



REFERRAL FOR MST SERVICES

Today's Date:		Payment Method (CIRCLE ONE): <input type="checkbox"/> INS <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHILD WELFARE FUNDS <input type="checkbox"/> OTHER			
First Name (Child):		MI	Last Name (Child):		<input type="checkbox"/> M <input type="checkbox"/> F
Child's DOB:	SS #:		School:		Grade:
Mother's Name(s):			Father's Name:		
Address (City/St/Zip):				Phone (H):	
				Phone (W):	
County of residence			Medicaid # (if applicable)		
Presenting Problems: <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>					
Current & Past Treatment					
<hr/> <hr/> <hr/>					
Is the child or family currently receiving Medicaid benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
Contact Person is:				Phone:	
Is the child a ward of the State of Nebraska? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
Contact Person is:				Phone:	
Is the child committed to Probation/Diversion <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
Contact Person is:				Phone:	
Person and / or Agency referring and their phone #:					
Has the family been informed of referral by you or your agency? <input type="checkbox"/> Yes <input type="checkbox"/> No					

I authorize the release of this information to Mid-Plains Center for Behavioral Health Care _____

Parent and/or Legal Guardian Signature

Date

Referrals may be emailed or faxed to the following:
mst@midplainscenter.org
Fax: 308-385-1105

Assigned to _____

For phone inquiries please call:
Lincoln Area: 402-261-9273
Grand Island/Kearney Area: 308-627-6302

Date Assigned _____ by _____