

**Children's Services Act (CSA) Referral for Residential Treatment Services**

*The top portion of the form is to be completed by the Authorized CSA; once completed, please forward to the Residential Treatment Provider to complete the bottom portion of the form.*

**Name of Youth:** \_\_\_\_\_

**Medicaid Number:** \_\_\_\_\_

**Residential Treatment Provider:** \_\_\_\_\_

**Name of Locality:** \_\_\_\_\_ **FIPS/CSA Locality Code:** \_\_\_\_\_

I certify that this youth has been referred by the local CSA for:

Therapeutic Group Home Services (this includes Early and Periodic Screening, Diagnostic and Treatment (EPSDT) TGHs)

Psychiatric Residential Treatment Facility Services (this includes EPSDT PRTFs)

Effective Date of Residential Admission: \_\_\_\_\_

This youth is in the custody of the local department of social services and has been determined eligible for title IV-E

Yes

No

*For Medicaid members, CSA may not pay for any service that can be funded through Medicaid.*

Authorized CSA Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**For Provider Use Only**

*Once this portion is complete, please forward to the Service Authorization Contractor*

**NPI:** \_\_\_\_\_

**Provider Address:** \_\_\_\_\_

Street

City

State

ZIP