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: _____

<u>For Provider Use Only</u>

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

NPI: _____

Provider Address: _____

Street

_____

City State ZIP