REFERRAL FOR PCIT 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)		

Indication of Which Parental Figure(s) Will Be Participating in PCIT and Detailed Description of Presenting Problem:

_____

_____

_____

_____

_____

_____

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 mailed or faxed to the following:

Mid-Plains Center
914 Bauman Dr. Grand Island NE, 68801

Fax 308-385-5271
Off 308-385-5250

Assigned to _____

Date Assigned _____ by _____