REFERRAL FOR MST SERVICES

Today's Date:	Payment Method (CIRCLE ONE): OPT 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:
mst@midplainscenter.org
Fax 308-385-1105

For phone inquiries please call:
Lincoln Area: 402-261-9273
Grand Island/Kearney Area: 308-385-5250 Option 5

Assigned to _____
Date Assigned _____ by _____