CLEAR

The Department of Medical Assistance Services
Community Stabilization (S9482) Referral Form

MEMBER INFORMATION			
Member First Name:		**Member Last Name:**	
Medicaid #:		**Member Date of Birth:**	
Member Plan ID #:		**Gender:**	
Member Address:			
City, State, ZIP:			
Member Phone #:			
Parent/Guardian Name (if applicable):		**Parent/Guardian Phone # (if applicable):**	

REFERRING PROVIDER INFORMATION		COMMUNITY STABILIZATION PROVIDER	
Organization Name:		**Organization Name:**	
Provider Phone #:		**Provider Phone #:**	
Provider E-Mail:		**Provider E-Mail:**	
Provider Address:		**Provider Address:**	
City, State, ZIP:		**City, State, ZIP:**	
Provider Fax #:		**Provider Fax #:**	
Clinical Contact Name & Credentials:		**Clinical Contact Name & Credentials:**	
Clinical Contact Phone #:		**Clinical Contact Phone #:**	

REASON FOR REFERRAL
Date of Discharge/anticipated discharge:_____

By my signature (below), I am attesting that 1) I have performed care coordination activities and collaborated with the Community Stabilization provider as part of my discharge planning 2) the member is in need of Community Stabilization Services as part of a comprehensive discharge plan.

Signature (actual or electronic) referring provider:_____

Printed Name of referring provider: _____

Title: _____

Credentials (if applicable):_____

Date: _____