Department of Social Services
Division of Behavioral Health
605-773-3123

HIGH INTENSITY REFERRAL FORM

TO BE COMPLETED BY REFERRAL AGENCY

*All fields are REQUIRED. Incomplete forms will be returned*

Client's First and Last Name:____

STARS ID:____________________

DOB__________ **Last 4 of Social Security #**______ **Mother's First Name**__________

Street Address____

City________________ **State**______ **Zip Code**__________ **County**__________

Home Phone # ____________ **Cell Phone #** ______________

Date Approval Form Completed:__________ **Date Assessment Completed:**_________

Agency Submitting the request:_____________________________

Agency Contact Person:_____________________________

Email Address:____

Provider Recommended ASAM Level of Care: ________________________________

Provider Recommended Placement:____

Please check boxes if the following applies: IVC County:____________________

Pregnant (EDD date:____________) Medicaid Number_______________________

☐ Currently on probation/parole **JCA/CSO/Parole Agent/:**_____________________

☐ Pending legal charges ☐ Currently incarcerated County of charges______________

List of pending legal charges

☐ IV drug use in the last 30 days ☐ IV Drug use lifetime

☐ Current Heroin Drug Use ☐ Current Prescription (Opioid) Drug Use

Level of Motivation to change

- All referrals must include:
  - ☐ Release of information signed by the client
  - ☐ Financial means form
  - ☐ Completed integrated assessment which matches the recommended level of care being made on this form
- Medicaid funded referrals must include a physician referral that medical necessity exists
- Pregnant Women or Pregnant Adolescent referrals must also include a Physicians Letter verifying pregnancy with estimated due date (EDD).

Please send completed forms to the Division of Community Behavioral Health via fax at (605)367-5239 or email at: DSS.DCBHTNANotifications@state.sd.us.