Community Integrated Health Services

School Based Services Referral Form

Our School Based Services program offers a full spectrum of behavioral health services. Based on individuals needs we can provide mental health services to include case management, prescriber services, and peers.

This is a voluntary program for individuals who are eligible for Medicaid, who have a primary behavioral health diagnosis, and who meet program eligibility standards.

Instructions:

- Please complete this referral form and attach a copy of your insurance card and any additional information if available.
- Submit this referral form and any attachments in person or via:
  - Email Scheduling@cihealthservices.com
  - Fax: (844) 554-3370 or (360) 748-4480
  - Postal Mail (see last page for mailing addresses.)
- CIHS will confirm receipt of the referral and will contact you within one business day of receipt of request.
- Check the county where you anticipate services being provided:

  ☐ Cowlitz ☐ Lewis

- How did you hear about us? _____

Referent Information

Are you Self Referring? ☐ Yes ☐ No (if yes skip to next section)

Date: _____ Agency Name: _____

Referring School Name and District:_____

☐ Early Childhood Education ☐ Elementary School ☐ Middle School ☐ High School

Contact Name: _____ Job Title: _____

Contact Email Address: _____

If the parent/guardian has been contacted and are waiting for CIHS to call and schedule an intake, please mark this box: ☐

Student Information

First & Last Name: _____ Grade: _____

Birthdate: _____ Preferred Gender Pronoun: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Cell Phone: _____ Home Phone: _____

If the Youth is 13 years of age or older, they can legally consent to behavioral health treatment on their own. If the youth does not wish to have Medicaid Insurance statements or other treatment-related correspondence sent to the above mailing address please mark this box: ☐

If the Youth is 13 years of age or older; does that Youth want their parent/guardian to have knowledge of the referral: ☐ Yes ☐ No

Parent/Guardian Information

First & Last Name: _____

Relationship: _____ Phone: _____

First & Last Name: _____

Relationship: _____ Phone: _____

First & Last Name: _____

Relationship: _____ Phone: _____

Reason for Referral

Briefly tell us why you feel this child would benefit from our services:

Community Integrated Health Services Mailing Addresses:
Cowlitz County: 1116 14th Avenue, Longview, WA 98632
Lewis County: 1707 Cooks Hill Road, Centralia, WA 98531

Phone: (360) 261-6930 or (855) 303-4834 | Fax: (360) 748-4480 or (844) 554-3370
Website: www.cihealthservices.com

For Office Use Only:

Received By: _____Date: _____

Received Via: ☐ Email ☐ Fax ☐ Mail ☐ In-Person ☐ Other_____

Provider One # _____