







## The Department of Medical Assistance Services Community Stabilization (S9482) Referral Form

| MEMBER INFORMATION   |                      |                                      |                      |
|--|----------------------|--------------------------------------|----------------------|
| Member First Name:   |                      | Member Last Name:                    |                      |
| Medicaid #:  |                      | Member Date of Birth:                |                      |
| Member Plan ID #:  |                      | Gender:                              |                      |
| Member Address:  |                      |                                      |                      |
| City, State, ZIP:  |                      |                                      |                      |
| Member Phone #:  |                      |                                      |                      |
| Parent/Guardian Name   |                      | Parent/Guardian                      |                      |
| (if applicable):   |                      | Phone # (if applicable):             |                      |
| DEFENDING  | DDOVIDED INFORMATION | CORARALIBUTY CT                      | CARLIZATION PROVIDER |
|  | PROVIDER INFORMATION |                                      | ABILIZATION PROVIDER |
| Organization Name:   |                      | Organization Name:                   |                      |
| Provider Phone #:  |                      | Provider Phone #:                    |                      |
| Provider E-Mail:   |                      | Provider E-Mail:                     |                      |
| Provider Address:  |                      | Provider Address:                    |                      |
| City, State, ZIP:  |                      | City, State, ZIP:                    |                      |
| Provider Fax #:  |                      | Provider Fax #:                      |                      |
| Clinical Contact Name & Credentials:   |                      | Clinical Contact Name & Credentials: |                      |
| Clinical Contact Phone #:  |                      | Clinical Contact Phone #:            |                      |
| Cimical Contact I Hone #.  |                      | Cililical Contact i Hone #.          |                      |
| REASON FOR REFERRAL  |                      |                                      |                      |
| Date of Discharge/anticipated discharge:   |                      |                                      |                      |
| By my signature (below), I am attesting that 1) I have performed care coordination activities and collaborated with the Community Stabilization provider as part of my discharge planning 2) the member is in need of Community Stabilization Services as part of a comprehensive discharge plan.  Signature (actual or electronic) referring provider:  Printed Name of referring provider: |                      |                                      |                      |
| Title:   |                      |                                      |                      |
| Credentials (if applicable):   |                      |                                      |                      |
| Date:  |                      |                                      |                      |