REFERRAL FOR MST SERVICES

Today's Date:	Payment Method (CIRCLE ONE): ☐ ***INS*** ☐ ***MEDICAID*** ☐ CHILD WELFARE FUNDS ☐ OTHER		
First Name (Child):	MI	Last Name (Child):	☐ ***M*** ☐ 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:

Current & Past Treatment

Is the child or family currently receiving Medicaid benefits? ☐ ***Yes*** ☐ No ☐ Unknown

Contact Person is: Phone:

Is the child a ward of the State of Nebraska? ☐ Yes ☐ ***No*** ☐ Unknown

Contact Person is: Phone:

Is the child committed to the Office of Juvenile Services? ☐ Yes ☐ ***No*** ☐ 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? ☐ ***Yes*** ☐ **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:

Terry or Sandra
mst@midplainscenter.org
Fax 308-385-1105
Off 308-385-5250 Ext 1037

Assigned to _____

Date Assigned _____ by _____