grade Level (if school): _______________

Address:____

Date range enrolled (MM/YYYY): _____________________

Has an individualized education program (IEP)? Y / N Has an individual family service plan (IFSP)? Y / N

EDUCATIONAL PROFILE

Please indicate schools attended in chronological order.

School Name	City/State	Grade Level	Attendance Date Range (MM/YYYY)

Has this person ever received special education services? Please explain:

____

Any current school programs? Please explain:

____

Has this person ever received any developmental evaluation or testing in the past? Please explain:

____

Notice to Families Funded through HIMAT

If you are unsure of how much funding is available for your child within your insurance plan year, please contact your insurance provider to obtain that information. **Before any services can start with Firefly, authorization must be provided in writing from your healthcare insurer.** Please contact your insurance provider to find out if you are eligible for the HIMAT funding. Be specific in asking whether or not your insurer will cover ABA Therapy (Applied Behavior Analysis).

INSURANCE AND/OR FUNDING INFORMATION

Firefly can accept: *Aetna, Anthem BCBS, Cigna, Kaiser Permanente, Tricare, United Healthcare, Bright Health Plan, Medicaid (Health First Colorado)*

Insurance name: ____ Co-Pay for Specialty Services: $ ___________________

Plan #: ________________________________ Group #: ______________________ Plan renewal date: _______________________

Customer service phone number: ( ) _____________________________

Name of Insurance Cardholder: ____ Social Security Number: ___________________

Relationship to client: _____________________________ Date of birth: _________________________

Name of Employer: ____

MEDICAID INFORMATION / WAIVER STATUS

Currently enrolled in a Medicaid waiver program, HealthFirst Colorado, or Medicaid State Plan? Y / N

If YES, which program?: _______________________________________ Medicaid Identification Number: ________________________

Applied for a Medicaid waiver? Y / N

If YES, which waiver?: ___CWA ___CES ___Other:___________________________________

Currently on Medicaid waiver waiting list? Y / N.

If YES, which waiver?: ___CWA ___CES ___Other: ___________________________________

FINANCIAL ASSISTANCE FROM FIREFLY AUTISM

Firefly Autism has limited availability and limited amounts of financial aid available to offer.

If you have interest in obtaining Firefly's financial aid when it becomes available, please check **ONE** of the boxes below:

______ I qualify for FRL (Free and Reduced Lunch)
______ I qualify for "middle class relief": We have an income of $52,000 or less and a family of 4 or more.
______ Please send us a federal worksheet to figure out our family's eligibility.

I attest that this information is true and correct to the best of my knowledge.

____ _______________________________________ ______________________
Signature Printed Name Date

FAMILY SUPPORT QUESTIONNAIRE

We are in contact with our local community centered board (CCB). Y /N

If YES, which CCB?: ____ Contact Name: _______________________________________

We need assistance obtaining siblings programs or support. Y / N
We need assistance obtaining educational advocates. Y / N
We need financial assistance. Y / N
We need parent training or family education. Y / N
We would like to know how we can help other families. Y / N

Any other family support needs or concerns?: ____