Mid-Plains Center for Behavioral Healthcare Services, Inc.

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 Probation/Diversion ☐ 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:
mst@midplainscenter.org
Fax 308-385-1105

Assigned to _____

Date Assigned _____ by _____

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